



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

March 12, 2024

Licensee
Everbloom Home Health Care
1864 Bear Path Trail
Eagan, MN 55122

RE: Project Number(s) SL35547015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on February 14, 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.

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. 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>

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **<https://forms.office.com/g/Bm5uQEPhVa>**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,



Jodi Johnson, Supervisor

State Evaluation Team

Email: jodi.johnson@state.mn.us

Telephone: 507-344-2730 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35547	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/14/2024
NAME OF PROVIDER OR SUPPLIER EVERBLOOM HOME HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1864 BEAR PATH TRAIL EAGAN, MN 55122		
(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: SL35547015 On February 12, 2024, through February 14, 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 two residents 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.		
0 110 SS=C	144G.10 Subdivision 1a Assisted living director license required Each assisted living facility must employ an	0 110			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35547	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/14/2024
NAME OF PROVIDER OR SUPPLIER EVERBLOOM HOME HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1864 BEAR PATH TRAIL EAGAN, MN 55122		
(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
0 110	Continued From page 1 assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensed assisted living director (LALD) was listed as the Director of Record for the licensee. This had the potential to affect all the licensee's residents, staff, and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the client/resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On February 9, 2024, the Board of Executives for Long-Term Services and Support (BELTSS) website was reviewed. The BELTSS website indicated LALD-A held a current assisted living director license (issued February 17, 2022; and to expire October 31, 2024). The website did not list LALD-A as the Director of Record for the licensee, rather LALD-A was listed as the Director of Record for a different license. On February 12, 2024, at 3:46 p.m. LALD-A stated she had completed the training and was the primary LALD for the licensee and did not know she needed to be listed as the Director of Record for the licensee. The surveyor and	0 110			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35547	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/14/2024
NAME OF PROVIDER OR SUPPLIER EVERBLOOM HOME HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1864 BEAR PATH TRAIL EAGAN, MN 55122		
(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
0 110	Continued From page 2 LALD-A reviewed the BELTSS website together and LALD-A agreed the site did not show her as the director of record. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110			
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 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 and interview, the licensee failed to provide a means for residents to request assistance for health and safety needs 24 hours a day, seven days a week. This had the potential to affect all current residents.	0 460			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35547	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/14/2024
NAME OF PROVIDER OR SUPPLIER EVERBLOOM HOME HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1864 BEAR PATH TRAIL EAGAN, MN 55122		
(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
0 460	Continued From page 3 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 February 12, 2024, at 1:15 p.m. during the entrance conference, licensed assisted living director (LALD)-A and owner (O)-C stated they did not have a call light or pendant system residents could use to summon staff. On February 12, 2024, at 2:35 p.m. during the facility tour, the surveyor observed the facility was a split foyer style home with a main floor and basement. One resident's room was in the basement while the other resident rooms were on the main floor. No pendants or call light system was observed during the facility tour. On February 12, 2024, at 2:45 p.m. LALD-A stated the licensee had a pendant call light system in storage, but was not currently using the system. LALD-A stated she would get it out of the storage and start using the system. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 460			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35547	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/14/2024
NAME OF PROVIDER OR SUPPLIER EVERBLOOM HOME HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1864 BEAR PATH TRAIL EAGAN, MN 55122		
(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
0 470	Continued From page 4	0 470			
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 by: Based on interview and record review, the licensee failed to ensure the required staffing plan was developed as required, potentially affecting the licensee's residents, staff, and any visitors of the licensee. This practice resulted in a level two violation (a	0 470			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35547	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/14/2024
NAME OF PROVIDER OR SUPPLIER EVERBLOOM HOME HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1864 BEAR PATH TRAIL EAGAN, MN 55122		
(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
