Electronically Delivered

May 1, 2025

Licensee
CLINIQUE HEALTHCARE SERVICES INC
7924 June Avenue North
Brooklyn Park, MN 55443

RE: Project Number(s) SL35377016

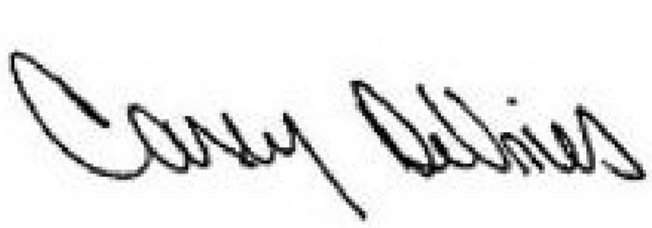
Dear Licensee:

On April 7, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on January 15, 2025. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,



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

HHH

Electronically Delivered

February 20, 2025

Licensee
Clinique Healthcare Services Inc.
7924 June Avenue North
Brooklyn Park, MN 55443

RE: Project Number(s) SL35377016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 15, 2025, 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 . . ."

IMPOSITION OF FINES

In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this survey:

0470 - 144g.41 Subdivision 1 - Minimum Requirements - $3,000.00
1290 - 144g.60 Subdivision 1 - Background Studies Required - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $6,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

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

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in

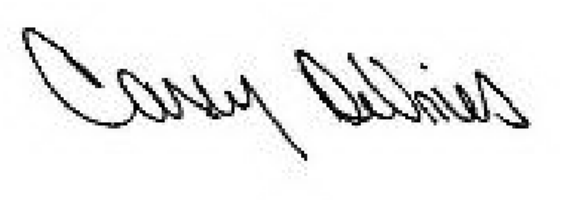
a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

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,



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

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35377	A. BUILDING: _____ B. WING _____	01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLINIQUE HEALTHCARE SERVICES I	7924 JUNE AVENUE NORTH BROOKLYN PARK, MN 55443

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL35377016-0 On January 13, 2025, through January 15, 2025, 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. An immediate correction order was identified on January 13, 2025, issued for SL35377016-0, tag identification 1290. During the survey, the licensee took action to mitigate the immediate risk. However, noncompliance remained, and the scope and level remain unchanged. An immediate correction order was identified on January 14, 2025, issued for SL35377016-0, tag identification 0470.	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.	

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0 000	Continued From page 1 During the survey, the licensee took action to mitigate the immediate risk. However, noncompliance remained, and the scope and level remain unchanged.	0 000		
0 340 SS=F	144G.30 Subd. 5 Correction orders (a) A correction order may be issued whenever the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, an agent of the facility, or staff of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction. (b) The commissioner shall mail or email copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must: (1) document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed provide documentation	0 340		

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0 340	Continued From page 2 with actions taken to comply with correction orders from a survey completed on April 19, 2022. The lack of action to ensure compliance with regulations had the potential to affect all residents receiving services from the licensee. 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: INTERCONNECTED SMOKE ALARMS: During a survey that was conducted April 19, 2022, the licensee was cited using the 0780 tag identification number for failing to provide interconnected smoke alarms throughout the facility. On January 15, 2025, survey staff confirmed the deficient condition remained, as the facility smoke alarms were not interconnected. ANNUAL SERVICE OF FIRE EXTINGUISHERS: During a survey that was conducted April 19, 2022, the licensee was cited using the 0790 tag identification number for failing to provide annual service of the fire extinguishers and for failing to provide monthly inspections of the fire extinguishers by facility staff. On January 15, 2025, survey staff confirmed the deficient condition remained, as the licensee failed to provide annual service of the fire extinguishers and failed to maintain	0 340		

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0 340	Continued From page 3 documentation of monthly inspections of the fire extinguishers. FIRE SAFETY AND EVACUATION PLAN: During a survey that was conducted April 19, 2022, the licensee was cited using the 0810 tag identification number for failing to provide a fire safety and evacuation plan (FSEP) that included resident procedures for evacuation, for failing to provide training of staff on the FSEP at time of hire and at least twice per year after, and for failing to offer residents training at least once per year on the FSEP. On January 15, 2025, survey staff confirmed the deficient condition remained, as the licensee failed to provide a FSEP that included resident procedures for evacuation, for failing to provide training of staff on the FSEP at time of hire and at least twice per year after, and for failing to offer residents training at least once per year on the FSEP. HAZARD VULNERABILITY ASSESSMENT: During a survey that was conducted on April 19, 2022, the licensee was cited using the 2040 tag identification number for failing to provide a hazard vulnerability or safety risk assessment (HVA) plan to identify hazard vulnerabilities and mitigation on and around the property. On January 15, 2025, survey staff confirmed the deficient condition remained, as the licensee failed to provide a hazard vulnerability or safety risk assessment (HVA) plan to identify hazard vulnerabilities and mitigation on and around the property. INTERVIEW: The surveyor conducted an interview on January	0 340		

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0 340	Continued From page 4 15, 2025, with licensed assisted living director (LALD)-D. LALD-D stated new smoke alarms were installed in the facility that were capable of being interconnected. LALD-D stated they were not sure why the new smoke alarms were not interconnected at the time of survey. LALD-D stated the fire extinguishers had been replaced after the last survey. When asked about the annual service and monthly inspection, LALD-D stated that they have not performed or completed monthly inspections or annual service of the fire extinguishers since installation. LALD-D stated they did not know the exact date of fire extinguisher replacement. LALD-D provided a FSEP that had a policy effective date of January 14, 2025. LALD-D stated the FSEP was printed the day before the surveyor arrived on site and that it was a third-party policy that had not been customized to fit the facilities needs. LALD-D stated they lacked documentation indicating staff were trained upon hire and twice per year thereafter on the FSEP and lacked documentation indicating residents who are capable of assisting in their own evacuation were offered training once a year on the FSEP. LALD-D stated they did not have an HVA, and that it did not matter because they are not currently providing dementia care to residents. LALD-D also stated that they are planning on giving up the dementia care portion of their license, so they are not planning on complying with the requirement to have an HVA. No further information was provided.	0 340		

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0 340	Continued From page 5 TIME PERIOD FOR CORRECTION: Seven (7) days	0 340		
0 470 SS=I	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 observation, interview, and record review, the licensee failed to ensure sufficient	0 470	During the survey, the licensee took action to mitigate the immediate risk. However,	

