Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF REMOVAL OF CONDITIONAL LICENSE

Electronic Delivery

April 24, 2024

Licensee
Fantum Home Health Care, LLC
8032 France Avenue North
Brooklyn Park, MN 55443

RE: Provisional Conditional License Number 411494
Health Facility Identification Number (HFID) 39851
Project Number(s) SL39851015

Dear Licensee:

On March 28, 2024, The Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed February 1, 2024. The follow-up survey found the facility to be in substantial compliance. Based on these findings, the condition(s) on the license were removed effective April 24, 2024.

Effective April 24, 2024, MDH is granting your Assisted Living Facility facility license. Your license effective and expiration dates remain the same as on your provisional license. Your license number is 411494. You will not receive a replacement license certificate until your license is due to renew. If you have not received a letter from us with information regarding renewing your license within 60 days prior to your expiration date, please contact us at (651) 201-5273 or by email at: Health.assistedliving@state.mn.us.

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

Sincerely,

Rick Michals

Rick Michals, J.D.
Interim Assistant Division Director

Minnesota Department of Health
Health Regulation Division

PMB

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF PROVISIONAL EXTENSION AND CONDITIONAL LICENSE

Electronically Delivered

March 7, 2024

Licensee
Fantum Home Health Care, LLC
8032 France Avenue North
Brooklyn Park, MN 55443

RE: Provisional Conditional License Number 411494
Health Facility Identification Number (HFID) 39851
Project Number(s) SL39851015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on February 1, 2024, for the purpose of assessing compliance with state licensing statutes. Based on the survey results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, pursuant to Minn. Stat. § 144G.16, Subd. 3(b), MDH is issuing a 90-day conditional provisional license due to expire on **June 5, 2024**.

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

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

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the provisional licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval. **If corrections are not made, MDH may impose fines as described above and in accordance with Minnesota Statutes 144G.**

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.

- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

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

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

To submit a reconsideration request, please visit:

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

CONDITIONAL LICENSE ISSUED:
MDH will issue Fantum Home Health Care, LLC a conditional provisional assisted living facility license for 90 calendar days from the date of this notice. At an unannounced point in time, within the 90 calendar days, MDH will conduct a follow-up survey, as defined in Minn. Stat. § 144G.30, Subd. 6. Based on the results of the follow-up survey, MDH will determine if Fantum Home Health Care, LLC is in substantial compliance.

The following conditions apply:

a. **Health Facility Construction Permit:** Fantum Home Health Care, LLC, will contact The Minnesota Department of Labor and Industry (MNDLI) and obtain a construction permit for a health facility. Within 14-days from the date of this notice, Fantum Home Health Care, LLC, will provide MDH with a copy of the permit obtained from MNDLI.

b. **General Contractor:** Fantum Home Health Care, LLC must provide the following to Casey DeVries (casey.devries@state.mn.us) via email within two (2) weeks of the date of this notice:

   1. Name
   2. License Number
   3. Contract Information

c. **Egress Window Requirements:** Fantum Home Health Care, LLC will replace at least one window in occupied resident sleeping room #1 meeting the minimum size requirements. At least one window in each resident bedroom must meet the minimum window opening size of no less than 20 inches in width, with a total of at least 648 square inches (4.5 square feet) required for egress, and have a windowsill height from the floor to the clear opening area of 648 square inches and have a minimum dimension of 20 inches in height and a minimum dimension of 20 inches in width and have a windowsill height from the floor to the clear opening of not more than 48 inches. Egress windows must be openable from the inside without the use of keys, tools, or special knowledge.

d. **Follow-up survey:** At the time of the follow-up survey, MDH may pursue additional enforcement actions, up to and including immediate temporary suspension or revocation of the license if MDH identifies any level 3 or 4 violations or widespread care related violations.

RESULTS OF FOLLOW-UP EVALUATION DURING THE CONDITIONAL PROVISIONAL LICENSE PERIOD:
MDH will determine if Fantum Home Health Care, LLC is in substantial compliance based on the results of the follow up survey. MDH will make this determination within the 90-day conditional provisional license period. If MDH determines Fantum Home Health Care, LLC is in substantial compliance on the follow up survey, MDH will remove the conditions from Fantum Home Health Care LLC's assisted living facility provisional license, and Fantum Home Health Care, LLC will correct violations identified during the survey to come into substantial compliance. If MDH determines Fantum Home Health Care, LLC is not in substantial compliance, MDH may take additional enforcement action against Fantum Home Health Care, LLC, including placement of additional conditions, issuing an extension to the conditional provisional license, or employ any of the enforcement tools listed in Minn. Stat. § 144G.20 up to and including immediate temporary suspension and revocation.

