Electronically Delivered

November 20, 2021

Administrator
Synergycare LLC
1486 Rounds House Circle
Shakopee, MN 55379

RE: Project Number(s) SL35539015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on October 22, 2021, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

The enclosed State Form documents the state licensing orders. The Department of Health documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Home Care 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 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 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.

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment.
The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572. subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5)(b), immediate fine imposition is authorized for both surveys and investigations conducted. When a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, no immediate fines are assessed.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order. A copy of the provider's records documenting those actions may be requested for follow-up surveys. The licensee is not required to submit a plan of correction for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the client(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's clients/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 issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the Department of Health within 15 calendar days.

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat.
§ 626.557. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general reconsideration requests to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

Free from Maltreatment reconsideration requests should addressed to:
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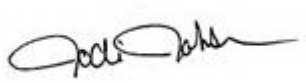
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,



Jodi Johnson, Supervisor
Health Regulation Division
State Evaluation Team
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St. Paul, MN 55101-3879
Email: jodi.johnson@state.mn.us
Telephone: 507-696-2437 Fax: 651-215-9697

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35539	A. BUILDING: _____ B. WING _____	10/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYNERGYCARE LLC	1486 ROUNDS HOUSE CIRCLE SHAKOPEE, MN 55379

(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 Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER 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: SL#35539015 On October 20 through October 21, 2021, the Minnesota Department of Health conducted a survey with the above provider, and the following correction orders are issued. At the time of the survey, there were three (3) residents receiving services under the provider's Assisted Living licensure.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared according to the Minnesota Food Code. This had the potential to affect all three current 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: Please refer to the additional documentation included in the Food and Beverage Establishment	0 480		

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0 480	Continued From page 2 Inspection Reports dated October 20, 2021. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC). The licensee failed to ensure screening for active TB (either a two-step tuberculin skin test (TST) or blood test) was completed and documented for one of one unlicensed personnel (ULP)-A with employee records reviewed. This practice resulted in a level two violation (a	0 660		

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0 660	Continued From page 3 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: Unlicensed personnel (ULP)-A was hired by the licensee on December 2, 2020, to provide direct care services to the licensee's residents. On October 21, 2021, at approximately 9:11 a.m. ULP-A was observed to assist R1 with morning medication administration. ULP-A's employee records lacked evidence of being screened for active TB with either a two-step TST or blood test. ULP-A's personnel record included a screening for active TB; a TST was administered on March 22, 2021, with a negative result on March 25, 2021. A second TST was administered on April 20, 2021; however, the test result was not in the employee file. On October 21, 2021, at 3:01 p.m. LALD (licensed assisted living director) verified the results of the second TST was not in ULP-A's personnel record. LALD stated it was read, but was unable to locate the documentation. The licensee's policy was requested, but was not provided. No further information was provided. TIME PERIOD FOR CORRECTION:	0 660		

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0 660	Continued From page 4 Twenty-One (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (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 tenant 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 observation, interview, and record review the licensee failed to have a written emergency disaster preparedness plan with all the required content and failed to post an emergency preparedness plan prominently. This	0 680		

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0 680	Continued From page 5 had the potential to affect all three residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On October 20, 2021, at approximately 10:43 a.m. during the entrance conference, a request was made to review the licensee's emergency disaster preparedness plan. On October 20, 2021, at approximately 12:19 p.m. during a facility tour, the licensee lacked evidence of signage posted or information regarding the licensee's emergency plan. There was no observed signage posted or information regarding the licensee's emergency plan or emergency exit diagrams at the facility entrance, hallways, in the dining area or in the living areas. The licensee's emergency disaster preparedness plan lacked evidence of the following required content: - a comprehensive program to include infectious diseases and pandemics; - a description of the population served by the licensee; - process for emergency preparedness (EP) cooperation with state and local EP officials/organizations; - procedure for tracking staff and residents;	0 680		

