Protecting, Maintaining and Improving the Health of All Minnesotans

AMENDED

Electronically Delivered

November 29, 2023

Licensee
We Care Home Health Service
12423 Partridge Street Northwest
Coon Rapids, MN 55448

RE: Project Number(s) SL34925015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on November 14, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the 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.

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

STATE CORRECTION ORDERS
The enclosed State Form documents the state correction orders. The 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 the 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.

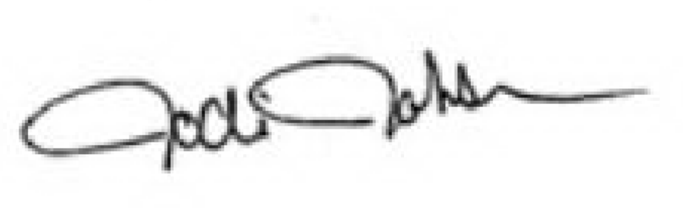
To submit a reconsideration request, please visit:

https://www.web.health.state.mn.us/form/HRD-Appeals-Form

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,



Jodi Johnson, Supervisor
State Evaluation Team
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

HHH

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November 29, 2023

Licensee
We Care Home Health Service
12423 Partridge Street Northwest
Coon Rapids, MN 55448

RE: Project Number(s) SL36203015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on November 14, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the 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.

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

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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:

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If you have any questions, please contact me.

Sincerely,

Jodi Johnson, Supervisor
State Evaluation Team
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34925	A. BUILDING: _____ B. WING _____	11/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARTRIDGE HOME	12423 PARTRIDGE STREET NW COON RAPIDS, MN 55448

(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: SL34925015 On November 13, 2023, through November 14, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were five active residents; all of whom were receiving services under the Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 460 SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request assistance for health and safety needs 24 hours	0 460		

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0 460	Continued From page 1 per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide a means for one of one resident (R1) to request assistance for health and safety needs as required. The licensee did not have a system in place for residents at the facility to request assistance for health and safety needs 24 hours a day, seven days a week. This had the potential to affect all five residents at 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).	0 460		

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0 460	Continued From page 2 The findings include: The licensee held an assisted living facility license and was licensed for a capacity of five residents, with a census of five residents. During the entrance conference on November 13, 2023, at 11:23 a.m., licensed assisted living director (LALD)/clinical nurse supervisor (CNS)-A stated the licensee use to have a call light system in place, however, it was broken. LALD/CNS-A further stated staff did safety checks on all residents throughout the day and night. R1's diagnoses included anxiety, schizoaffective disorder, diabetes, and schizophrenia. During the resident interview on November 14, 2023, at 10:35 a.m., R1 stated if R1 needed assistance from staff, R1 would walk out to the staff area and talk with the staff that was working. R1 stated the facility did not have a call system in place. R1's assessment dated November 5, 2023, indicated R1 was disorientated at times based on mental status. The licensee's Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) dated August 24, 2022, indicated a non-emergency call system was not offered. The licensee's Staffing policy dated August 1, 2021, indicated residents are provided with a means to request assistance for health and safety needs 24 hours per day 7 days per week; during night shifts, the home health aide will respond to resident requests for assistance as	0 460		

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0 460	Continued From page 3 soon as possible. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 460		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for 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	0 470		

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0 470	Continued From page 4 by: Based on interview and record review, the licensee failed to ensure the clinical nurse supervisor (CNS) developed and implemented a staffing plan to determine staffing levels to meet the needs of all residents. 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) 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: The licensee held an assisted living facility license and was licensed for a capacity of five residents, with a census of five residents. During the entrance conference on November 13, 2023, at 11:35 a.m., licensed assisted living director (LALD)/CNS-A stated the licensee had a staffing plan developed by LALD/CNS-A, licensee's registered nurses (RNs), and the facility supervisor. On November 14, 2023, at 9:50 a.m., the surveyor reviewed the staffing plan dated 2022, with LALD/CNS-A. LALD/CNS-A stated the licensee reviewed the staffing plan as needed based on resident needs or at least annually. LALD/CNS-A further stated the licensee was not aware the staffing plan needed to be reviewed twice annually by the CNS. The licensee's Staffing policy dated August 1,	0 470		