REQUEST FOR RECONSIDERATION:
Pursuant to Minn. Stat. §144G.16, Subd. 4, if a provisional licensee whose assisted living facility license has been denied, or extended with conditions, disagrees with the action taken against the provisional license under this section, the provisional licensee may request a reconsideration no later than 15 calendar days after provisional licensee receives notice of the action. To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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

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

Sincerely,

Rick Michals

Rick Michals, J.D.
Interim Assistant Division Director

Minnesota Department of Health
Health Regulation Division

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39851	A. BUILDING: _____ B. WING _____	02/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FANTUM HOME HEALTH CARE LLC	8032 FRANCE AVENUE NORTH BROOKLYN PARK, MN 55443

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(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: SL39851015-0 On January 29, 2024, through February 1, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were five residents: five receiving services under the Assisted Living license. An immediate correction order was identified on January 29, 2024, issued for SL39851015-0, tag identification 0820. On January 31, 2024, the immediacy of correction order 0820 was removed, however non-compliance remained, and the scope and level remained unchanged.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470		

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0 470	Continued From page 1 determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a written staffing plan that included an evaluation completed by the clinical nurse supervisor (CNS) (as indicated in Minnesota Administrative Rule 4659.0180) at least twice a year. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 470		

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0 470	Continued From page 2 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 staffing plan was a template that had not been customized to the licensee. On February 1, 2024, at approximately 1:00 p.m., licensed assisted living director (LALD)-C and administrator (A)-D, during an interview stated that the registered nurse had previously not been involved in the development of the licensee's staffing plan but would be expected to participate in future staffing plans. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was	0 480		

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0 480	Continued From page 3 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 January 29, 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		
0 660 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.	0 660		

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0 660	Continued From page 4 This MN Requirement is not met as evidenced by: Based on 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), which included a two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test for one of four employees (registered nurse (RN)-A). 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: RN-A was hired January 16, 2023, to provide assisted living services. RN-A's employee record contained TB history and symptom screening dated January 12, 2023, two days prior to employment. RN-A's employee record also contained a TB history and symptom screen from October 11, 2022, which indicated a past positive TB result as well as a T-Spot TB blood test indicating which indicated that RN-A was currently negative for TB, dated October 11, 2022. RN-A's employee record lacked documentation of a chest x-ray to verify negative results.	0 660		

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0 660	Continued From page 5 On January 31, 2024, at approximately 3:00 p.m., administrator (A)-D verified that RN-A's employee record was accurate, and that the licensee's practice was to accept Tb blood tests and chest x-rays up to 90 days prior to hire. The licensee's current TB risk assessment completed July 22, 2023 indicated a low risk level. The Minnesota department of health's,"Regulations for Tuberculosis Control in Minnesota Health Care Setting, A guide for implementing tuberculosis (TB) infection control regulations in your facility" dated July 2013 indicated the following: Before the health care worker (HCW) has direct patient contact, the following should be documented in their record: 1. Test result, 2. Assessment for current TB symptoms, 3. Chest X-ray to rule out infectious TB disease. The chest X-ray should be done after the date of the positive TST or IGRA; however, a chest X-ray done within the three months prior to the TST/IGRA is acceptable, provided that the HCW has not been exposed to infectious TB disease since the chest X-ray was done, and 4. Medical evaluation to rule out a diagnosis of infectious TB disease. The CDC's Morbidity and Mortality Weekly Report, "Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Settings, 2005", dated December 30, 2005, indicates the following: HCWs with a baseline positive or newly positive test result for M. tuberculosis infection (i.e., TST or BAMT) or documentation of treatment for LTBI	0 660		

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0 660	Continued From page 6 or TB disease should receive one chest radiograph result to exclude TB disease (or an interpretable copy within a reasonable time frame, such as 6 months). Repeat radiographs are not needed unless symptoms or signs of TB disease develop or unless recommended by a clinician. The licensee's undated Tuberculosis Screening policy indicated that each employee or volunteer having direct contact with resident must have documentation of baseline health symptom screening prior to providing care to residents. This includes, at a minimum, the health symptom screening, TB testing via the Mantoux method. Testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step tuberculin test (TST) or a single blood test. If the employee has proof of a TB blood test or negative Chest X-ray within 90 days of employment, it does not have to be repeated at the time of hire. 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;	0 680		