0 470	Continued From page 5 violation that did not harm a licensee's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living license and was licensed for a capacity of four residents with a current census of two residents. The licensee failed to develop and implement a staffing plan for determining its staffing level that included an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility. On February 12, 2024, at 1:15 p.m. the facility staffing plan was requested. Licensed assisted living director (LALD)-A stated the licensee had not developed a staffing plan and needed to review what the requirements were for developing the plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 470			
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according	0 480			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35547	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/14/2024
NAME OF PROVIDER OR SUPPLIER EVERBLOOM HOME HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1864 BEAR PATH TRAIL EAGAN, MN 55122		
(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
0 480	Continued From page 6 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 February 14, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that	0 660			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35547	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/14/2024
NAME OF PROVIDER OR SUPPLIER EVERBLOOM HOME HEALTH CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1864 BEAR PATH TRAIL EAGAN, MN 55122			
(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
0 660	Continued From page 7 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 establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) to include a facility TB risk assessment. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on February 12, 2024, at 1:15 p.m. with licensed assisted living director (LALD)-A and owner (O)-B, a request was made to review the facility TB risk assessment. On February 12, 2024, at 1:45 p.m. a TB risk assessment dated April 26, 2021, was produced for the facility. LALD-A and O-B stated the licensee had not completed their annual TB facility risk assessment for the Assisted Living	0 660			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35547	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/14/2024
NAME OF PROVIDER OR SUPPLIER EVERBLOOM HOME HEALTH CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1864 BEAR PATH TRAIL EAGAN, MN 55122			
(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
0 660	Continued From page 8 license, and were unaware of the requirement. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines, indicated a TB infection control program should include a facility TB risk assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) 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 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 provide current tags and documentation of annual inspections of all the fire extinguishers. This deficient condition had the ability to affect all staff and residents.	0 790			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35547	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/14/2024
NAME OF PROVIDER OR SUPPLIER EVERBLOOM HOME HEALTH CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1864 BEAR PATH TRAIL EAGAN, MN 55122			
(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
0 790	Continued From page 9 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). Findings include: On a facility tour on February 13, 2024, at 11:15 a.m., with owner (O)-C, survey staff observed that the fire extinguishers throughout the facility, did not have current tags or documentation to indicate that annual inspections had been performed as required. Annual and monthly inspections of the fire extinguishers are required to ensure that all systems are maintained and remain in working order. O-C verbally confirmed survey staff observations. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 790			
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program.	0 800			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35547	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/14/2024
NAME OF PROVIDER OR SUPPLIER EVERBLOOM HOME HEALTH CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1864 BEAR PATH TRAIL EAGAN, MN 55122			
(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
0 800	Continued From page 10 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 problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On February 13, 2024, at 11:05 a.m., survey staff toured the facility with owner (O)-C, it was observed that one of the emergency exit door exited out into the garage. The means of egress is required to lead and exit directly to a yard or court from occupied spaces within the facility or through a room of equal or less hazard which excludes the garage. This exit door was included on the fire safety evacuation plan. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35547	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/14/2024
NAME OF PROVIDER OR SUPPLIER EVERBLOOM HOME HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1864 BEAR PATH TRAIL EAGAN, MN 55122		
(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
0 810	Continued From page 11	0 810			
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 drill. This MN Requirement is not met as evidenced by: Based on a record review and interview, the	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35547	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/14/2024
NAME OF PROVIDER OR SUPPLIER EVERBLOOM HOME HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1864 BEAR PATH TRAIL EAGAN, MN 55122		
(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