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0 470	Continued From page 5 2021, indicated the staffing plan shall be evaluated as part of the Quality Management program at least twice per year. The results of the evaluation are documented in the meeting minutes. No further information was provided. TIME PERIOD OF CORRECTION: Seven (7) days	0 470		
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 6 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all residents, staff, and visitors 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), 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: The licensee's EPP last reviewed October 10, 2022, included a Missing Resident policy. The licensee's EPP provided did not include a quarterly review of the Missing Resident policy. On November 14, 2023, at 1:04 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the missing resident policy was reviewed annually with the EPP and was not aware the missing resident policy needed to be reviewed quarterly. The licensee's Missing Resident policy dated August 1, 2021, did not address how frequently the Missing Resident policy would be reviewed. The licensee's Emergency Preparedness policy dated August 1, 2021, indicated the EPP would be reviewed/updated at least annually.	0 680		

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0 680	Continued From page 7 Per Assisted Living Facilities: Minnesota Rules Chapter 4659, 4659.0110, Subp. 4. Review missing resident plan. The assisted living director and clinical nurse supervisor must review the missing person plan at least quarterly and document any changes to the plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect some of the 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	0 800		

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0 800	Continued From page 8 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 November 13, 2023 at 1:30 p.m., survey staff toured the facility with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A, it was observed the emergency exit door in the dining room went outside to a deck that did not have a staircase which made egress inaccessible. This emergency exit door is included in the facility's evacuation plan. On November 13, 2023 at 1:30 p.m., LALD/CNS-A verbally confirmed survey staff observations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
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, 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	0 910		

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0 910	Continued From page 9 by: Based on interview and record review, the licensee failed to execute a written contract with the required content for one of one resident (R1). This had the potential to affect all five residents who received assisted living services. 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 of the residents). The findings include: R1's Assisted Living Contract was signed by the R1 on September 17, 2021. R1's assisted living contract did not include the provider's identification number (HFID) or authorized agent. On November 14, 2023, at 9:44 a.m., licensed assisted living director (LALD)/clinical nurse supervisor (CNS)-A stated the same contract was used for all residents. LALD/CNS-A further stated the assisted living contract contained the assisted living license number, not the provider HFID, and did not list an authorized agent. No further information as provided. TIME PERIOD OF CORRECTION: Twenty-one (21) days	0 910		

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01470	Continued From page 10	01470		
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this	01470		

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	34925	A. BUILDING: _____ B. WING _____	11/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARTRIDGE HOME	12423 PARTRIDGE STREET NW COON RAPIDS, MN 55448

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01470	Continued From page 11 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 the challenges it poses to communication; (2) 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 orientation to assisted living statutes included all the required content for one of two employees (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 potential to affect a large portion or all of the residents). The findings include: ULP-B was hired on June 6, 2023, to provide direct care services under the assisted living	01470		

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01470	Continued From page 12 license. On November 13, 2023, throughout the day, the surveyor observed ULP-B providing safety checks and interacting with residents at the facility. ULP-B's employee record did not include the following required orientation content: -an overview of chapter 144G; -an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; -compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); -the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; -handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; -consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other advocacy services; and - a review of the types of assisted living services the employee will be providing and the facility's category of licensure. On November 13, 2023, at 2:05 p.m., licensed	01470		

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01470	Continued From page 13 assisted living director/clinical nurse supervisor (LALD/CNS)-A stated ULP-B did not complete all the required orientation to assisted living as noted above, and no staff would have completed all the required orientation to assisted living due to the licensee still assigning home care orientation. LALD/CNS-A further stated the licensee was not aware the online education the provider used had a separate course for orientation to assisted living. The licensee's Staff Orientation and Education policy dated August 1, 2021, indicated before providing service to residents, all employees will attend a general orientation conducted by the licensee with topics that included the following: -overview of Minnesota assisted Living Statute 144G and Minnesota Rules Chapter 4659; -introduction to and review the organization's policies and procedures; -compliance with Minnesota's Vulnerable Adult; -the assisted living bill of rights and the employee's responsibilities to ensure the exercise and protection of those rights; -the principles of person-centered planning and service delivery and how they apply to direct support services provided by staff; -grievance policy/process, including reports to the office of Health Facility Complaints; -consumer advocacy services including Office of Ombudsman for Long-Term-Care [sic], Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county managed care advocates, and other advocacy services; and -the types of assisted living services the employee will be providing based on the Uniform Checklist Disclosure of Services and the organizations' category of licensure.	01470		

