Electronically Delivered

May 17, 2024

Licensee
Perfection Health Care Service
1225 Cook Avenue East
Saint Paul, MN 55106

RE: Project Number(s) SL34881015

Dear Licensee:

On May 2, 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 on January 18, 2024. This follow-up survey determined your facility had corrected all of the state correction orders issued pursuant to the January 18, 2024, survey.

The Department of Health 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.

Also, at the time of this follow-up survey completed on May 2, 2024, we identified the following violation(s):

0660-Tuberculosis Prevention And Control-144g.42 Subd. 9

The details of the violation(s) noted at the time of this follow-up survey are delineated on the attached State Form. Only the ID Prefix Tag in the left hand column without brackets will identify these state correction orders. It is not necessary to develop a plan of correction.

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.

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.

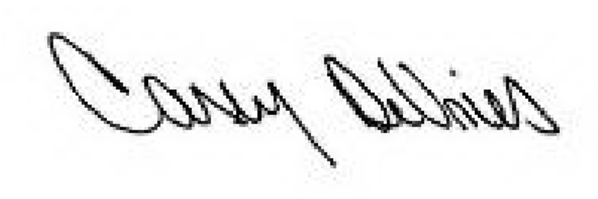
A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. §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

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

We urge you to review these orders carefully. If you have questions, please contact Casey DeVries at 651-201-5917.

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,



Casey DeVries, Supervisor
State Evaluation Team
Email: casey.devries@state.mn.us
Telephone: 651-201-5917 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
	34881	A. BUILDING: _____ B. WING _____	R 05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERFECTION HEALTH CARE SERVICE	1225 COOK AVENUE EAST SAINT PAUL, MN 55106

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL34881015-1 On April 30, 2024, through May 2, 2024, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on January 18, 2024. At the time of the survey, there were two residents; both of whom received services under the Assisted Living license. As a result of the revisit, the following orders were issued.	{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 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 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 evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	{0 480}		

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{0 480}	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: No further action required	{0 480}		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on 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 testing for the presence of Mycobacterium TB for one of two employees	0 660		

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0 660	Continued From page 2 (unlicensed personnel (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, 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: The facility TB risk assessment form dated February 5, 2024, indicated the facility was at a low risk for TB transmission. In addition, licensed assisted living director (LALD)-A was responsible for maintaining the TB screening records. ULP-E started employment with licensee April 10, 2024, to provide assisted living services for licensee's residents. ULP-E's record included TB history and symptom screen dated April 4, 2024, and QuantiFERON Gold TB Blood test dated May 24, 2023, with a negative result. ULP-E's QuantiFERON Gold TB Blood test was completed over 90 days before ULP-E started working with licensee. In addition, ULP-E's record was missing required TB training at hire. On May 1, 2024, LALD-A stated licensee was not aware of the TB completed within 90 day of hire requirement. Also, LALD-A stated during their audit, ULP-E was the only employee who had brought their TB result from an outside provider. LALD-A also stated every employee completed	0 660		

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0 660	Continued From page 3 TB training at hire during orientation through Educare (training software) and there after annually. When the surveyor reviewed ULP-E's transcript of training it lacked TB training at hire. The Minnesota Department of health's Assisted Living Resources & Frequently Asked Questions (FAQs) indicated an Interferon-Gamma Release Assays (IGRAs) test should be dated within 90 days of hiring. The licensee's Infection Control Policy dated August 1, 2021, indicated [licensee] will 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 (MMWR). No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one days	0 660		
{0 790} SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and	{0 790}		

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{0 790}	Continued From page 4 maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: No further action required	{0 790}		
{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees	{0 810}		

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{0 810}	Continued From page 5 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: No further action required	{0 810}		

Electronically Delivered

February 8, 2024

Licensee
Perfection Health Care Service
1225 Cook Avenue East
Saint Paul, MN 55106

RE: Project Number(s) SL34881015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 18, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