0 810	Continued From page 12 licensee failed to develop a fire safety and evacuation plan with required elements. This had the potential to affect all staff, residents, 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 February 13, 2024, at 4:56 p.m., owner (O)-C provided documents via email on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review of the available documentation indicated that the licensee did not have employee actions to be taken in the event of a fire or similar emergency. The facility plan was vague and did not provide complete actions for employees to take in the event of a fire or similar emergency as well as complete procedures for residents' movement, evacuation, and relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. During an interview on February 14, 2024, at 9:35 a.m., O-C verified that the fire safety and evacuation plan for the facility lacked these provisions. TIME PERIOD FOR CORRECTION: Twenty-one	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35547	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/14/2024
NAME OF PROVIDER OR SUPPLIER EVERBLOOM HOME HEALTH CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1864 BEAR PATH TRAIL EAGAN, MN 55122			
(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
0 810	Continued From page 13 (21) days.	0 810			
0 920 SS=C	144G.50 Subd. 2 (c) Contract information (c) The contract must include: (1) a disclosure of the category of assisted living facility license held by the facility and, if the facility is not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license; (2) a description of all the terms and conditions of the contract, including a description of and any limitations to the housing or assisted living services to be provided for the contracted amount; (3) a delineation of the cost and nature of any other services to be provided for an additional fee; (4) a delineation and description of any additional fees the resident may be required to pay if the resident's condition changes during the term of the contract; (5) a delineation of the grounds under which the resident may be transferred or have housing or services terminated or be subject to an emergency relocation; (6) billing and payment procedures and requirements; and (7) disclosure of the facility's ability to provide specialized diets. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have all required content in the contract for two of two residents (R2, R3). This practice resulted in a level one violation (a violation that has no potential to cause more than	0 920			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35547	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/14/2024
NAME OF PROVIDER OR SUPPLIER EVERBLOOM HOME HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1864 BEAR PATH TRAIL EAGAN, MN 55122		
(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
0 920	Continued From page 14 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: R2's Assisted Living Contract was signed by R2 August 1, 2022. R3's Assisted Living Contract was signed by R3 August 1, 2022. R2 and R3's resident contract failed to include the following required content: -a disclosure that it does not hold an assisted living facility with dementia care license; and -a disclosure of the facility's ability to provide specialized diets On February 14, 2024, at 10:28 a.m. licensed assisted living director (LALD)-A and owner (O)-B stated the contract needed to be updated. The contract would be the same for all residents and it should have included all required content. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 920			
0 950 SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the	0 950			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35547	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/14/2024
NAME OF PROVIDER OR SUPPLIER EVERBLOOM HOME HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1864 BEAR PATH TRAIL EAGAN, MN 55122		
(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
0 950	Continued From page 15 contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensee provided the required notice for right to a designated representative with the required verbiage on a document separate from the contract for two of two residents (R2, R3). 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	0 950			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35547	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/14/2024
NAME OF PROVIDER OR SUPPLIER EVERBLOOM HOME HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1864 BEAR PATH TRAIL EAGAN, MN 55122		
(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
0 950	Continued From page 16 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 Assisted Living Contract was signed by R2 August 1, 2022. R3's Assisted Living Contract was signed by R3 August 1, 2022. R2 and R3's records lacked evidence in writing of providing on a document separate from the contact verbatim notice of "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." On February 14, 2024, at 10:24 a.m. licensed assisted living director (LALD)-A and owner (O)-B stated the contract needed to be updated. The contract would be the same for all residents and it should have included all required content. The licensee's Assisted Living Contracts policy, undated, indicated clients have the right to designate a representative before they sign a contract. The facility must offer the resident for the opportunity to identify a representative in	0 950			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35547	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/14/2024
NAME OF PROVIDER OR SUPPLIER EVERBLOOM HOME HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1864 BEAR PATH TRAIL EAGAN, MN 55122		
(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