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01470	Continued From page 14 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01470		
01500 SS=D	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: (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	01500		

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01500	Continued From page 15 (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 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 an employee received all of the required annual training content for each 12 months of employment for one of one employee (licensed assisted living director/clinical nurse supervisor (LALD/CNS)-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 an isolated scope (when one or a	01500		

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01500	Continued From page 16 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: LALD/CNS-A had a start date of October 1, 2016, and had begun providing supervision and direct care services under the assisted living license on August 1, 2021. Throughout the survey, the surveyor observed LALD/CNS-A supervise unlicensed personnel (ULP) and provide direct care services to residents. LALD/CNS-A's employee record did not include the following required annual training for 2022: - training on reporting of maltreatment of vulnerable adults under section 626.557; - review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; - a review of infection control techniques and implementation of infection control standards including a review of hand washing techniques; the need for an 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; - review of the facility's policies and procedures related to the provision of assisted living services and how to implement those policies and procedures; and - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person.	01500		

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01500	Continued From page 17 On November 14, 2023, at 10:27 a.m., LALD/CNS-A stated LALD/CNS-A had not completed annual training that was assigned in the licensee's online education system. LALD/CNS-A further stated LALD/CNS-A was aware of the required annual training contents. The licensee's Staff Orientation and Education policy dated August 1, 2021, indicated all staff providing assisted living services will complete at least eight hours of education for every 12 months of employment. Education topics would include the above noted content. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		
01750 SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the	01750		

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01750	Continued From page 18 registered nurse (RN) prepared in writing specific instructions for one of one resident (R2) who received medication management. 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: During the entrance conference on November 13, 2023, at 11:24 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee provided medication management services to the residents at the facility. R2's diagnoses included schizoaffective disorder, respiratory failure, bipolar, and chronic pain. R2's service plan dated September 14, 2022, indicated R2 received medication administration three times daily. R2's prescriber order dated September 18, 2023, included an order for Breo Ellipta 100-25 micrograms (mcg) (used to decrease lung inflammation) one puff inhaled daily. R2's November 2023 electronic medication administration record (EMAR) indicated Breo Ellipta 100-25 mcg inhale one puff by mouth once daily, however, did not include instructions to rinse resident's mouth and spit the water out after	01750		

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01750	Continued From page 19 use. On November 14, 2023, at 8:41 a.m., the surveyor observed unlicensed personnel (ULP)-D conduct a medication pass for R2, which included administration of the Breo Ellipta 100-25 mcg inhaler. ULP-D activated the Breo Ellipta inhaler and handed it to R2 for self-administration. R2 returned the Breo Ellipta inhaler back to ULP-D. ULP-D did not offer R2 water to rinse mouth and spit out water after the inhaler administration. On November 14, 2023, at 9:00 a.m., ULP-D stated ULP-D forgot to offer water to rinse and spit after administration of R2's inhaler. On November 14, 2023, at 9:06 a.m., LALD/CNS-A stated residents should be offered water to rinse their mouth and spit out the water after inhaler administration, even if the resident normally declines to rinse out their mouth after inhaler administration. LALD/CNS-A further stated all inhalers prescribed to residents normally have instructions on the EMAR, however, R2's Breo Ellipta inhaler had been missed. The manufacturer's instructions for use of Breo Ellipta inhaler dated July 2021, indicated to rinse mouth with water and spit the water out. Do not swallow the water. The licensee's Service Plan for Medication Management policy dated August 1, 2021, indicated the medication management plan would include any resident-specific requirements related to verification that all medications are administered as prescribed. No further information was provided.	01750		