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0 680	Continued From page 7 (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 maintain a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. 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 provided EPP appeared to be a general template that had not been customized to	0 680		

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0 680	Continued From page 8 the licensee's facility. The licensee's written emergency disaster preparedness plan lacked evidence of the following required content: - A process for cooperation and collaboration with local, tribal, regional, State and Federal EP to maintain integrated response; - Policies and procedures related to subsistence needs for staff and patients; - Policies and procedures for system to track the location of on-duty staff and sheltered residents; - Policies and procedures to shelter in place for residents, staff, and volunteers who remain in the facility; - Policies and procedures to address a system of medical documentation that preserves resident information, protects confidentiality, and secures/maintains availability of records; - Policies and procedures to address the development of arrangements with other facilities/providers to receive residents in the event of limitations/cessation of operations to maintain the continuity of services to residents; - Policies and procedures to address the role of facility under a waiver declared by the Secretary in accordance with section 1135 of the Act; - Policies and procedures to address the development of a written communication plan that is updated on an annual basis; - A written communication plan that includes contact information for Federal, State, tribal, regional & local EP staff, State Licensing and Certification Agency, MN Office of Ombudsman for LTC, and any other sources of assistance; - A written communication plan that includes primary and alternate means of communicating with facility staff and Federal, State, tribal, regional & local emergency management agencies;	0 680		

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0 680	Continued From page 9 - A written communication plan that includes methods for sharing information and medical documentation for residents under the facility's care, as necessary, with other HCPs to maintain continuity of care, means, in event of evacuation, to release resident information as permitted under 45 CFR 164.510(b)(1)(ii) and means of providing information about general condition/ location of residents under the facility's care as permitted under 45 CFR 164.510(b)(4); - A written communication plan that includes a means to providing information about the facility's occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee; and, - A written communication plan that includes methods for sharing information from the emergency plan, that the facility has determined appropriate, with residents and their families/representatives. On February 1, 2024, at approximately 1:00 p.m., administrator (A)-D and licensed assisted living director (LALD)-C acknowledged that the licensees emergency preparedness plan was not complete in its current state and required further customization. The licensee's undated Emergency Management Policy indicated that the facility would have an identified plan in place to ensure the safety and well-being of residents and employees during periods of an emergency or disaster that disrupts facility services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 700	Continued From page 10	0 700		
0 700 SS=F	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure resident's personal health and medical information was kept private for 10 of 10 memory care 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 January 29, 2024, at approximately 5:00 p.m., during a tour of the facility, the surveyor observed a white board in the licensee's dining room. The white board contained resident information related to upcoming medical appointments. On February 1, 2024, at approximately 1:00 p.m., licensed assisted living director (LALD)-C stated that the white board was used to help residents remember their upcoming appointments.	0 700		

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	39851	A. BUILDING: _____ B. WING _____	02/01/2024

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0 700	Continued From page 11 Administrator (A)-D added that residents will also remind each other of upcoming appointments. The licensee's undated Resident Records policy indicated that all resident information shall be regarded as confidential and available to only authorized users, and that resident records, whether written or electronic, will be protected against loss, tampering or unauthorized disclosure in compliance with federal and state laws. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 700		
0 800 SS=D	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect one resident. This practice resulted in a level two violation (a	0 800		

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0 800	Continued From page 12 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: On January 29, 2024, at 5:00 p.m., survey staff toured the home with licensed assisted living director (LALD)-C and administrator (A)-D. The window blinds in occupied resident bedroom 2 were in disrepair. During the facility tour, it was explained that the resident often slides the window open without opening the blinds. During an interview on January 30, 2024, at 2:00 p.m., LALD-C verified the window blinds were damaged and stated these blinds would be replaced. 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	0 810		

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0 810	Continued From page 13 (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 record review and interview, the licensee failed to develop a fire safety and evacuation plan with the required content. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of	0 810		