0 950	Continued From page 17 writing on the contract and must provide the following notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 950			
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 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	01650			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35547	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/14/2024
NAME OF PROVIDER OR SUPPLIER EVERBLOOM HOME HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1864 BEAR PATH TRAIL EAGAN, MN 55122		
(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
01650	Continued From page 18 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 two 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 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2 R2 started receiving services on June 28, 2021, with diagnoses that included schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly) and type 2 diabetes. R2's service plan dated August 1, 2021, indicated	01650			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35547	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/14/2024
NAME OF PROVIDER OR SUPPLIER EVERBLOOM HOME HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1864 BEAR PATH TRAIL EAGAN, MN 55122		
(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
01650	Continued From page 19 R2 received assistance with medication set up, medication administration, treatment/behavioral management, registered nurse (RN) coordination, RN supervision, assistance with daily living (ADLs-such as bathing, grooming, dressing), instrumental assistance with daily living (IADLs-such as cooking, cleaning, transportation, laundry and managing finances), and mental health management. On February 13, 2024, a.m. at 9:28 a.m. clinical nurse supervisor (CNS)-B was observed to administer oral medications to R2. R3 R3 started receiving services on June 1, 2020, with diagnoses that included schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly). R3's service plan dated August 1, 2021, indicated R3 received assistance with medication set up, medication administration, treatment/behavioral management, RN coordination, RN supervision, ADLs, IADLs, and mental health management. R2 and R3's service plan lacked the following required content: - current home care services to be provided; - frequency of each service; - the schedule and methods of monitoring staff providing home care services; and - a contingency plan that includes: - the action to be taken by the home care provider and the client or client's representative if the scheduled service cannot be provided. On February 13, 2024, at 3:35 p.m. owner (O)-C stated R2 and R3's service plan had not been developed to include the above required content,	01650			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35547	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/14/2024
NAME OF PROVIDER OR SUPPLIER EVERBLOOM HOME HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1864 BEAR PATH TRAIL EAGAN, MN 55122		
(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
01650	Continued From page 20 stating this simply was missed. All of the licensee's residents would be missing the same information. The licensee's Service Plans policy, undated, indicated the service plan would include: - current home care services to be provided; - frequency of each service; - the schedule and methods of monitoring staff providing home care services; and - a contingency plan that includes: - the action to be taken by the home care provider and the client or client's representative if the scheduled service cannot be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01650			
01730 SS=F	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	01730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35547	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/14/2024
NAME OF PROVIDER OR SUPPLIER EVERBLOOM HOME HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1864 BEAR PATH TRAIL EAGAN, MN 55122		
(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
01730	Continued From page 21 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. (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 an individualized medication management plan with the required content for one of one resident (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 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large	01730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35547	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/14/2024
NAME OF PROVIDER OR SUPPLIER EVERBLOOM HOME HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1864 BEAR PATH TRAIL EAGAN, MN 55122		
(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
01730	Continued From page 22 portion or all of the residents). The findings include: R2's diagnoses included schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly) and type 2 diabetes. R2's service plan dated August 1, 2021, indicated R2 received assistance with medication administration. On February 13, 2024, a.m. at 9:28 a.m. clinical nurse supervisor (CNS)-B was observed to administer oral medications to R2. R2's record lacked a medication management plan to include the documentation of specific resident instructions relating to the administration of medications On February 13, 2024, at 3:50 p.m. owner (O)-C stated they were not aware of all the specific requirements of the individual medication management plan and all of the licensee's residents would be missing it. The licensee's Individualized Medication Management Plan and Record policy, undated, indicated the medication management plan must include documentation of specific resident instructions relating to the administration of medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35547	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/14/2024