The correction order documentation should include the following:

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

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

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

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,

Casey DeVries, Supervisor
State Evaluation Team
Email: casey.devries@state.mn.us
Telephone: 651-201-5917 Fax: 1-866-890-9290

PMB

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0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL34881015-0 On January 16, 2024, through January 18, 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 three residents, all of whom received 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.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480		

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0 480	Continued From page 1 following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated January 17, 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		
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults;	0 630		

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0 630	Continued From page 2 and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for one of two residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: R3 admitted to the licensee on December 15, 2023, and began receiving assisted living services. R3's diagnoses included post-traumatic stress disorder (PTSD), and major depressive disorder. R3's Master Care Plan - dated December 18, 2023, indicated R3 received assistance with bathing needs, meal setup, hygiene, housekeeping, laundry, medication administration, and medication management. R3's IAPP dated January 8, 2024, indicated R3 was not at risk to be abused by others, however,	0 630		

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0 630	Continued From page 3 did not include the following required content: - the person's risk of abusing other vulnerable adults. On January 17, 2024, at 3:26 p.m., clinical nurse supervisor (CNS)-B stated the licensee created an IAPP for every resident. CNS-C was unaware why R3's IAPP lacked the above content, but after reviewing documentation, acknowledged that the requirement had been overlooked. The licensee's 6.05 Individual Abuse Prevention Plan policy dater November 19, 2023, indicated that the plan will contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including: - other vulnerable adults; - the person's risk of abusing other vulnerable adults; and -statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules;	0 650		

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0 650	Continued From page 4 (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training documentation was maintained for one of two unlicensed personnel ((ULP)-C) to include all required content. 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: ULP-B was hired on November 1, 2023, to provide direct care services to the licensee's residents. On January 18, 2024, between 12:00 p.m. and	0 650		

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0 650	Continued From page 5 1:23 p.m., the surveyor observed ULP-C complete medication administration on R2 and R3 as well as provide assisted living services. ULP-C's record lacked documentation of completed training for the following topics: -understanding appropriate boundaries between staff and resident's family; -safe transfer techniques and ambulation; -range of motion and positioning; and -appropriate and safe techniques in person hygiene and grooming, including: - hair care and bathing; - care of teeth, gums, and oral prosthetic devices; - care and use of hearing aids; and - dressing and assisting with toileting. On January 18, 2024, at 9:59 a.m., ULP-C stated they recalled receiving training on the previously listed topics from clinical nurse supervisor (CNS)-B. On January 18, 2024, at 11:02 a.m., licensed assisted living director (LALD)-A stated they were unable to locate the content listed above. In addition, LALD-A stated ULP-C had completed required training, but documentation of the training had yet to be put into ULP-B's employee record. LALD-A stated they would continue to look for the training documents. The surveyor was not provided the documents of training during the survey. The licensee's 5.02 Competency Training Evaluations policy dated November 19, 2023, indicated that a copy of all education, training, and competency testing shall be kept in each employee's personnel file. No further information provided.	0 650		

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0 650	Continued From page 6 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a written emergency preparedness (EP) plan with all the required content as defined in Appendix Z. This had the	0 680		

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0 680	Continued From page 7 potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On January 16, 2024, at 2:10 p.m., the surveyor retrieved the licensee's Emergency preparedness plan binder from the licensed assisted living director (LALD)-A. LALD-A stated the binder was complete in its required contents and was normally stored behind locked doors in their office. The licensee's written emergency disaster preparedness plan lacked evidence of the following required content: - Annual review of the Emergency Preparedness Plan; - Quarterly review of missing resident policy; - A written risk assessment utilizing an all-hazards approach; - Categorization of probable risks by likelihood of occurrence; - Written strategies addressing facility and community-based risks; - Missing Resident Plan; - Annual review of policies; - Policies and procedures for system to track the location of on-duty staff and sheltered residents; and, - Method for sharing information and medical	0 680		