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0 470	Continued From page 6 staffing to meet the needs of one of one resident (R1), who required a two-person transfer with a mechanical lift. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at 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 lacked sufficient staffing to meet R1's needs on a 24-hour basis as required by the licensee's resident care guide dated August 15, 2024. The licensee's resident care guide dated August 15, 2024, indicated, "Resident [sic] who require use of stand assist or mechanical lift must have assist of two staff." The licensee's employee schedule from January 12 to January 18, 2025, indicated the following: - January 12, 2025, one unlicensed personnel (ULP) for day shift (7:00 a.m., to 3:00 p.m.); one ULP for evening shift (3:00 p.m., to 10:00 p.m.); one ULP for night shift (10:00 p.m., to 7:00 a.m.). - January 13, and 14, 2025, one ULP for day shift (7:00 a.m., to 12:00 p.m.); one ULP for mid shift (11:00 a.m.,to 3:00 p.m.); two ULP for evening shift (3:00 p.m., to 11:00 p.m.); one ULP for night shift (10:00 p.m., to 7:00 a.m.). - January 15, 2025, one ULP for day shift (7:00 a.m., to 12:00 p.m.), one ULP for mid shift (11:00 a.m. to 3:00 p.m.); one ULP for evening shift	0 470	noncompliance remained, and the scope and level remain unchanged.	

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0 470	Continued From page 7 (3:00 p.m., to 10:00 p.m.); one ULP for night shift (10:00 p.m., to 7:00 a.m.). - January 16, 2025, one ULP for day shift (7:00 a.m., to 3:00 p.m.), one ULP for mid shift (10:00 a.m., to 1:00 p.m.); one ULP for evening shift (3:00 p.m., to 11:00 p.m.); one ULP for night shift (11:00 p.m., to 7:00 a.m.). - January 17 and 18, 2025, one ULP for day shift (7:00 a.m., to 3:00 p.m.); one ULP for evening shift (3:00 p.m., to 11:00 p.m.); one ULP for night shift (11:00 p.m., to 7:00 a.m.). R1 was admitted to the licensee on July 31, 2024. R1's diagnoses included functional quadriplegia, paroxysmal atrial fibrillation, other specific disorder of the muscle, aphonia, major depressive disorder, and dependance on wheelchair. R1's Clinical Update assessment completed on January 13, 2025, indicated R1 was non ambulatory, and needed mechanical lift for all transfers. R1's Individual Abuse Prevention Plan dated January 13, 2025, indicated R1 needed help in an emergency. R1 was unable to evacuate without help and required frequent supportive nursing care and observation and significant assistance during evacuation. It also indicated R1 required mechanical lift for all transfers. R1's undated document printed from Rtasks (web-based software for healthcare management) titled Transfer Assistance indicated, "Two persons with mechanical lift transfers. The night shift is to call [licensed practical nurse (LPN)-G] at [phone number] and the nurse if the resident needs transfers. Nurse to assist with weekend transfers."	0 470		

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0 470	Continued From page 8 On January 14, 2025, at 9:41 a.m., LPN-G stated R1 needed a two person assist with mechanical lift for all transfers. LPN-G stated they always have two ULPs scheduled. LPN-G also stated they live ten minutes away and stated they will come and help if they need help with transfers at night. On January 14, 2025, at 9:44 a.m., R1 stated one person helps them with transfers if they need help at night. On January 14, 2025, at 9:47 a.m., ULP-B stated R1 is a two person assist for transfers, and R1 was incontinent and used incontinent products. ULP-B also stated R1 was one person assist for help with incontinent products if R1 was to get changed at night. On January 14, 2025, at 9:57 a.m., clinical nurse supervisor (CNS)-C stated they call 911 in case of emergency and they have staff who lives ten minutes away. CNS-C stated LPN-G lives ten minutes away and they are on call if night staff needed help with transfers. On January 14, 2025, at 10:13 a.m., ULP-B stated they did not need a two person assist for the weekends. ULP-B stated they do one person transfers R1 with the mechanical lift on the weekends, the licensee makes sure the person who was scheduled overnight and on the weekends were efficient enough to do the mechanical lift transfers by themselves. ULP-B stated they have transferred R1 without a second person in the past when they worked on the weekends. On January 14, 2025, at 10:15 a.m., R1 stated	0 470		

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0 470	Continued From page 9 they usually get transferred with mechanical lift by one person. On January 14, 2025, at 10:23 a.m., CNS-C stated they usually worked the weekends. CNS-C stated they come in at 8:00 a.m, and leave at 8:00 p.m., both days on the weekend. On January 14, 2025, at 10:37 a.m., via telephone ULP-F stated R1 was a two person assist with mechanical lift for transfers. ULP-F stated they sometimes work PM shifts on the weekends. ULP-F stated when they come in to work at 3:00 p.m., R1 is usually in bed and licensed assisted living director (LALD)-D usually stops by around dinner time to help with transfers on the weekends. ULP-F stated LALD-D did not have set time and stated they would just wait for the LALD-D to come and help R1 get up for dinner and activities, and LALD-D usually shows up around dinner time. Minnesota Administrative Rule 4659.0180, Subpart 5 dated August 11, 2021, indicated "A minimum of two direct-care staff must be scheduled and available to assist at all times whenever a resident requires the assistance of two direct-care staff for scheduled reasonably foreseeable and unscheduled needs, as reflected in the resident's assessments and service plan." No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	0 470		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food	0 480		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLINIQUE HEALTHCARE SERVICES I	7924 JUNE AVENUE NORTH BROOKLYN PARK, MN 55443

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 480	Continued From page 10 must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean	0 480		

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0 480	Continued From page 11 and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. 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 13, 2025, 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.	0 480		

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0 680	Continued From page 12	0 680		
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 an emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 680		

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0 680	Continued From page 13 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's EPP reviewed on January 14, 2025, during the survey, lacked evidence that the licensee reviewed the missing resident plan quarterly, and the EPP annually. The licensee's EPP also lacked evidence of the following required contents: - subsistence needs for staff and residents; - policies and procedures for medical documents; - risk assessment for the facility; - policies and procedures for volunteers; - primary and alternative means for communication; - methods for sharing information; - sharing information on occupancy and needs; and - long-term care (LTC) family notifications. On January 15, 2025, at approximately 9:50 a.m., licensed assisted living director (LALD)-D stated they reviewed the EPP plan yearly and the missing resident policy quarterly; LALD-D stated they did not have documentation for the quarterly or yearly review. LALD-D stated the EPP was "work-in-progress", and they were aware of the missing documents, and they were working on it. The licensee's Emergency Preparedness policy dated January 14, 2025, indicated the licensee would have an identified plan in place to assure	0 680		