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0 810	Continued From page 14 the residents). The findings include: On January 30, 2024, the licensed assisted living director (LALD)-C provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and employee evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The FSEP floor plan labels the back door of the garage as an exit. Emergency exits are required to lead directly to the exterior of the building and not through a higher hazard room. The FSEP included a fire policy template and this policy was not developed for use at this facility. The fire policy included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan inappropriately referenced smoke compartment doors, fire sprinklers, and doors on magnetic holders. The employee actions for fire were limited to the acronym RACE (Remove, Alarm, Confine, and Extinguish or Evacuate). The fire policy failed to include specific fire protection procedures necessary for residents evident by limited instructions directing employees to evacuate residents to the nearest safe exit. During an interview on January 30, 2024, at 2:00 p.m., LALD-C verified the fire policy was based on a template and stated the licensee would revise the FSEP.	0 810		

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0 810	Continued From page 15 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 820 SS=G	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the egress window in an occupied resident bedroom met the minimum opening size. This had the potential to directly affect one resident and all staff. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).	0 820	This immediate correction order identified on January 29, 2024, has had the immediacy lifted as of January 31, 2024, however non-compliance remained a scope and level of G.	

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0 820	Continued From page 16 The findings include: On January 29, 2024, at 5:00 p.m., survey staff toured the home with licensed assisted living director (LALD)-C and administrator (A)-D. The egress windows in resident bedrooms were opened and measured. The egress window in bedroom 1, occupied by R3, did not meet the minimum opening size required for safe egress. The double-hung style egress window in bedroom 1 occupied by R3 measured 28 inches in width, 21 inches in height, with a total clear openable area of 588 inches. The egress window in bedroom 1 did not meet the minimum total clear openable area of at least 648 square inches. One window in each resident bedroom must meet the minimum window opening size of at least 20 inches in height and, a minimum width of 20 inches, with a total of at least 648 square inches (4.5 square feet). Additionally, egress windows must be openable from the inside without the use of keys, tools, or special knowledge. During the facility tour interview, LALD-C and A-D verified the egress window measurements. TIME PERIOD FOR CORRECTION: Immediate	0 820		
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility. (b) The contract must include the name,	0 910		

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0 910	Continued From page 17 telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for all of the licensee's residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: On January 31, 2024, at approximately 3:00 p.m., administrator (A)-D verified that the contract provided to the surveyor is used by all new admits to the licensee. The licensee's Residency Agreement/ Assisted Living Contract lacked the following required contents per 144G.50 Subd. 2: - Legal name and health facility identification of the facility; - Name, phone number, and physical mailing address of the licensee;	0 910		

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0 910	Continued From page 18 - The managing agent of the facility; and - Authorized agent of the facility. The licensee's undated Assisted Living Contracts policy indicated the contract must include the following: - The legal name and license number of the facility - The name, telephone number and physical mailing address of the facility, which may not be a post office box; - The name, telephone number and physical mailing address of contracted service provider when applicable; and, - The licensee of the facility, Managing agent of the facility and/or Authorized agent of the facility, if applicable. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 910		
0 920 SS=C	144G.50 Subd. 2 (c) Contract information (c) The contract must include: (1) a disclosure of the category of assisted living facility license held by the facility and, if the facility is not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license; (2) a description of all the terms and conditions of the contract, including a description of and any limitations to the housing or assisted living services to be provided for the contracted amount; (3) a delineation of the cost and nature of any other services to be provided for an additional fee;	0 920		

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0 920	Continued From page 19 (4) a delineation and description of any additional fees the resident may be required to pay if the resident's condition changes during the term of the contract; (5) a delineation of the grounds under which the resident may be transferred or have housing or services terminated or be subject to an emergency relocation; (6) billing and payment procedures and requirements; and (7) disclosure of the facility's ability to provide specialized diets. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for all of the licensee's residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: On January 31, 2024, at approximately 3:00 p.m., administrator (A)-D verified that the contract provided to the surveyor is used by all new admits to the licensee. The licensee's Residency Agreement/ Assisted Living Contract lacked the following required contents per 144G.50 Subd. 2: - Disclosure of category of assisted living facility	0 920		

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0 920	Continued From page 20 license & disclosure if not licensed as an assisted living facility with dementia care. The licensee's undated Assisted Living Contracts policy indicated the contract must include all terms concerning the provision of Housing, Assisted Living Services, and the resident's service plan, if applicable. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 920		
01290 SS=E	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 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 a background study was conducted prior to staff providing services for two of four employees	01290		