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0 680	Continued From page 8 documentation for residents under the facility's care, as necessary, with other HCPs to maintain continuity of care. The licensee's 9.07 Fire Safety, Evacuation Plan, Fire Drills policy, dated November 11, 2023, indicated that the plan will include procedures for resident movement, evacuation, or relocation during fire or similar emergencies including the identification of unique or unusual resident needs for movement or evacuation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to install and maintain the portable fire extinguishers as required by statute. This	0 790		

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0 790	Continued From page 9 deficient condition 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: On January 16, 2024, at 1:54 p.m., survey staff toured the facility with licensed assisted living director (LALD)-A. During the tour, survey staff observed the following: 1. A tag or label was not attached to the portable fire extinguisher showing annual maintenance had been performed by certified service personnel. 2. The kitchen fire extinguisher was stored on the floor of a cabinet and the location not identified. Fire extinguishers must be properly mounted to prevent them from being moved or damaged. A sign must be provided indicating the fire extinguisher's location if it is not visible. 3. A portable fire extinguisher was not installed in the basement of the home. Portable fire extinguishers must be located so the travel distance to the nearest fire extinguisher does not exceed 75 feet. During an interview on January 17, 2024, at 4:00 p.m., LALD verified annual maintenance had not been performed on the fire extinguisher. LALD-A verified the kitchen fire extinguisher was not properly mounted and identified. LALD-A verified a fire extinguisher was not installed in the	0 790		

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0 790	Continued From page 10 basement. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation	0 810		

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0 810	Continued From page 11 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, and provide required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On January 17, 2024, the licensed assisted living director (LALD)-A 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 During an interview on January 17, 2024, at 4:00 p.m., LALD-A stated the FSEP was stored in the office which was sometimes kept locked. Survey staff explained the FSEP was not located in a central location accessible to all occupants of the building. LALD-A stated starting today, the FSEP would be relocated to a readily available location on the main floor. The FSEP included a fire safety policy dated	0 810		

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0 810	Continued From page 12 September 29, 2022. This policy was a template and had not been developed for use at the facility. The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The employee actions for fire were limited to the acronym RACE (Remove, Alarm, Confine, and Extinguish or Evacuate). The FSEP did not identify specific fire protection procedures for residents evident by limited instructions directing residents to stoop or crawl to avoid smoke. No additional fire protection procedures necessary for residents were included. The FSEP directs employees to evacuate residents from the building but fails to include information on where residents should relocate to in the event of a fire. The FSEP failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. During an interview on January 17, 2024, at 4:00 p.m., LALD-A verified the FSEP was a template and had not been developed for use at this facility. TRAINING Record review indicated the licensee failed to provide training to employees on the FSEP upon hire and/or at least twice per year as evident by incomplete training documentation.	0 810		

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0 810	Continued From page 13 Record review indicated the licensee failed to provide fire safety and evacuation training to residents at least once per year as evident by incomplete training documentation. During an interview on January 17, 2024, at 4:00 p.m., LALD-A verified dates were not recorded on the training documentation. LALD-A stated these trainings were completed in September 2023. LALD-A explained employees were trained upon hire and then at a frequency of every 3 months. DRILLS Record review indicated the licensee failed to conduct employee evacuation drills twice per year, per shift with at least one evacuation drill every other month as evident by no fire drill records for October and November 2023. Six fire drills were recorded on the 2023 log, these drills were completed in January, March, May, July, September, and December. During an interview on January 17, 2024, at 4:00 p.m., LALD-A verified fire drills were not performed in October or November 2023. LALD-A stated the licensee did not know evacuation drills were required at a frequency of every other month. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01620 SS=D	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	01620		

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01620	Continued From page 14 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 reassessment not to exceed 90 days for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).	01620		