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0 680	Continued From page 6 - subsistence needs for staff and residents during emergency situation; - development of policies/procedures to address: - evacuation plan (not customized for the facility); - fire (not customized for the facility); - shelter in place; - a tracking system used to document locations or residents and staff; - the medical record documentation system to preserve resident information; - emergency staff strategies; - the facilities role in providing care and treatment at alternative sites; - a communication plan that included: - arrangement with other facilities; - names and contact information for staff, resident physicians, other facilities; - contact information for federal, state, tribal, local EP staff, ombudsman; - primary and alternative means for communicating with facility staff, federal, state, regional and local emergency management agencies; - a method of sharing information and medical documentation for residents; - a means to provide information regarding the facility's needs, and its ability to provide assistance to include information about their occupancy; -a method of sharing information from the emergency plan with residents and their families; - EP training and testing program; - EP training program for staff (including documentation of training provided); and - EP testing/annual testing requirements On October 21, 2021, at 2:56 p.m. the licensed assisted living director (LALD) and registered nurse (RN)-A both confirmed staff were not	0 680		

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0 680	Continued From page 7 familiar with Appendix Z (a section of the Centers for Medicare and Medicaid Services [CMS] State Operations Manual which includes the emergency preparedness guidelines.) In addition, both LALD and RN-A verified the licensee had not fully developed and implemented the facility's emergency preparedness plan/program. The licensee's Emergency Preparedness policy dated August 1, 2021, indicated the facility would prominently post a disaster plan on each floor of the facility. This plan would include evacuation routes; as applicable smoke stops and fire doors; emergency exit diagrams; exit doors; and location of the fire extinguishers and fire alarm boxes. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) 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	0 780		

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0 780	Continued From page 8	0 780		

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;

This MN Requirement is not met as evidenced by:
Based on observation and interview, the licensee failed to provide smoke alarms in all sleeping rooms. In addition, the license failed to provide smoke alarms that were interconnected so that actuation of one alarm causes all alarms in the dwelling unit to actuate as required by MN Statute 144G.45 Subd. 2 (a)(1). This had the potential to affect all current residents, staff and visitors.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).

The findings include:

During the facility tour on October 20, 2021, with the licensed assisted living director (LALD) between 1:30 p.m. and 2:25 p.m, it was observed the smoke alarm in bedroom #2 on the upstairs level was missing. In an interview with the LALD, it was indicated that the detector had been

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0 780	Continued From page 9 removed due to the destructive behaviors of the resident occupying the room. Education was provided to the LALD about finding alternative methods for keeping the smoke alarm installed and providing protection for it. In addition, the smoke alarms were not interconnected so that actuation of one alarm causes all alarms to operate as required when there is more than one smoke alarm in a dwelling unit. Alarms were tested on both the upper and lower levels. LALD accompanying on the facility tour verified all of the findings listed above. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	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: Based on observation and interview, the licensee failed to maintain fire extinguishers in accordance with MN State Fire Code as required by MN	0 790		

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0 790	Continued From page 10 Statute 144G.45 Subd.2 (a)(2). This had the potential to affect all current residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During a facility tour on October 20, 2021, with the licensed assisted living director (LALD) between 1:30 p.m. and 2:25 p.m, it was observed that the fire extinguisher did not have an annual maintenance tag showing that it had been inspected as required by MN State Fire Code. The LALD verified the facility did not have anyone to come in and inspect the fire extinguishers, and the extinguisher in question was not very old. No proof of purchase date was observed on the extinguisher or provided, and further follow up with a local fire extinguisher contractor was recommended. The LALD accompanying on the facility tour verified the findings listed above. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 790		
0 800 SS=D	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including	0 800		

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0 800	Continued From page 11 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 regarding the health, safety, comfort, and well-being of the residents as required by MN Statute 144G.45 Subd.2 (a)(4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: During facility tour on October 20, 2021, with the licensed assisted living director (LALD) between 1:30 p.m. and 2:25 p.m., it was observed the outer pane of the egress window in bedroom #4 was broken. This broken pane can lead to weathering and moisture affecting the ability to operate this window in an emergency event. This deficient condition was visually verified by the LALD accompanying on the tour.	0 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35539	A. BUILDING: _____ B. WING _____	10/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYNERGYCARE LLC	1486 ROUNDS HOUSE CIRCLE SHAKOPEE, MN 55379