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0 680	Continued From page 14 the safety and well-being of residents and staff during periods of an emergency or disaster. Minnesota Administrative Rule 4659.0110, Subpart 4 dated August 11, 2021, indicated the assisted living director and clinical nurse supervisor must review the missing person plan at least quarterly and document any changes to the plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans;	0 730		

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0 730	Continued From page 15 (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record included documentation of all services provided for three of three residents (R1, 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) 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).	0 730		

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0 730	Continued From page 16 The findings include: R1 R1's Service Plan (Waiver) - Addendum to Contract signed and dated October 15, 2024, indicated R1 received assistance with medication administration, grooming, dressing, incontinence care, manage behavior, manage symptoms, positioning, mobility assistance, and meal assistance. R1's Service Recap Summary from January 1, 2025, through January 14, 2025, lacked the following documentation for services provided during multiple shifts: -2 of 28 scheduled services for record blood pressure; -2 of 28 scheduled services for record oxygen saturation; -2 of 28 scheduled services for record pulse; -4 of 28 scheduled services for record temperature; -2 of 14 scheduled services for dressing; -2 of 14 scheduled services for drinking assistance; -2 of 14 scheduled services for glasses care; -1 of 14 scheduled services for grooming; -2 of 28 scheduled services for housekeeping; -2 of 28 scheduled services for incontinence care; -2 of 28 scheduled services for linen change; -2 of 28 scheduled services for behaviors - agitation; -2 of 28 scheduled services for behaviors - other mental health needs; -2 of 28 scheduled services for behaviors - physical aggression; -1 of 14 scheduled services for outcome - activity; -2 of 14 scheduled services for record bowel movement;	0 730		

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0 730	Continued From page 17 -1 of 14 scheduled services for record meal percentage; -4 of 28 scheduled services for remove garbage; -1 of 14 scheduled services for safety checks; -2 of 28 scheduled services for toileting; -1 of 14 scheduled services for wheelchair use; -1 of 14 scheduled services for meal assistance; -2 of 28 scheduled services for housekeeping; -2 of 28 scheduled services for position/reposition; and -2 of 56 scheduled services for medication administration. R2 R2's unsigned service plan dated January 15, 2025, indicated R2 received assistance with dressing, grooming, bathing reminder, meal reminder, manage behaviors, manage symptoms, and medication administration. R2's Service Recap Summary from January 1, 2025, through January 14, 2025, lacked the following documentation for services provided during multiple shifts: -2 of 2 scheduled services for nail care; -2 of 28 scheduled services for record blood pressure; -4 of 42 scheduled services for record bowel movement; -3 of 28 scheduled services for record oxygen saturation; -2 of 28 scheduled services for record pulse; -5 of 42 schedule service for record respiration; -8 of 42 scheduled services for record temperature; -1 of 14 scheduled services for dressing; -3 of 42 scheduled service for record blood glucose; -1 of 14 scheduled services for ambulation; -1 of 14 scheduled services for grooming;	0 730		

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0 730	Continued From page 18 -1 of 14 scheduled services for housekeeping; -1 of 14 scheduled services for incontinence care; -2 of 28 scheduled services for laundry; -3 of 28 scheduled services for behaviors - anxiety; -3 of 28 scheduled services for behaviors - other mental health needs; -3 of 28 scheduled services for behaviors - self isolation; -1 of 14 scheduled services for behaviors - depression; -1 of 14 scheduled services for record meal percentage; -3 of 28 scheduled services for remove garbage; -3 of 28 scheduled services for safety checks; -2 of 28 scheduled service for meal reminders; -1 of 14 scheduled service for monitor hours of sleep; -2 of 28 scheduled services for toileting; -1 of 14 scheduled service for skin care; and -6 of 56 scheduled services for medication administration. R3 R3's unsigned service plan dated January 15, 2025, indicated R3 received assistance with dressing, grooming, bathing, bed making, incontinence care, meal reminder, manage behaviors, manage symptoms, and medication administration. R3's Service Recap Summary from January 1, 2025, through January 14, 2025, lacked the following documentation for services provided during multiple shifts: -3 of 28 scheduled services for record temperature; -2 of 28 scheduled services for laundry; -2 of 28 scheduled services for behaviors - agitation;	0 730		

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0 730	Continued From page 19 -2 of 28 scheduled services for behaviors - elopement threat; -2 of 28 scheduled services for behaviors - resistive tendencies; -1 of 14 scheduled services for outcome - exercise; -1 of 14 scheduled services for meal assistance; -2 of 28 scheduled services for monitor hours of sleep; -2 of 28 scheduled services for position/reposition; -1 of 14 scheduled services for record blood pressure; -2 of 14 scheduled services for record bowel movement; -1 of 14 scheduled services for record meal percentage; -1 of 14 scheduled services for incontinence care; -1 of 14 scheduled services for antipsychotic side effect monitoring; -1 of 14 scheduled services for record oxygen saturation; -1 of 14 scheduled services for record pulse; -1 of 14 scheduled services for record respiration; -2 of 28 scheduled services for safety checks; -2 of 28 scheduled services for toileting; -4 of 56 scheduled services for transfer assist; -1 of 14 scheduled services for drinking assist; and -1 of 14 scheduled services for medication administration. On January 15, 2025, at 2:40 p.m., clinical nurse supervisor (CNS)-C stated R1 was on leave of absence and staff forgot to chart service and medication administration to reflect the leave of absence. CNS-C stated they did not know why R1 and R2's service and medication administration were not charted; CNS-C stated, "I have to look into that."	0 730		

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0 730	Continued From page 20 The licensee's undated Resident Record Policy indicated the contents of resident record should include documentation of services provided as identified in the service plan for each resident. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated;	0 780		