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01290	Continued From page 21 (unlicensed personnel (ULP)-B, ULP-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-B ULP-B began employment with the licensee on March 3, 2023, to provide assisted living services. ULP-B's employee record contained a background study clearance dated February 11, 2023, affiliated to licensee's sister facility HFID 36547. ULP-B's record lacked evidence the licensee submitted a background study under the current assisted living license and affiliated to the current HFID number prior to the start of the survey. On January 31, 2024, at 2:00 p.m., the surveyor observed ULP-B administer medications to residents within the facility. ULP-E ULP-E began employment with the licensee on December 8, 2023, to provide assisted living services. ULP-E's employee record contained a background study clearance dated December 7,	01290		

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01290	Continued From page 22 2023, affiliated to licensee's sister facility HFID 36547. ULP-E's record lacked evidence the licensee submitted a background study under the current assisted living license and affiliated to the current HFID number prior to the start of the survey. On January 29, 2024, at 4:00 p.m., administrator (A)-D stated that they were responsible for processing and maintaining employee background checks and had previously missed cross affiliating employees between the facilities operated under the same parent company umbrella. The undated Licensee's Background Studies policy dated August 1, 2021, indicated that the facility requires background screening to be completed on all employees, contractors, and regularly scheduled volunteers. Employees will not be able to start working with residents until the background che3ck clearance has been received by the facility. No further information was provided.	01290		
01530 SS=D	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed	01530		

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01530	Continued From page 23 at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure all staff received eight hours of initial dementia care training within the first 160 working hours of employment for direct care staff as required for one of four employees (unlicensed personnel (ULP)-B) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-B was hired March 3, 2023, to provide	01530		

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01530	Continued From page 24 assisted living services. ULP-B's My Transcript included dementia training courses completed between March 9, 2023, and December 19, 2023, to include a total of six and a one quarter hours (6.25) hours of dementia training. On January 31, 2024, at approximately 3:00 p.m., administrator (A)-D verified ULP-B had worked over 160 hours since the time of their hire and had only completed 6.25 hours of the required eight hours of initial dementia training. The licensee's undated Dementia Care Training policy indicated direct care employees must have completed at least eight hours of initial training on required topics in the 160 hours from employment. Until this training is complete, the employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training related to dementia care who can act as a resource and assist if issues arise. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01610 SS=E	144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective	01610		

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	39851	A. BUILDING: _____ B. WING _____	02/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FANTUM HOME HEALTH CARE LLC	8032 FRANCE AVENUE NORTH BROOKLYN PARK, MN 55443

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01610	Continued From page 25 resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed an initial comprehensive nursing assessment prior to the execution of the assisted living contract/providing services for two of three residents (R1, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 admitted for assisted living services on June 14, 2023. R1 Service Plan (Waiver) Addendum to Contract signed on January 31, 2024, indicated R1 received assistance with ambulation, bathing	01610		

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01610	Continued From page 26 assistance, dressing assistance, grooming, housekeeping, incontinence care, laundry, behavior management, medication administration, skin treatments, and wound care. R1's record indicated the RN completed an initial assessment on June 15, 2023, which indicated one day had passed since start of services. R3 R3 admitted for assisted living services on August 28, 2023. R3's Service Plan (Waiver) Addendum to Contract signed on January 31, 2024, indicated R3 received assistance with activity assistance, bathing assistance, dressing, housekeeping, behavior management, meal assistance, medication administration, and transportation assistance. R3's record indicated the RN completed an admission assessment on August 29, 2022, which indicated 1 day had passed since start of services. The licensee's undated Comprehensive Resident Assessment policy indicated that the facility will complete a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date that a prospective resident executes a contract with a facility or the day the resident moves in, whichever is earlier. On January 31, 2024, at approximately 3:00 p.m., administrator (A)-D verified that R1's initial assessment was completed as a change of condition as they knew her from a previous house.	01610		

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01610	Continued From page 27 No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01610		
01620 SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed a 14-day reassessment for two	01620		