NAME OF PROVIDER OR SUPPLIER EVERBLOOM HOME HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1864 BEAR PATH TRAIL EAGAN, MN 55122		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01760	Continued From page 23	01760			
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 interview and record review, the licensee failed to ensure the registered nurse documented medications as ordered by the physician to include the route of administration for one of one resident (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: R2's diagnoses included schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly) and type 2 diabetes.	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35547	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/14/2024
NAME OF PROVIDER OR SUPPLIER EVERBLOOM HOME HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1864 BEAR PATH TRAIL EAGAN, MN 55122		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01760	Continued From page 24 R2's Service Plan Agreement dated August 1, 2021, identified services included medication administration. R2's prescriber's orders dated June 1, 2023, included: - Metformin HCL ER 500 milligrams (mg) oral tablet extended release 24 hour take 4 tablets (2000 mg) by mouth once daily with food; - Atorvastatin Calcium 20 mg take 1 tablet (20 mg) by mouth at bedtime; - Quetiapine Fumarate 50 mg take 1 tablet by mouth daily prior to bedtime as needed (PRN) for sleep. Okay to take in the morning when patient works the night shift; - Invega Sustenna 234 mg/1.5 milliliter (ml) intramuscular suspension prefilled syringes 1.5 millimeters inject the contents of 1 syringe intramuscularly every 4 weeks; - Lisinopril 10 mg take 1 tablet by mouth daily; - Victoza 18 mg/3 ml subcutaneously solution pen-injector inject 1.8 mg subcutaneously once daily. Discard 30 days after first use, may store at room temp after first use; - Hydroxyzine HCL 25 mg take 2 tablets (50 mg) by mouth at bedtime as needed; and - Stool softener 100 mg take 1 tablet by mouth daily as directed. R2's February 2024, medication administration record (MAR) included: 4-Metformin HCL ER 500 mg Eve; 1-Atorvastatin 10 mg PM; Invega 234 mg/1.5 ml Monthly; Quetiapine Fumarate 50 mg PRN; Hydroxyzine HCL-25 mg PRN; Albuterol Sulfate dHFA 108 (90 base) mcg/act inhalation PRN Docusate Sod cap 100 mg 9:00 a.m.	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35547	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/14/2024
NAME OF PROVIDER OR SUPPLIER EVERBLOOM HOME HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1864 BEAR PATH TRAIL EAGAN, MN 55122		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01760	Continued From page 25 Lisinopril tab 10 mg 9:00 a.m. Victoza 18 mg 3 ml self The MAR did not include the route for administration as ordered. On February 13, 2024, at 9:36 a.m. clinical nurse supervisor (CNS)-B stated R2's medication routes were not listed and further stated staff need to know the route of medication to give the ordered medications. The licensee's Medication Prescriptions and Refills policy, undated, indicated the RN will make any changes to the MAR immediately after receiving a prescription/order for a change in medication or a new medication. The RN will make any necessary changes to the service plan and/or care plan, including specific written directions for the administration of the new or changed medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or	01910			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35547	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/14/2024
NAME OF PROVIDER OR SUPPLIER EVERBLOOM HOME HEALTH CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1864 BEAR PATH TRAIL EAGAN, MN 55122			
(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
01910	Continued From page 26 expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to complete in the resident's record the disposition of medications, including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition for one of one discharged resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1 began receiving services on February 2, 2021, with diagnoses including developmentally delayed. R1's discharge summary dated September 5,	01910			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35547	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/14/2024
NAME OF PROVIDER OR SUPPLIER EVERBLOOM HOME HEALTH CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1864 BEAR PATH TRAIL EAGAN, MN 55122			
(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
01910	Continued From page 27 2023, identified R1 received services which included assistance with medication management. R1 was discharged from the licensee on September 1, 2023. R1's record lacked a completed documentation of a disposition of medications upon discharge. On February 12, 2024, at 3:19 p.m. clinical nurse supervisor (CNS)-B stated the licensee did not complete a disposition of medications upon R1's discharge including medication strength, prescription number as applicable, to whom the medications were given, date of disposition and names of staff or other individuals involved in the disposition. CNS-B stated she gave the medications to the family but forgot to document it in R1's record. The licensee's Medication Disposition or Disposal policy, undated, indicated drugs given to residents when the medication management services have terminated would include staff documenting in the resident's record the name of the person to whom the medications were given, the time and date, the name of each medication, dose and the amount of the medication remaining. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910			