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0 780	Continued From page 21 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that functioned and were interconnected so that the actuation of one alarm caused all alarms in the dwelling unit to actuate. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On January 15, 2025, from 10:50 a.m. to 11:30 a.m., the surveyor toured the facility with licensed assisted living director (LALD)-D. Survey staff asked LALD-D to initiate a test of the smoke alarms throughout the facility. Upon testing, it was found that the smoke alarms in the facility were not interconnected. The facility is equipped with hard wired smoke alarms in the common hallways on first floor and basement. The hard-wired smoke alarms are not interconnected and only sounded locally. The surveyor requested that LALD-D test the smoke alarms in the resident rooms on the first floor to confirm that the smoke alarms were interconnected. Each resident room was equipped with two battery-operate smoke alarms. LALD-D tested the battery-operated smoke	0 780		

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0 780	Continued From page 22 alarms that had the ability to be interconnected. It appeared that when LALD-D attempted to test, the smoke alarms entered programming mode. The smoke alarms inside of the resident rooms on first floor only began to chirp and would not stop chirping until the button was pressed in each resident room. They surveyor requested that LALD-D test the alarms again as it appeared that they had entered programming mode. When tested, the smoke alarms throughout the facility only sounded locally and were not interconnected. All dwelling units required to have multiple smoke alarms are required to have interconnected alarms so activation of one alarm activates all alarms within the dwelling unit. These deficient conditions were visually verified by LALD-D accompanying on the tour. TIME PERIOD FOR CORRECTION: Two (2) day.	0 780		
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:	0 790		

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0 790	Continued From page 23 Based on observation and interview, the licensee failed to maintain the portable fire extinguishers. This deficient condition 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) 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 15, 2025, from 10:50 a.m. to 11:30 a.m., the surveyor toured the facility with licensed assisted living director (LALD)-D. The portable fire extinguishers throughout the facility lacked records to show the required annual certification was completed. The portable fire extinguishers throughout the facility lacked records to show monthly visual inspections were complete. Documentation is required to demonstrate fire extinguishers have been inspected by facility personnel monthly, and annually replaced with a new extinguisher or serviced annually by a certified technician. LALD-D stated that the fire extinguishers were purchased new after the last survey. The last survey was completed in 2022. On January 15, 2025, at 11:30 a.m., the surveyor explained to LALD-D that the portable fire extinguishers must be provided annual certification tags and monthly visual inspections or "quick checks" of each extinguisher by their	0 790		

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0 790	Continued From page 24 employees to ensure all portable extinguishers are readily available, fully charged, and operable at their designated location with no obvious physical damage or condition to the extinguisher that would prevent their operation when needed. LALD-D stated they understood the requirements. 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. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain 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. This deficient condition 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	0 800		

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0 800	Continued From page 25 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 15, 2025, from 10:50 a.m. to 11:30 a.m., the surveyor toured the facility with licensed assisted living director (LALD)-D. The following was observed. During the tour, the surveyor asked LALD-D to open the windows in the resident bedrooms for measurement. The storm windows were frozen shut and would not open in resident rooms 1, 2, and 3. LALD-D left the inside windows open in resident rooms 1, 2, and 3. At approximately 11:50 a.m. LALD-D informed the surveyor that the frozen shut windows in resident rooms 1,2, and 3 were now able to be opened fully. The surveyor visually confirmed that the windows were able to be opened fully. Emergency rescue and escape openings shall be always maintained in a readily usable condition, and in a manner that does not delay egress. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms;	0 810		

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0 810	Continued From page 26 (2) staff 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) Staff 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 staff 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 interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the 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	0 810		

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0 810	Continued From page 27 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 the residents). The findings include: FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP, titled "Fire Safety", dated January 14, 2025, failed to include the following: 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 provided FSEP was from a third-party provider and had not been updated to the specific facility. The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. The policy reviewed was an unedited policy purchased from a third-party provider that was not specific to the facility. TRAINING: The licensee failed to provide evacuation training to residents at least once per year. Licensed assisted living director (LALD)-D lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan. The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year.	0 810		

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0 810	Continued From page 28 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
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 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:	0 950		

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0 950	Continued From page 29 Based on interview and record review, the licensee failed to include the required statutory language giving residents the right to identify a designated representative in writing in the contract and failed to provide the required verbatim notice on its own separate page for two of two residents (R1, R2). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R1 R1's Assisted Living Contract was signed on September 29, 2024. R2 R2's Assisted Living Contract was signed on November 21, 2024. The licensee's Assisted Living Contract form utilized for all residents lacked the required verbatim "right to designate a representative for certain purposes" notice on a document separate from the contract. On January 15, 2025, at 1:30 p.m., licensed assisted living director (LALD)-D stated they thought it was covered under the legal guardian as the guardian has all the rights. They were not aware of the requirement to include "right to designate a representative for certain purposes" notice in the assisted living contract and on a	0 950		

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0 950	Continued From page 30 document separate from the contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 950		
01290 SS=G	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a background study (BGS) was submitted and received in affiliation with the assisted living licensee for one of 14 employees (unlicensed personnel (ULP)-E). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death,	01290	During the survey, the licensee took action to mitigate the immediate risk. However, noncompliance remained, and the scope and level remain unchanged.	

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01290	Continued From page 31 or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). This resulted in an immediate correction order on January 13, 2025. The findings include: ULP- E was hired on March 1, 2022, to provide direct cares and services to residents. The licensee's staffing schedule for January 12, 2025, through January 18, 2025, indicated ULP-E was scheduled to work the day shifts (11:00 a.m. to 3:00 p.m.,) for the following dates: January 13, 14, 15, 20, 21, 22, 27, 28, 29 and day shift, (10:00 a.m. to 1:00 p.m.,) for the following dates: January 16, 23, and 30, 2025. The licensee's NETstudy2.0 (web-based system used to submit background study requests to the Department of Human Services (DHS)) indicated the "Eligible covid 19 study" status for the BGS was expired on December 31, 2022. The licensee lacked evidence the licensee submitted a new BGS for ULP-E after the covid 19 eligible status had expired. On January 13, 2025, at 12:29 p.m., licensed assisted living director (LALD)-D stated they did not know the "eligible covid 19 study" status was expired and they did not know they had to resubmit a BGS. LALD-D stated ULP-E currently worked with residents unsupervised. The licensee's undated Background Studies policy indicated BGS study will be completed on	01290		