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01620	Continued From page 28 of three residents (R1, R3) and ongoing resident reassessments did not exceed 90 days for one of three residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 R1 admitted for assisted living services on June 14, 2023. R1 Service Plan (Waiver) Addendum to Contract signed on January 31, 2024, indicated R1 received assistance with ambulation, bathing assistance, dressing assistance, grooming, housekeeping, incontinence care, laundry, behavior management, medication administration, skin treatments, and wound care. R1's record included an initial assessment dated June 15, 2023, and a 90-day assessment dated September 30, 2023, indicating that 107 days had passed between assessment dates. R1's record lacked a 14-day assessment. R3 R3 admitted for assisted living services on August 28, 2023. R3's Service Plan (Waiver) Addendum to	01620		

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01620	Continued From page 29 Contract signed on January 31, 2024, indicated R3 received assistance with activity assistance, bathing assistance, dressing, housekeeping, behavior management, meal assistance, medication administration, and transportation assistance. R3's record included an initial assessment completed on August 29, 2023, and a 14-day assessment that was completed on September 30, 2023, which indicated that 32 days had passed between initial and 14-day assessment. On February 1, 2024, at 12:30 p.m., administrator (A)-D verified that there was no 14-day assessment on record for R1. The licensee's undated Comprehensive Resident Assessment policy indicated that resident assessment and monitoring must be conducted no more than 14 days after initiation of services. On-going resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. All assessments will be included in the resident record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer	01910		

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01910	Continued From page 30 part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide documentation in the resident's record regarding the disposition of medication to include medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition for one of one discharged resident (R6). 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:	01910		

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01910	Continued From page 31 R6 was discharged from the licensee on August 16, 2023. R6's diagnoses included depression and post-traumatic stress disorder (PTSD). R6's Discharge - Transfer Summary lacked documentation describing the disposition of R6's medications. On January 31, 2024, at approximately 11:30 a.m., the surveyor observed a bag of medications prescribed to R6. Registered nurse (RN)-A stated that the medications were to be picked up by a previous resident. On January 31, 2024, at 12:02, licensed assisted living director (LALD)-C stated that the medications belonged to a resident that had lived at the facility for a short time. LALD-C stated that they had forgotten about the medications but had initially held on to them with the intent of returning to the resident or the resident's emergency contact. LALD-C stated that they had been unable to reach the prior resident, and the resident's emergency contact, and the resident's case manager had also been unable to contact the resident. The licensee's undated Medication Disposition or disposal policy indicated the following: Drugs Given to Residents When the Medication Management Services Have Been Terminated: - A resident's current medications that are secured or stored by our facility will be given to the resident or the resident's representative when the resident 's medication management services are terminated, except that the conditions listed below must be met before controlled medications	01910		

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01910	Continued From page 32 belonging to a resident will be given to the resident or the resident's representative. - Staff will document in the resident's record the name of the person to whom the medications were given, the time and date, the name of each medication, dose, and the amount of medication remaining. - When the resident and/or family do not take the medications with them, the facility will dispose of the medications following the steps outlined below. Medications to be disposed of will be listed, counted, and the person disposing of the medications will sign the note/form. This documentation will be in the resident record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that	01940		

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01940	Continued From page 33 will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of five residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 admitted to the licensee on June 14, 2023, to receive assisted living services. R1's Service Plan (Waiver) Addendum to Contract signed on January 31, 2024, indicated	01940		

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01940	Continued From page 34 R1 received assistance with ambulation, bathing assistance, dressing assistance, grooming, housekeeping, incontinence care, laundry, behavior management, medication administration, skin treatments, and wound care. R1's signed provider orders dated December 7, 2023, included the following instructions for wound care. - Cleanse with wound cleanser or tap water and gauze, pat dry. - Cut Aquacel Ag into spiral so it's one long "rope" and gently pack tunnel/wound. Make sure you fill the wound depth as far as you are able. - Cover with Mepilex foam dressing. If you run out of these dressings, you can use ABD pad and tape. - I will order supplies and they will be delivered to you. - Change daily. R1's Individualized Treatment and Therapy Plan dated January 30, 2024, indicated that R1 was to receive skin treatments two times daily, but lacked information on prescribed wound care. R1's monthly treatment administration record (TAR) for January 2024, showed documentation for skin treatment two times daily, but lacked information on prescribed wound care. R1's individualized treatment management plan lacked the following required content: - Written statement of treatments and therapies to provide. - Written instructions for each treatment or therapy. - Procedures to notify a registered nurse (RN) or other licensed health professional when problems arose with treatment or therapies.	01940		