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01750	Continued From page 20 TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01760 SS=D	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 the steps of the medication administration process was followed for one of one employee (unlicensed personnel ((ULP)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).	01760		

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01760	Continued From page 21 The findings include: During the entrance conference on November 13, 2023, at 11:24 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee provided medication management services to the residents at the facility. On November 14, 2023, at 8:25 a.m., the surveyor observed ULP-D provide scheduled morning medication administration to R2. ULP-D compared the prescription labels with the electronic medication administration record (EMAR), placed the medications into a cup, documented on the EMAR that medications were verified and administered. On November 14, 2023, at 8:41 a.m., the surveyor observed ULP-D administer R2's medications. On November 14, 2023, at 9:00 a.m., ULP-D stated ULP-D documented R2's medications as administered before the medications were administered. ULP-D stated normally ULP-D does not document medications as administered until after the resident takes the medication. On November 14, 2023, at 9:08 a.m., LALD/CNS-A stated medications should be administered to residents and then documented on the EMAR the medications were taken. The licensee's Medication Documentation policy dated August 1, 2021, indicated complete documentation of medication administration includes the following: resident's name, medication name, medication dosage, date and time of administration, method/route of administration, and signature and title of staff administering the medication. Documentation of	01760		

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01760	Continued From page 22 medication administration will be completed promptly. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
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, interview, and record review, the licensee failed to ensure medications were maintained with the original prescription label 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) 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: During the entrance conference on November 13, 2023, at 11:24 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A	01890		

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01890	Continued From page 23 stated the licensee provided medication management services to the residents at the facility. On November 14, 2023, at 8:25 a.m., the surveyor observed unlicensed personnel (ULP)-D remove R2's medications from the locked medication cabinet. ULP-D stated R2's Breo Ellipta 100- 25 micrograms (mcg) inhaler did not bear an original prescription label and was not stored in the original packaging with the prescription label. On November 14, 2023, at 9:05 a.m., LALD/CNS-A stated all resident medications should be stored with the original prescription label for ULPs to verify medications with the resident's electronic medication administration record (EMAR), however, R2's Breo Ellipta inhaler did not contain the original prescription label. The licensee's Storage/Control of Medications policy dated August 1, 2021, indicated prescription drugs, prior to being set up for immediate or later administration, must be kept in the original container(s) in which they were dispensed by the pharmacy bearing the original prescription label with legible information. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
02310 SS=F	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted	02310		

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02310	Continued From page 24 living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the care and services were provided according to acceptable health care and medical, or nursing standards for one of one resident (R2) with a consumer bedrail. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2's diagnoses included schizoaffective disorder, respiratory failure, bipolar, and chronic pain. On November 13, 2023, during the facility tour from 12:27 p.m. through 12:43 p.m., the surveyor observed an upper consumer bedrail on the right side of R2's bed with the left side of the bed tight up against the wall. The consumer bed rail was an upside-down U shape with two horizontal bars in the center. On November 14, 2023, at 7:43 a.m., unlicensed personnel (ULP)-C stated ULP-C could not recall when R2 had the bedrail installed, however, R2 used the bedrail for bed mobility to get in and out	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34925	A. BUILDING: _____ B. WING _____	11/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARTRIDGE HOME	12423 PARTRIDGE STREET NW COON RAPIDS, MN 55448

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02310	Continued From page 25 of bed. R2's Service Plan dated September 14, 2022, indicated R2 required assistance with medication administration, behavior management, housekeeping, and reminders for bathing, grooming, toileting, and dressing. R2's Assessment dated November 5, 2023, indicated R2 had a partial side rail (bedrail) on the right side of R2's bed. R2 used the bedrail to aid in transfers to and from bed, turning, and repositioning self in bed. R2 was evaluated by physical therapy (PT) and deemed safe to use. R2 was educated on the risk/benefits of the bedrail. The bedrail did not function as a restraint, R2 was not at high risk for injury with the bedrail, R2 did not have a previous injury related to the bedrail, there were no alternatives that could be used in the place of the bedrail, and R2 had verbalized the understanding of the risk of using the bedrail. In addition, the following was documented: -Zone 1: The area within the rail was less than 4 ¾ inches; -Zone 2: The area under the rail, between the rail supports or next to a single rail support was less than 4 ¾ inches; -Zone 3: The area between the rail and mattress was less than 4 ¾ inches; -Zone 4: The area under the rail, at the ends of the rail was less than 2 3/8 inches and greater than a 60-degree angle at the end of the bed rail relative to the top; -Zone 5: The space between the split bedrails did not present a risk of head, neck, and chest entrapment; -Zone 6: The gap between the end of the bed rail and the side edge of the headboard did not present a risk of entrapment of the head, neck, or	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34925	A. BUILDING: _____ B. WING _____	11/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARTRIDGE HOME	12423 PARTRIDGE STREET NW COON RAPIDS, MN 55448