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01290	Continued From page 32 all employees and employees may not work with residents until background study has been received. The DHS website for Emergency Background Studies End dated as updated September 28, 2023, indicated, "Expiration dates for emergency studies are displayed as 12/31/2022 in NETStudy 2.0" and "The Background Studies Division no longer reviews new records or information for an individual who only has an emergency study in NETStudy 2.0." The DHS website for Background Studies updated December 28, 2023, indicated, "DHS temporarily modified background studies during the COVID-19 pandemic. Those modifications ended Jan. 1, 2023. Learn more about the return to fully compliant studies." No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01290		
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in	01500		

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01500	Continued From page 33 the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies,	01500		

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01500	Continued From page 34 assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure two of three employees (unlicensed personnel (ULP)-E, ULP-F) received all the required contents of annual training. 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: ULP-E ULP- E was hired on March 1, 2022, to provide direct cares and services to residents. On January 13, 2025, at 10:56a.m., the surveyor observed ULP-E administer oral medications to R2. ULP-E's employee records included annual training last completed October 17, 2024. ULP-E's annual training record did not include the following required content: - review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures. ULP-F	01500		

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01500	Continued From page 35 ULP-F was hired on July 20, 2022, to provide direct cares and services to residents. ULP-F's employee records included annual training last completed on March 3, 2024. ULP-F's annual training record did not include the following required content: - review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures. On January 15, 2025, at 1:15 p.m., clinical nurse supervisor (CNS)-C stated they were not aware of the requirement for all staff to review policies and procedures annually. The licensee's undated Annual Training Requirements policy indicated all staff providing assisted living services would complete at least eight hours of education for each 12 months of employment and the education topics would include the following: 1. Training on reporting of maltreatment of vulnerable adults under section 626.557 2. Review of the Assisted Living Bill of Rights and staff responsibilities related to ensuring the exercise and protection of those rights 3. Review of infection control techniques used in the home and implementation of infection control standards 4. Effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease or related disorders 5. Review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedure	01500		

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01500	Continued From page 36 6. The principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person 7. Training on providing services to residents with hearing loss. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
01540 SS=D	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure direct-care staff completed at least eight hours of initial dementia care training within 80 working hours of the	01540		

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01540	Continued From page 37 employment start date for one of three employees (licensed practical nurse (LPN)-G). 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: The licensee had a current Assisted Living Facility with Dementia Care (ALFDC) license effective November 1, 2024, through October 31, 2025. LPN-G was hired on October 28, 2024, and started providing nursing care and assisted living services to resident. LPN-G's employee record included five and a half hours of dementia care training completed from November 1, 2024, through December 1, 2024. LPN-G'S earning statement dated December 20, 2024, indicated LPN-G had worked 83.5 hours year to date, and earning statement dated January 3, 2025, indicated LPN-G had worked 16 hours year to date. LPN-G had worked a total of 99.5 hours for the licensee since hire. LPN-G's employee records lacked eight hours of initial dementia care training within 80 working hours of the employment start date. On January 15, 2025, at 2:10 p.m., clinical nurse supervisor (CNS)-C stated they were not aware LPN-G was lacking hours on dementia training.	01540		

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	35377	A. BUILDING: _____ B. WING _____	01/15/2025

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01540	Continued From page 38 CNS-C stated they have now assigned more dementia training for LPN-G to complete. The licensee's undated Dementia Care Training Policy indicated, "For assisted living facilities with dementia care, direct care employees must have completed at least eight hours of initial training within 80 working hours of employment start date. Until this training is complete, an employee must not provide care unless there is another employee on site who has completed the training and can act as a resource and assist if issues arise. A trainer of the requirements or a supervisor must be available for consultation with the new employee until the training requirement is complete." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01540		
01620 SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must	01620		

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01620	Continued From page 39 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) conducted ongoing resident assessment and reassessment, not to exceed 90 calendar days from the last date of the assessment for two of three residents (R1, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 R1 was admitted to the licensee on July 31, 2024, and began receiving assisted living services. R1's diagnoses included functional quadriplegia, paroxysmal atrial fibrillation, other specific disorder of the muscle, aphonia, major	01620		

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01620	Continued From page 40 depressive disorder, and dependance on wheelchair. R1's Service Plan (Waiver) - Addendum to Contract signed and dated October 15, 2024, indicated R1 received assistance with medication administration, grooming, dressing, incontinence care, manage behavior, manage symptoms, positioning, mobility assistance, and meal assistance. R1's record included pre-admission assessment completed on July 17, 2024, admission assessment completed on August 3, 2024, 14-day nursing assessment completed on August 22, 2024, and 90-day nursing assessments completed on January 13, 2025, during the survey. The assessment completed on August 22, 2024, was 3 days past 14-calendar day requirement. The assessment completed January 13, 2025, was 54 days past the 90-calendar day requirement. R3 R3 was admitted to the licensee on June 22, 2023, and started receiving assisted living services. R3's diagnosis included amnestic disorder, insomnia, depression, anxiety, alcohol disorder, dementia, and hypertension. R3's unsigned service plan dated January 15, 2025, indicated R3 received assistance with dressing, grooming, bathing, bed making, incontinence care, meal reminder, manage behaviors, manage symptoms, and medication administration. R3's record included 90-day nursing assessment	01620		

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01620	Continued From page 41 completed on February 19, 2024, May 11, 2024, and January 13, 2025, during the survey. The assessment completed January 13, 2025, was 157 days past the 90-calendar day requirement. On January 15, 2025, at 2:24 p.m., clinical nurse supervisor (CNS)-C stated they were shocked when they found out the assessments were not completed. CNS-C stated they opened the assessments on time, but they forgot to close the assessments. The licensee's undated Nursing Assessment and Reassessment of Resident Policy indicated, "A comprehensive assessment is conducted by a registered nurse pre-admission, completed within 14 days after start of services, with change in condition and at least every 90 days." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01640 SS=E	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for	01640		

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01640	Continued From page 42 Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the current service plan included a signature or other authentication by the resident or resident's designated representative and the licensee to document agreement on the services to be provided 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 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: R2 R2 was admitted to the licensee on November 21, 2024, and started receiving assisted living services. R2's diagnosis included major depressive	01640		