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01940	Continued From page 35 On January 9, 2023, at 3:30 p.m., registered nurse (RN)-A stated they were not aware that the treatment plan did not contain required information related to wound care for R1. The licensee's undated Treatment and Therapy Management Plan policy indicated the following information: When the resident has been assessed and orders for treatments and therapies are obtained, an individualized treatment/therapy plan and management record will be developed. The plan will include the following: a. A written statement of the treatment or therapy that will be provided; b. Documentation of specific instructions that relate to providing the treatment or therapy administration; c. Identification of treatment or therapy tasks that will be delegated to unlicensed personnel; d. Procedures for notifying a registered nurse or other licensed health professional if problems arise with the treatment or therapy services; e. Any resident-specific requirements that relate to documentation of treatments and therapy, and direction on where tasks are to be documented; f. Frequency of supervision of personnel providing the delegated treatment or therapy services; g. Verification by the registered nurse that services are administered as prescribed and monitoring of treatment or therapy to prevent complications or adverse reactions; h. The treatment or therapy plan will be updated when there are changes; and i. The Facility may provide Care Plans and other supportive documents to communicate the plan to caregivers by referencing them on the individualized plan.	01940		

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01940	Continued From page 36 No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of five residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).	01960		

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01960	Continued From page 37 The findings include: R1 admitted to the licensee on June 14, 2023, to receive assisted living services. R's1 Service Plan (Waiver) Addendum to Contract signed on January 31, 2024, indicated R1 received assistance with ambulation, bathing assistance, dressing assistance, grooming, housekeeping, incontinence care, laundry, behavior management, medication administration, skin treatments, and wound care. R1's signed provider orders dated December 7, 2023, included the following instructions for wound care. - Cleanse with wound cleanser or tap water and gauze, pat dry. - Cut Aquacel Ag into spiral so it's one long "rope" and gently pack tunnel/wound. Make sure you fill the wound depth as far as you are able. - Cover with Mepilex foam dressing. If you run out of these dressings, you can use ABD pad and tape. - I will order supplies and they will be delivered to you. - Change daily. R1's Individualized Treatment and Therapy Plan dated January 30, 2024, indicated that R1 was to receive skin treatments two times daily, but lacked information on prescribed wound care. R1's monthly treatment administration record (TAR) for January 2024, showed documentation for skin treatment two times daily, but lacked documentation of completed wound care. On January 9, 2023, at 3:30 p.m., registered nurse (RN)-A stated they were not aware that the	01960		

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01960	Continued From page 38 treatment plan did not contain required information related to wound care for R1. The licensee's undated Treatment and Therapy Management Plan policy indicated that each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		
02410 SS=D	144G.91 Subd. 13 Personal and treatment privacy (a) Residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Staff must respect the privacy of a resident's space by knocking on the door and seeking consent before entering, except in an emergency or unless otherwise documented in the resident's service plan. (b) Residents have the right to have and use a lockable door to the resident's unit. The facility shall provide locks on the resident's unit. Only a staff member with a specific need to enter the unit shall have keys. This right may be restricted in certain circumstances if necessary for a resident's health and safety and documented in the resident's service plan. (c) Residents have the right to respect and privacy regarding the resident's service plan. Case discussion, consultation, examination, and	02410		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39851	A. BUILDING: _____ B. WING _____	02/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FANTUM HOME HEALTH CARE LLC	8032 FRANCE AVENUE NORTH BROOKLYN PARK, MN 55443

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02410	Continued From page 39 treatment are confidential and must be conducted discreetly. Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. This MN Requirement is not met as evidenced by: Based on observation, the licensee failed to ensure privacy was maintained during treatment administration for one of five residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 admitted to the licensee on June 14, 2023, to receive assisted living services. R1's Service Plan (Waiver) Addendum to Contract signed on January 31, 2024, indicated R1 received assistance with ambulation, bathing assistance, dressing assistance, grooming, housekeeping, incontinence care, laundry, behavior management, medication administration, skin treatments, and wound care. On January 31, 2024, at approximately 2:30 p.m., the surveyor observed R1 standing in their room with their pants pulled all the way down and shirt pulled up in back to mid torso while leaning over their bed for a dressing change. Blinds on window	02410		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39851	A. BUILDING: _____ B. WING _____	02/01/2024

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02410	Continued From page 40 were left open, and resident was in clear view of any individuals that may have walked past their bedroom window. The Minnesota Bill of Rights for Assisted Living Residents provided to R1 at the time of their admission to the facility on June 14, 2023, indicated the resident have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02410		

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

Type: Full
Date: *01/29/24*
Time: 13:10:55
Report: 1004241015

Food and Beverage Establishment Inspection Report

Location:
Fantum Home Health Care LLC
8032 France Ave N
Brooklyn Park, MN55443
Hennepin County, 27

Establishment Info:
ID #: 0040070
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/22

Operator:

Phone #:
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.