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01620	Continued From page 15 The findings include: R2 was admitted to the licensee on August 31, 2023, and began receiving assisted living services. R2's diagnoses included major depressive disorder, unspecified psychosis, generalized anxiety disorder, and stimulant abuse. R2's Master Care Plan, dated September 1, 2023, indicated R2 received services including bathing assistance, case management, housekeeping, medication management, and medication administration. R2's record included a 90-day assessment completed on September 5, 2023, and December 5, 2023. R2's 90-day reassessment exceeded 90 calendar days from the date of the last review by two days. On January 17, 2023, at approximately 3:30 p.m., during a phone interview, CNS-B acknowledged R2's 90-day reassessment exceeded 90 days from the previous assessment, but did not give clarifying information on the reason for the lapse. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current	01650		

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01650	Continued From page 16 assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plan included the required content for two of three residents (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect	01650		

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01650	Continued From page 17 a large portion or all of the residents). The findings include: R2 R2 was admitted to the licensee on August 31, 2023, and began receiving assisted living services. R2's diagnoses included major depressive disorder, unspecified psychosis, generalized anxiety disorder, and stimulant abuse. R2's Master Care Plan, dated September 1, 2023, indicated R2 received services including bathing assistance, case management, housekeeping, medication management, and medication administration. R3 R3 admitted to the licensee on December 15, 2023, and began receiving assisted living services. R3's diagnoses included post-traumatic stress disorder (PTSD) and major depressive disorder. R3's Master Care Plan - dated December 18, 2023, indicated R3 received assistance with bathing needs, meal setup, hygiene, housekeeping, laundry, medication administration, and medication management. On January 17, 2024, at 3:26 p.m., clinical nurse supervisor (CNS)-B stated that they were unaware that the licensee's service plans provided during survey lacked required contents. CNS-B instructed the surveyor to consult with the licensed assisted living director on service plan issues.	01650		

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01650	Continued From page 18 On January 18, 2023, at 9:10 a.m., the surveyor requested signed service plans from LALD-A. On January 18, 2023, at 12:00 p.m., LALD-A emailed the surveyor the requested service plans for R2 and R3. The provided documents lacked the following information: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C. On January 18, 2024, at 1:40 p.m., during the exit conference, LALD-A stated that they were unaware that the service plans lacked required content, but would look into correcting this moving forward.	01650		

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01650	Continued From page 19 The licensee's 6.08 Service Plan policy dated November 19, 2023, indicated the service plan must include: a. A description of the services that are to be provided based on the most recent assessment and resident preferences; b. Fees for services to be provided; c. The frequency of each service to be provided based on the most recent assessment and resident preferences; d. An identification of staff or categories of staff who will be providing services; e. A schedule and method for the next planned assessment or monitoring; f. A schedule and method for the next planned monitoring of staff providing services; and, g. A contingency plan that includes: - Actions Perfection Health Care Services, Inc will take if scheduled services cannot be provided; - Information regarding how the resident can contact Perfection Health Care Services, Inc; - The names and contact information the resident wishes, if any, to have notified in an emergency or if there is a significant adverse change in the resident's condition; - Identification and contact information of who the resident has authorized, if any, to sign for the resident in an emergency; and, - How the facility will support documented resident health care directive decisions, if any - including circumstances when emergency medical services are not to be summoned. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34881	A. BUILDING: _____ B. WING _____	01/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERFECTION HEALTH CARE SERVICE	1225 COOK AVENUE EAST SAINT PAUL, MN 55106

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01730	Continued From page 20	01730		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes.	01730		

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01730	Continued From page 21 (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and maintain a current individualized medication management record for each resident to include all required content for one of three residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: R3 admitted to the licensee on December 15, 2023, and began receiving assisted living services. R3's diagnoses included post-traumatic stress disorder (PTSD) and major depressive disorder. R3's Master Care Plan - dated December 18, 2023, indicated R3 received assistance with bathing needs, meal setup, hygiene, housekeeping, laundry, medication administration, and medication management. R3's medication management plan lacked the	01730		