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01640	Continued From page 43 disorder, paranoia, anxiety disorder, and diabetes mellitus type I. R2's unsigned service plan dated January 15, 2025, indicated R2 received assistance with dressing, grooming, bathing reminder, meal reminder, manage behaviors, manage symptoms, and medication administration. R3 R3 was admitted to the licensee on June 22, 2023, and started receiving assisted living services. R3's diagnosis included amnestic disorder, insomnia, depression, anxiety, alcohol disorder, dementia, and hypertension. R3's unsigned service plan dated January 15, 2025, indicated R3 received assistance with dressing, grooming, bathing, bed making, incontinence care, meal reminder, manage behaviors, manage symptoms, and medication administration. R2 and R3's service plans lacked a signature or other authentication by the residents or residents' designated representatives and the licensee to document agreement on the services to be provided. On January 15, 2025, at 1:40 p.m., clinical nurse supervisor (CNS)-C stated they thought the service plans for all residents were signed, but they could not find the signed service plans for R2 and R3. The licensee's undated Service Plan policy indicated, "The service plan and any revisions must include a signature or other authentication	01640		

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01640	Continued From page 44 by the assisted living provider and by the resident or resident's representative documenting agreement on the services to be provided." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01760 SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to accurately transcribe medication orders and document medication administration for three of three residents (R1, 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	01760		

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01760	Continued From page 45 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted to the licensee on July 31, 2024, and began receiving assisted living services. R1's diagnoses included functional quadriplegia, paroxysmal atrial fibrillation, other specific disorder of the muscle, aphonia, major depressive disorder, and dependance on wheelchair. R1's Service Plan (Waiver) - Addendum to Contract signed and dated October 15, 2024, indicated R1 received assistance with medication administration, grooming, dressing, incontinence care, manage behavior, manage symptoms, positioning, mobility assistance, and meal assistance. R1's medication administration record (MAR) for the month of January 2025, indicated R1 received the following medications: vitamin D3, 50 micrograms (mcg), daily vitamin 1 tablet, escitalopram oxalate 20 milligrams (mg), metoprolol succinate extended release (ER) 25 mg, potassium chloride 20 milliequivalents (mEq), baclofen 5 mg, metformin 1000 mg, rosuvastatin 5 mg, acetaminophen 500 mg, Eliquis 5 mg, mirtazapine 15 mg, and olanzapine 5 mg. R1's Medication Administration Summary - Month dated January 1, 2025, through January 14, 2025, lacked medication administration documentation for the following medication	01760		

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01760	Continued From page 46 administration opportunities during multiple shifts: 12:00 P.M. ADMINISTRATION - 1/14 baclofen 5 mg 6:00 P.M. ADMINISTRATION - 1/14 metformin 1000 mg; - 1/14 potassium chloride 20 mEq; and - 1/14 rosuvastatin 5 mg tab. 8:00 P.M. ADMINISTRATION - 1/14 acetaminophen 1000 mg - 1/14 baclofen 5 mg; - 1/14 Eliquis 5 mg; - 1/14 mirtazapine 15 mg; and -1/14 olanzapine 10 mg. R2 R2 was admitted to the licensee on November 21, 2024, and started receiving assisted living services. R2's diagnosis included major depressive disorder, paranoia, anxiety disorder and diabetes mellitus type I. R2's unsigned service plan dated January 15, 2025, indicated R2 received assistance with dressing, grooming, bathing reminder, meal reminder, manage behaviors, manage symptoms, and medication administration. R2's MAR for the month of January 2025, indicated R2 received the following medications: aspirin 81 mg, bupropion 450 mg, creative-antioxidant 1 tablet, clindamycin phosphate 1 %, escitalopram 10 mg, insulin aspart 16 units and sliding scale, Lantus Solostar 22 units, lisinopril 5 mg, metoprolol succinate 25 mg, tamsulosin 0.4 mg, vitamin D3 25 mcg, rosuvastatin 5 mg, mirtazapine 15 mg, melatonin 3 mg, olanzapine 5 mg and trazadone 100 mg.	01760		

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01760	Continued From page 47 R2's Medication Administration Summary - Month dated January 1, 2025, through January 14, 2025, lacked medication administration documentation for the following medication administration opportunities during multiple shifts: 8:00 A.M. ADMINISTRATION -1/14 aspirin 81 mg; -1/14 bupropion 450 mg; -1/14 creative-antioxidant 1 tablet; -1/14 clindamycin phosphate 1 %; -1/14 escitalopram 10 mg, -1/14 insulin aspart, subcutaneous sliding scale (three times daily with meals) hold insulin with skipped meals If blood glucose is: 140-179 = 2 units, 180-219 = 4 units, 220-259 = 6 units, 260-299 = 8 units, 300-339 = 10 units, 340-379 = 12 units, 380-399 =13 units > 399 call MD; -1/14 insulin aspart 16 units (hold insulin with skipped meals); -1/14 Lantus Solostar 22 units; -1/14 lisinopril 5 mg; -1/14 metoprolol succinate 25 mg; -1/14 tamsulosin 0.4 mg; and -1/14 vitamin D3 25 mcg. 12:00 P.M. ADMINISTRATION -3/14 insulin aspart, subcutaneous sliding scale (three times daily with meals) hold insulin with skipped meals: If blood glucose is: 140-179 = 2 units, 180-219 = 4 units, 220-259 = 6 units, 260-299 = 8 units, 300-339 = 10 units,	01760		

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01760	Continued From page 48 340-379 = 12 units, 380-399 =13 units > 399 call MD; -1/14 insulin aspart 16 units (hold insulin with skipped meals); 6:00 P.M. ADMINISTRATION -1/14 insulin aspart, subcutaneous sliding scale (three times daily with meals) hold insulin with skipped meals If blood glucose is: 140-179 = 2 units, 180-219 = 4 units, 220-259 = 6 units, 260-299 = 8 units, 300-339 = 10 units, 340-379 = 12 units, 380-399 =13 units > 399 call MD; and -1/14 insulin aspart 16 units (hold insulin with skipped meals); 8:00 P.M. ADMINISTRATION -1/14 Lantus Solostar 22 units; -1/14 clindamycin phosphate 1 %; -1/14 rosuvastatin 5 mg; -1/14 mirtazapine 15 mg; -1/14 melatonin 3 mg; -1/14 olanzapine 5 mg; and -1/14 trazadone 100 mg. R3 R3 was admitted to the licensee on June 22, 2023, and started receiving assisted living services. R3's diagnosis included amnestic disorder, insomnia, depression, anxiety, alcohol disorder, dementia, and hypertension. R3's unsigned service plan dated January 15, 2025, indicated R3 received assistance with	01760		