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 800	Continued From page 12 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35539	A. BUILDING: _____ B. WING _____	10/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 810	Continued From page 13 drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have a fire safety and evacuation plan that showed the location and number of resident rooms and failed to always have the fire safety and evacuation plan readily available within the facility as required by MN Statute 144G.45 Subd.2 (b) and (d). This had the potential to affect all current residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client'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 clients). The findings include: On October 19, 2021, between 12:50 p.m. and 1:30 p.m. an interview and record review were conducted with the licensed assisted living director (LALD) on the fire safety and evacuation plan for the facility. The facility did not have a fire safety and evacuation plan that showed the location and number of resident rooms, thus it was not readily available within the facility. The LALD indicated the facility did not have a fire safety and evacuation plan prepared at this time that showed the number and location of resident rooms; therefore they could not make one readily available within the facility until it was developed.	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35539	A. BUILDING: _____ B. WING _____	10/22/2021

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SYNERGYCARE LLC	1486 ROUNDS HOUSE CIRCLE SHAKOPEE, MN 55379

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0 810	Continued From page 14 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01620 SS=E	144G.70 Subd. 2 Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing client monitoring and reassessment, not to exceed 90 calendar days	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35539	A. BUILDING: _____ B. WING _____	10/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01620	Continued From page 15 from the last date of the assessment for two of two residents (R1, R2) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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's record lacked a 90-day assessments as required. R1 was admitted January 25, 2021, and had diagnoses including, but not limited to, schizoaffective disorder (a combination of symptoms of schizophrenia and mood disorder, such as depression) and anxiety. On October 21, 2021, at 9:11 a.m. unlicensed personnel (ULP)-A was observed to administer R1's morning medications. R1's record included documentation of a 90-day comprehensive nursing assessment completed May 4, 2021, and August 27, 2021, (115 days between the two assessments). On October 21, 2021, at 10:32 a.m. registered nurse (RN)-A verified R1's assessment was 115 days after the previous comprehensive nursing assessment. R2 R2's record lacked a 90-day assessment as required. R2 was admitted December 2, 2021, with diagnoses including, but not limited to,	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35539	A. BUILDING: _____ B. WING _____	10/22/2021

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01620	Continued From page 16 self-injurious behavior and anxiety. On October 21, 2021, at 9:57 a.m. ULP-A was observed to administer an as needed medication for R2. R2's record included documentation of a 90-day comprehensive nursing assessment completed April 20, 2021, and September 14, 2021, (147 days between the two assessments.) On October 21, 2021, at 11:42 a.m. RN-A verified R2's assessment was 147 days after the previous comprehensive nursing assessment. The licensee's Assessment and Reassessment policy dated August 1, 2021, indicated ongoing resident reassessment must be conducted by a RN and cannot exceed 90 days from the last date of assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		

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

Type: Full
Date: *10/20/21*
Time: 10:15:31
Report: 8075211251

Food and Beverage Establishment Inspection Report

Location:
Synergycare Llc
1486 Rounds House Circle
Shakopee, MN55379
Scott County, 70

Establishment Info:
ID #: 0037794
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 6122242019
ID #:

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

The following orders were issued during this inspection.

2-100 Supervision

2-102.12AMN

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

No state certified food protection manager.

Comply By: 02/01/22

Surface and Equipment Sanitizers

Utensil Surface Temp: = at 160 Degrees Fahrenheit
Location: dish machine
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: fridge - refried beans
Violation Issued: No

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: fridge - mashed potatoes
Violation Issued: No

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: fridge - deli meat
Violation Issued: No

Food and Beverage Establishment Inspection Report

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

Note: Facility prepares time/temperature control for safety food for same day service. In accordance with MN Rules, part 4626.0506, subpart G, facility is exempt from the equipment requirements of MN Rules, part 4626.0506, subpart A.

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

I acknowledge receipt of the Minnesota Department Of Health inspection report number 8075211251 of 10/20/21.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Signed:_____ Signed: Erin Tibbetts

Okechukwu Nnaji
Director of Operations

Erin Tibbetts
Public Health Sanitarian
Metro District Office
651-201-3987
erin.tibbetts@state.mn.us