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01730	Continued From page 22 following required content: - type of medication storage system, based on resident's needs; - person responsible for monitoring medication supplies and refills; and - procedures for staff to notify a registered nurse when problems arose. On January 17, 2024, at 3:26 p.m., CNS-B stated they were responsible for managing and maintaining resident medication management plans. CNS-B stated that they were unaware that R3's medication management plan lacked required content. On January 18, 2024, at 1:23 p.m., the surveyor observed unlicensed personnel (ULP)-C administer medications to R3. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation and record review, the licensee failed to ensure all medications were securely locked in substantially constructed compartments and permitted only authorized personnel to have access. This had the potential	01880		

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01880	Continued From page 23 to affect all three 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 18, 2024, at 1:15 p.m., the surveyor observed unlicensed personnel (ULP)-C enter the locked medication room to retrieve medications for administration. The surveyor observed ULP-C leave the keys in the doorknob after unlocking the door. Upon exiting the room with the retrieved medications, ULP-C left they keys to the door unattended and in the doorknob, with the door open, while they went upstairs to document medication administration. On January 18, 2024, at 1:22 p.m., the surveyor observed licensed assisted living director (LALD)-A return the keys to ULP-C and stated something to the ULP, which was unclear as it was said in a different language, however indicated the door to the medication room was left unsecured and unattended for approximately seven minutes. On January 18, 2024, at 1:40 p.m., during the exit conference, LALD-A stated that ULP-C likely forgot the keys in the door due to nervousness related to the survey process. They stated that this was out of the norm for their routine, but they would work at preventing future occurances.	01880		

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01880	Continued From page 24 The licensee's 7.11 Medication Storage policy dated November 18, 2023, indicated that medications managed outside of a resident's private "living space" must be in securely locked and substantially constructed compartments and permit only authorized personnel to have access. This may be a medication room, medication cart, or similar setup. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure prescription labels were maintained for all medications managed for one of three residents (R3). In addition, the licensee failed to ensure to discard expired medication for one of three residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and	01890		

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01890	Continued From page 25 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: MEDICATION LABEL On January 18, 2024, at 11:21 a.m., the surveyor observed R3's medication cabinet located in the nursing office and observed the following unlabeled medications: - A medication bottle that appeared to have had its label removed. The bottle contained no resident information, or medication information. The bottle was roughly ¾ full of capsules that were yellow in color. - A Flovent HFA inhaler that appeared to have had the prescription label removed. The inhaler lacked a label containing resident identifying information, or dosing instructions. EXPIRED MEDICATION On January 18, 2024, at 11:21 a.m., the surveyor observed R3's medication cabinet located in the nursing office and observed the following expired medications: - Flovent HFA 110mcg/Actuation with an expiration date March 26, 2020. On January 18, 2024, at approximately 11:30 a.m., licensed assisted living director (LALD)-A stated that they, or the nurse was responsible for monitoring the medications stored the nursing office. LALD-A stated that the unlabeled and expired medications stored in R3's storage bin were brought with the resident upon admission to the licensee, but had not been disposed of yet.	01890		

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01890	Continued From page 26 The licensee's 7.23 Medication Disposal dated November 18, 2023, indicated that expired medications managed by Perfection Health Care Service, Inc will dispose of according to the accepted practices of the Minnesota board of Pharmacy and the labels from the container will be destroyed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
02290 SS=F	144G.91 Subd. 2 Legislative intent The rights established under this section for the benefit of residents do not limit any other rights available under law. No facility may request or require that any resident waive any of these rights at any time for any reason, including as a condition of admission to the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee included language within the residency agreement contract which limited the rights of all residents residing within 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). Findings include:	02290		