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01760	Continued From page 49 dressing, grooming, bathing, bed making, incontinence care, meal reminder, manage behaviors, manage symptoms, and medication administration. R3's Medication Administration Summary - Month dated January 1, 2025, through January 14, 2025, lacked medication administration documentation for the following medication administration opportunities during the afternoon shift: -1/14 mirtazapine 7.5 mg; -1/14 olanzapine 5 mg; -1/14 oyster shell calcium 500 mg; and -1/14 pravastatin sodium 40 mg. On January 15, 2025, at 2:40 p.m., clinical nurse supervisor (CNS)-C stated R1 was on leave of absence and staff forgot to chart services and medication administration to reflect the leave of absence. CNS-C stated they did not know why R1 and R2's services and medication administration were not charted; CNS-C stated, "I have to look into that." The licensee's undated Content of Resident's Medication Records Policy indicated the resident's record must contain documentation of each medication administered by facility staff, or if the medication was not administered as prescribed the reason why the medication was not administered as prescribed and any follow up procedures that were provided. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		

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02040	Continued From page 50	02040		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide a hazard vulnerability assessment or safety risk assessment of the physical environment on and around the property. This deficient practice had the ability 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). Findings include: A record review of available documentation and interview were conducted January 15, 2025, at 11:30 a.m., with licensed assisted living director (LALD)-D, on the hazard vulnerability assessment	02040		

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CLINIQUE HEALTHCARE SERVICES I	7924 JUNE AVENUE NORTH BROOKLYN PARK, MN 55443

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02040	Continued From page 51 (HVA) for the physical environment of the facility. Record review of the available documentation indicated that the licensee had not performed a hazard vulnerability assessment with mitigation factors on and around the property. During an interview on January 15, 2025, at 11:45 a.m., LALD-D, stated an HVA had not been performed and documented on and around the property. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	02040		
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 a posting on a bulletin board located in common area in the living room 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	02290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35377	A. BUILDING: _____ B. WING _____	01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLINIQUE HEALTHCARE SERVICES I	7924 JUNE AVENUE NORTH BROOKLYN PARK, MN 55443

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02290	Continued From page 52 of the residents). The findings include: On January 13, 2025, at approximately 11:30 a.m., the surveyor observed a House Rule/Exception posting on a bulletin board located in common area in the living room, on the main floor. The posting contained the following contents: "1. [The licensee's name] reserves the authorization to perform random room checks 2. Client must be home by 10 pm unless a pre-arrangement is made with the Director. 3. Absolutely No Drug use/Alcohol** Zero Tolerance 4. No smoking anywhere within the house, including rooms/bathroom; smoking is permitted in the designated area only 5. No visiting in rooms of other clients 6. Visitation is in the common area (consult with the program director if provision is needed) 7. Vulgar or profane language around staff and housemates are discouraged 8. Clients must always be respectful of personal boundaries 9. No borrowing of any kind is allowed 10. Smoking is not allowed after 10pm 11. All meals are to be consumed in the dining area except for infection control circumstances. 12. Residents are encouraged to dress appropriately when in common areas and when out in the community 13. Living room is for entertainment only. No sleeping/laying on the sofa 14. Weapons are not allowed in persons or bedrooms 15. Lending or borrowing money or items is discouraged	02290		

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	35377	A. BUILDING: _____ B. WING _____	01/15/2025

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02290	Continued From page 53 16. Everyone is expected to adhere strictly to the House contract 17. No overnight visitors". On January 15, 2025, at 1:34 p.m., licensed assisted living director (LALD)-D stated they were aware some of the contents in the house rules were contradictory to the assisted living residents' bill of rights. LALD-D stated they were working on removing some of the contents of the house rules. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02290		
02310 SS=D	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for one of one resident (R1) with consumer bed rails. 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	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35377	A. BUILDING: _____ B. WING _____	01/15/2025

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02310	Continued From page 54 residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1 was admitted to the licensee on July 31, 2024, and began receiving assisted living services. R1's diagnoses included functional quadriplegia, paroxysmal atrial fibrillation, other specific disorder of the muscle, aphonia, major depressive disorder, and dependance on wheelchair. R1's Service Plan (Waiver) - Addendum to Contract signed and dated October 15, 2024, indicated R1 received assistance with medication administration, grooming, dressing, incontinence care, manage behavior, manage symptoms, positioning, mobility assistance, and meal assistance. On January 13, 2025, at approximately 11:45 a.m., the surveyor observed a consumer bed rail on both sides of R1's hospital bed. R1's record included Bed Rail Use Assessment Form dated July 31, 2024, August 22, 2024, and January 13, 2025, during the survey. The assessment completed January 13, 2025, was 54 days past the 90-calendar day requirement. R1's record lacked documentation the licensee checked the consumer product safety commission recall list to make sure there were no active recalls on the bed rails. On January 15, 2025, at 2:28 p.m., clinical nurse supervisor (CNS)-C stated they did not check the	02310		

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02310	Continued From page 55 consumer product safety commission website. CNS-C stated they did do the bed rail assessments with quarterly nursing assessments, which were late. The Food and Drug Administration's (FDA) A Guide to Bed Safety dated 2000, and revised April 2010, indicated following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients." The FDA also identified "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently Asked Questions (FAQs) last reviewed December 13, 2024, indicated the need for assistive devices, such as bed rails, must be assessed upon initial installation, with each 90-day assessment and change of condition. (Please refer to Rule 4659.0150 where it directs assessment of mobility, including ambulation, transfers, and assistive devices.) The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) last reviewed December 13, 2024, indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person	02310		

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02310	Continued From page 56 is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, documentation about a resident's hospital bed rail should include, but is not limited to: -Purpose and intention of the bed rail -Measurements -The resident's bed rail use/need assessment -Risk vs. benefits discussion (individualized to each resident's risks) -The resident's preferences -Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and -Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements. Assisted Living Facilities: Minnesota Rules Chapter 4659.0150 Subpart 2. Assessment tool elements B. (3) indicated a resident's mobility status must be assessed to include ambulation, transfers, and assistive devices. The licensee's Bed Rail and Assistive Devices Policy last revised on June 8, 2024, indicated "The assistive Device Process and Assessment: For Consumer Bed Rails: -An assessment was completed; -the bed rails were determined to not act as a restraint; -the portable bed rails were installed and maintained according to the manufacturer's guidelines; -the manufacturer's guidelines are accessible upon request (hint: you may need to search the	02310		

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02310	Continued From page 57 bed -rail for identifying manufacture and model number, and/or do a Google search to download the installation and maintenance instructions); -and the risk vs. benefits were discussed and documented with the resident/responsible party." No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	02310		

DEPARTMENT OF HEALTH

Type: Full
Date: *01/13/25*
Time: 13:55:54
Report: 1036251007

Food and Beverage Establishment Inspection Report

Location:
Clinique Healthcare Services I
7924 June Avenue North
Brooklyn Park, MN55444
Hennepin County, 27

Establishment Info:
ID #: 0039148
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7635034757
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.