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02310	Continued From page 26 chest; and -Zone 7: There was no large space between the inside surface of the headboard and the end of the mattress that could cause risk of head entrapment. R2's record lacked evidence the licensee referred to the Consumer Product Safety Commission (CSPC) for bedrail recall information. On November 14, 2023, from 9:54 a.m. through 10:25 a.m., the surveyor reviewed R2's consumer upper bed rail with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A. LALD/CNS-A physically grabbed R2's bed rail that was in between R2's mattress and box spring and observed the bedrail to be stable. LALD/CNS-A stated PT installed R2's portable bedrail with LALD/CNS-A present and LALD/CNS-A had done an assessment every 90 days on R2's bedrail since it was installed. LALD/CNS-A provided manufacturer instructions for R2's consumer bed rail and stated LALD/CNS-A was aware to check for recalls on bedrails, however, was unable to provide documentation recalls were being checked on the CSPC website. The CSPC website was reviewed with LALD/CNS-A and R2's consumer bedrail had not been recalled. The licensee's Side Rail Use policy dated August 1, 2021, indicated the registered nurse (RN) is responsible to ensure that the side rails in use are of a safe design and properly maintained. Side rails will be used consistent with the manufacturer's recommendations. The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) last updated August 7, 2023, indicated licensees should review	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34925	A. BUILDING: _____ B. WING _____	11/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02310	Continued From page 27 the CSPC website regularly for updates on recalled portable bed rails. The opportune time to do this would be with the 90-day assessment due to the requirement included in the uniform assessment tool for assessing assistive devices. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	02310		

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

Type: Full
Date: *11/14/23*
Time: 14:03:01
Report: 7963231145

Food and Beverage Establishment Inspection Report

Location:

We Care Home Health Service
12423 Partridge Street Nw
Coon Rapids, MN55448
Anoka County, 02

Establishment Info:

ID #: 0039414
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6122034758
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.

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Hot Water: = at 160 Degrees Fahrenheit
Location: DISHWASHER RINSE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: MILK
Temperature: 38 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: No

Process/Item: EGG SALAD
Temperature: 38 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: No

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

MET WITH MDH NURSE SURVEYOR SARA UMLAUF AND ESTABLISHMENT REPRESENTATIVE MATILDA AGYAPONG. NO FOLLOW-UP INSPECTION REQUIRED.

DISCUSSED THE FOLLOWING-
-EMPLOYEE ILLNESS POLICY AND LOG
-REPORTABLE DISEASES
-HIGHLY SUSCEPTIBLE POPULATION RESTRICTIONS
-DISHWASHER RINSE TESTING

KITCHEN HAS LINOLEUM FLOORING, WOOD CABINETS WITH LAMINATE COUNTERTOPS AND A POPCORN FINISHED CEILING.

Type: Full
Date: *11/14/23*
Time: 14:03:01
Report: 7963231145
We Care Home Health Service

Food and Beverage Establishment Inspection Report

DISHWASHER HAS A SANITIZER CYCLE THAT MEETS FOOD CODE REQUIREMENTS FOR RINSE TEMPERATURE.

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 7963231145 of 11/14/23.

Certified Food Protection Manager: Matilda Agyapong

Certification Number: FM 116139 Expires: 03/21/26

Inspection report reviewed with person in charge and emailed.

Signed: _____

Matilda Agyapong
PIC

Signed: Peggy Spadafore

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