3-300B Protection from Contamination: cross-contamination, eggs

3-302.11A(1) ***** Priority 1 *****

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

RAW SHELL EGGS FOUND STORED OVER PRODUCE IN KITCHEN REFRIGERATOR. DISCUSSED STORAGE ORDER REQUIREMENTS WITH STAFF ON SITE. EGGS WERE MOVED TO BOTTOM DRAWER DURING INSPECTION *CORRECTED ON SITE.

Comply By: 01/29/24

Food and Equipment Temperatures

Process/Item: MILK
Temperature: 41 Degrees Fahrenheit - Location: KITCHEN REFRIGERATOR
Violation Issued: No

Process/Item: AMBIENT TEMPERATURE
Temperature: <38 Degrees Fahrenheit - Location: KITCHEN REFRIGERATOR
Violation Issued: No

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

INSPECTION WAS CONDUCTED BY MOLLY DOUGHERTY (FPLS) IN CONJUNCTION WITH A HEALTH REGULATIONS DIVISION (HRD) SURVEY CONDUCTED BY PEGGY ANDERSON.

DISCUSSED:
-EMPLOYEE ILLNESS POLICY AND LOG
-HANDWASHING
-SANITIZER USE

-CLEANING/SANITIZING FOOD CONTACT SURFACES AND UTENSILS
-HIGH TEMPERATURE SANITIZING DISH MACHINE TEMPERATURE VERIFICATION
-DATE MARKING PROCEDURES
-THERMOMETER USE AND CALIBRATION
-SERVING A HIGHLY SUSCEPTIBLE POPULATION (NO RAW/UNDERCOOKED ANIMAL FOODS, NO UNPASTEURIZED JUICE, MILK, ETC)
-VOMIT/FECAL INCIDENT CLEAN UP PROCEDURES
-FOOD SOURCE
-FOOD SERVICE PROCEDURES
-PEST CONTROL
-PHYSICAL FACILITIES AND MAINTENANCE

*REPORT WAS DISCUSSED WITH THE PERSON IN CHARGE AND STAFF ON SITE AND WITH THE NURSE EVALUATOR, PEGGY.

*FLOORS ARE LAMINATE AND WALLS AND CEILING ARE SMOOTH PAINTED DRYWALL. COUNTERTOPS ARE LAMINATE AND CABINETS ARE VARNISHED WOOD WITH HALLOW BASE. ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT SUCH A TIME THEY ARE FOUND TO BE A CONCERN OR RISK OF CONTAMINATION, THEY WILL BE ORDERED TO BE REPLACED AND BROUGHT UP TO CODE.

*KITCHEN HAS A 2-BASIN SINK. ONE BASIN IS DESIGNATED AS THE HANDWASHING SINK. THIS BASIN MAY ONLY BE USED FOR HANDWASHING PURPOSES.

*ESTABLISHMENT HAS A HIGH TEMPERATURE SANITIZING DISH MACHINE THAT IS TESTED USING A DELTATRAK REGISTERING THERMOMETER DAILY.

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*IF ANY RESIDENT COMPLAINS OF ILLNESS, CONTACT THE MINNESOTA DEPARTMENT OF HEALTH AND PROVIDE THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER TO THE RESIDENT. THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER IS 1-877-366-3455.

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 1004241015 of 01/29/24.

Certified Food Protection Manager: PEARL A. ISAWUMI

Certification Number: FM117555 Expires: 06/30/26

Inspection report reviewed with person in charge and emailed.

Signed: _____

PEARL ISAWUMI
CFPM

Signed: Molly Dougherty

Molly Dougherty
Public Health Sanitarian
Metro District Office
651-201-3978
molly.dougherty@state.mn.us