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02290	Continued From page 27 On January 16, 2024, at 1:13 p.m., the surveyor requested a blank copy of the licensee's contract during entrance conference. On January 16, 2024, at 1:54 p.m., during a tour of facility, licensed assisted living director (LALD)-A pointed out house rules posted on the licensee's posting board. The surveyor requested a copy of the house rules for further evaluation. LALD-A stated that that residents are provided copies of house rules upon move in and they are included with all assisted living contracts. LALD-A stated that these rules are used as guidelines to help manage behaviors of residnets residing within the facility. The provided blank Assisted Living Contract for Housing and services included the following language on page three, under the section titled Contract Termination: "This contract maybe terminated by Perfection Health Care Services, Inc for non-payment of services and/or rent, violating facility rules, physical or verbal aggression toward staff or other residents or if the resident's care expands beyond the scope of Perfection Health Care Services, Inc 's capabilities." Licensee's form titled Perfection Health Care Services, Inc House Rules included the following language which limited the rights of residents: - ALWAYS inform staff when planning to leave the property and when you will come back; - Visitors are welcome to the home between 9AM-to-6PM. People of the opposite sex can meet with the residents only on the main floors, and not in their private rooms and no overnight stays allowed at all. The provider reserves the right to refuse visitors based on safety concerns;	02290		

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02290	Continued From page 28 - No alcohol, illegal drugs, knives, or any kind of weapons are allowed on home premises; and - The use of medical marijuana is prohibited in the home. On January 18, 2024, 1:40 p.m., during exit conference, LALD-A stated that they were not aware that the listed house rules had the potential to violate a resident's rights, and would work toward rectifying this issue moving forward. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02290		

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

Type: Full
Date: *01/17/24*
Time: 09:30:37
Report: 8058241013

Food and Beverage Establishment Inspection Report

Location:
Perfection Health Care Service
1225 Cook Avenue East
St Paul, MN55106
Ramsey County, 62

Establishment Info:
ID #: 0037934
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6513478037
ID #:

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

The following orders were issued during this inspection.

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.
DISCUSSED HOW TO TRANSFER EXISTING FOOD SAFETY TRAINING CERTIFICATE TO MN CERTIFIED FOOD PROTECTION MANAGER - NAVIGATED TO APPLICATION ONLINE WITH PIC
Comply By: 02/29/24

4-500 Equipment Maintenance and Operation

4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.
DISH WASHER UNABLE TO ACHIEVE SANITIZING TEMPERATURE - REPAIR OR REPLACE
Comply By: 03/31/24

4-600 Cleaning Equipment and Utensils

4-601.11C

MN Rule 4626.0840C Clean non-food contact surfaces of equipment and maintain free of accumulations of dust, dirt, food residue, and other debris.
HEAVY GREASE BUILT UP AROUND MICROWAVE AND ON CABINETS/WALLS/CEILING
Comply By: 01/31/24

Type: Full
Date: *01/17/24*
Time: 09:30:37
Report: 8058241013
Perfection Health Care Service

Food and Beverage Establishment Inspection Report

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.11

MN Rule 4626.1515 Maintain the physical facilities in good repair.

REPAIR DOOR WHICH OPENS FROM THE OUTSIDE TO THE KITCHEN, THRESHOLD GAP, AND DAMAGED SEALS OBSERVED

Comply By: 02/29/24

Food and Equipment Temperatures

Process/Item: TOMATO
Temperature: 35 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

Process/Item: BLUEBERRY
Temperature: 36 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	0	0	4

DISH WASHER TEMP VERIFIED BY THERMOLABEL RESULTS SENT VIA EMAIL

RESIDENTIAL HOME, NON COMMERCIAL APPLIANCES AND FINISHES

HRD INSPECTOR: ZACH MORTH
ESTABLISHMENT PIC: OSMAN

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 8058241013 of 01/17/24.

Certification Number: _____ Expires: __/__/____

Signed:_____
Establishment Representative

Signed:_____
Inspector Number 8058
Sanitarian 3
MDH Metro Office
651 201 4500
health.foodlodging@state.mn.us