2-200 Employee Health

2-201.11C ***** Priority 1 *****

MN Rule 4626.0040C The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority.

NO EMPLOYEE ILLNESS LOG ON SITE. EXAMPLE MDH ILLNESS LOG SENT TO ESTABLISHMENT ALONG WITH REPORT.

Comply By: 01/27/25

3-500C Microbial Control: date marking

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

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

OBSERVED OPENED PACKAGES OF TURKEY AND CHICKEN LUNCH MEAT WITH NO DATE LABEL. ADVISED TO DATE MARK ANY OPENED TCS FOODS AND MAINTAIN CONSISTENCY.

Comply By: 01/27/25

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

NO CURRENT CFPM AT ESTABLISHMENT. ELLEN SIEBENALER TOOK A FOOD SAFETY CLASS IN OCTOBER AND SHOULD APPLY FOR A CFPM CERTIFICATE SOON. INSTRUCTIONS FOR CFPM APPLICATION SENT ALONG WITH REPORT.

Comply By: 01/27/25

4-100 Equipment Construction Materials

4-101.11BCDE

MN Rule 4626.0450BCDE Remove all multi-use equipment, utensils, and food storage containers that are not durable, corrosion-resistant, nonabsorbent, smooth, easily cleanable, resistant to pitting, chipping, scratching or not able to withstand repeated warewashing.

OBSERVED SEVERAL BOWLS AND PLATES IN CUPBOARD WITH CHIPPED EDGES. ADVISED TO REPLACE DAMAGED ITEMS.

Comply By: 01/27/25

4-100 Equipment Construction Materials

4-101.17

MN Rule 4626.0490 Discontinue using wood and wood wicker as a food contact surface.

OBSERVED SOME WOODEN SPOONS IN DRAWER THAT WERE IN POOR CONDITION. ITEMS WERE DISCARDED ON SITE.

Comply By: 01/13/25

4-200 Equipment Design and Construction

4-201.11GMN

MN Rule 4626.0506G Discontinue serving TCS foods that are held for more than same-day service in an adult or child care center or boarding establishment or provide equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

OBSERVED A LEFTOVER PANCAKE IN THE FRIDGE. ITEM DISCARDED ON SITE.

Comply By: 01/13/25

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.

THE DISH MACHINE IS NOT ABLE TO POWER ON. ADVISED TO SET UP A TEMPORARY 3 COMPARTMENT SINK WITH BUCKETS TO WASH, RINSE, SANITIZE (WITH UNSCENTED BLEACH OR QUAT) OR UTILIZE DISPOSABLE PLATES/UTENSILS UNTIL DISH MACHINE IS SERVICED.

Comply By: 01/27/25

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.11

MN Rule 4626.1515 Maintain the physical facilities in good repair.

OBSERVED SOME DAMAGE TO THE LOWER CABINETS AND MISSING HANDLES ON DRAWERS. REPAIR AND MAINTAIN.

Comply By: 01/27/25

Type: Full
Date: *01/13/25*
Time: 13:55:54
Report: 1036251007
Clinique Healthcare Services I

Food and Beverage Establishment Inspection Report

Food and Equipment Temperatures

Process/Item: Ambient Temp
Temperature: 37 Degrees Fahrenheit - Location: AMANA FRIDGE
Violation Issued: No

Process/Item: Ambient Temp
Temperature: 0 Degrees Fahrenheit - Location: AMANA FREEZER
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	1	1	6

THIS INSPECTION WAS CONDUCTED IN CONJUNCTION WITH MDH HEALTH REGULATORY DIVISION (HRD) SURVEY. SURVEYOR FROM HRD WAS DEE MOSISSA. INSPECTION CONDUCTED IN PRESENCE OF ANTHONY ORJINTA, THE PERSON IN CHARGE.

THIS FACILITY DOES NOT HAVE COMMERCIAL GRADE ANSI EQUIPMENT. ALL FOOD MUST BE SERVED THE SAME DAY IT IS PREPARED, AND LEFTOVERS CAN NEVER BE SAVED. FOOD SERVICE AREA FLOORS, WALLS, CEILINGS, COUNTERTOPS, AND FINISH MATERIALS MUST BE NON-ABSORBANT, SMOOTH, DURABLE, AND EASILY CLEANABLE. CEILINGS CANNOT HAVE POPCORN TEXTURE. CABINETS CANNOT HAVE HOLLOW BASES. EXPOSED WOOD IS NOT APPROVED FOR FOOD SERVICE AREAS. WOOD IS NOT AN APPROVED FOOD CONTACT SURFACE.

ADDITIONAL TOPICS DISCUSSED WITH THE PERSON IN CHARGE:
- EMPLOYEE ILLNESS LOG AND EXCLUSION POLICY.
- HAND WASHING POLICY AND REVIEW.
- GLOVE USAGE.
- NO BHC WITH RTE FOODS.
- THERMOMETER USE AND CALIBRATION.
- DATE MARKING TCS FOODS.
- PEST CONTROL.
- FULLY COOKING FOOD FOR HIGH RISK POPULATIONS.
- ANSI 184 STANDARD FOR RESIDENTIAL DISH WASHER.

*FOR CORRECT BY DATES REFER TO COMPLETE REPORT ISSUED BY HRD.

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

Type: Full
Date: *01/13/25*
Time: 13:55:54
Report: 1036251007
Clinique Healthcare Services I

Food and Beverage Establishment Inspection Report

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the inspection report number 1036251007 of 01/13/25.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Inspection report reviewed with person in charge and emailed.

Signed:_____
ANTHONY ORJINTA
PERSON IN CHARGE

Signed:_____
Jeff Johanson