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

Type: Full
Date: 02/14/24
Time: 11:51:16
Report: 1004241027

Food and Beverage Establishment Inspection Report

Page 1

Location:

Everbloom Home Health Care
1864 Bear Path Trail
Eagan, MN 55122
Dakota County, 19

Establishment Info:

ID #: 0039027
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6512357828
ID #:

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

The following orders were issued during this inspection.

3-500B Microbial Control: hot and cold holding

3-501.16A2 **** Priority 1 ****

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

ITEMS IN THE REFRIGERATOR MEASURED AT 44-45°F. DISCUSSED TEMPERATURE REQUIREMENTS WITH OPERATOR AND INSTRUCTED TO ADJUST UNIT AND MONITOR.

Comply By: 02/14/24

4-700 Sanitizing Equipment and Utensils

4-703.11B **** Priority 1 ****

MN Rule 4626.0905B Sanitize food contact surfaces of equipment and utensils after cleaning by using mechanical hot water operations that achieve a utensil surface temperature of 160 degrees F (71 degrees C) and are set up and maintained in accordance with the specifications of NSF International and the manufacturer's data plate.

HIGH TEMPERATURE SANITIZING DISH MACHINE IS NOT REACHING THE REQUIRED MINIMUM SURFACE UTENSIL TEMPERATURE. HAVE UNIT SERVICED IMMEDIATELY AND USE ALTERNATIVE MEANS OF SANITIZING, SUCH AS AN APPROVED CHEMICAL SANITIZER.

*INFORMATION SUPPLIED WITH REPORT.

Comply By: 02/14/24

4-300 Equipment Numbers and Capacities

4-302.12B **** Priority 2 ****

MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.

FOOD THERMOMETER ON SITE DOES NOT HAVE A SMALL DIAMETER PROBE. PROVIDE A TEMPERATURE MEASURING DEVICE WITH A SMALL DIAMETER PROBE. DISCUSSED

Type: Full
Date: 02/14/24
Time: 11:51:16
Report: 1004241027
Everbloom Home Health Care

Food and Beverage Establishment Inspection Report

Page 2

REQUIREMENT AND EXAMPLES WITH OPERATOR ON SITE.

Comply By: 02/14/24

4-300 Equipment Numbers and Capacities

4-302.13B **** Priority 2 ****

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

NO IRREVERSIBLE TEMPERATURE INDICATORS FOR USE TO VERIFY SANITIZING TEMPERATURES FOR THE HIGH TEMPERATURE SANITIZING DISH MACHINE. PROVIDE AND USE FREQUENTLY.

Comply By: 02/14/24

2-100 Supervision

2-102.12DMN

MN Rule 4626.0033D Post the certified food protection manager certificate.

CERTIFIED FOOD PROTECTION MANAGER CERTIFICATION COULD NOT BE PRODUCED DURING INSPECTION. INFORMATION WAS FOUND IN THE STATE LOOK-UP SYSTEM. POST ORIGINAL CERTIFICATION ON SITE AND MAINTAIN.

Comply By: 02/14/24

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.

-REFRIGERATOR IS UNABLE TO MAINTAIN REQUIRED TEMPERATURES. ADJUST UNIT AND IF TEMPERATURE CANNOT BE MAINTAINED, HAVE UNIT SERVICED OR REPLACED.

-DISH MACHINE IS NOT REACHING REQUIRED MINIMUM UTENSIL SURFACE TEMPERATURE. HAVE UNIT SERVICED OR REPLACED.

Comply By: 02/14/24

Surface and Equipment Sanitizers

Hot Water: = at 150 Degrees Fahrenheit

Location: DISH MACHINE

Violation Issued: Yes

Food and Equipment Temperatures

Process/Item: RICE

Temperature: 45 Degrees Fahrenheit - Location: REFRIGERATOR

Violation Issued: Yes

Process/Item: LEFT OVER MEAL

Temperature: 45 Degrees Fahrenheit - Location: REFRIGERATOR

Violation Issued: Yes

Type: Full
Date: 02/14/24
Time: 11:51:16
Report: 1004241027
Everbloom Home Health Care

Food and Beverage Establishment Inspection Report

Page 3

Process/Item: PEPPER JUICE

Temperature: 44 Degrees Fahrenheit - Location: REFRIGERATOR

Violation Issued: Yes

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

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

DISCUSSED:

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

*REPORT WAS DISCUSSED WITH THE OPERATOR, MERIAM, AND WITH THE NURSE EVALUATOR, JENN.

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

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

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

INSPECTOR WILL RETURN FOR A FOLLOW-UP INSPECTION

Type: Full
Date: 02/14/24
Time: 11:51:16
Report: 1004241027
Everbloom Home Health Care

Food and Beverage Establishment Inspection Report

Page 4

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 1004241027 of 02/14/24.

Certified Food Protection Manager MERIAM ABRAHAM

Certification Number: FM110787 Expires: 01/14/25

Inspection report reviewed with person in charge and emailed.

Signed: _____

MERIAM ABRAHAM
OPERATOR

Signed: Molly Dougherty

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