



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

March 4, 2024

Licensee
Vaimar Suites, LLC
7900 Douglas Drive North
Brooklyn Park, MN 55443

RE: Project Number(s) SL36335015

Dear Licensee:

On February 21, 2024, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on November 30, 2023. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the November 30, 2023 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on November 30, 2023, found not corrected at the time of the February 21, 2024, follow-up survey and/or subject to penalty assessment are as follows:

0810-Fire Protection And Physical Environment-144g.45 Subd. 2 (b)-(f) \$500.00

The details of the violations noted at the time of this follow-up survey completed on February 21, 2024 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$500.00**. 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.

IMPOSITION OF FINES:

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.

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request

for reconsideration must be in writing and received by MDH within 15 calendar days of the correction order receipt date.

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

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

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.

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

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

Sincerely,

A handwritten signature in black ink, appearing to read "Casey DeVries". The signature is fluid and cursive, with the first name "Casey" written in a larger, more prominent script than the last name "DeVries".

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

PMB

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36335	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 02/21/2024
NAME OF PROVIDER OR SUPPLIER VAIMAR SUITES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 7900 DOUGLAS DRIVE 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 In accordance with Minnesota Statutes, section 144G.08 to 144G.95, this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL36335015-1 On February 20, 2024, through February 21, 2024, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on November 30, 2023. At the time of the survey, there were five residents; all of whom received services under the Assisted Living license. As a result of the revisit, the licensee is in substantial compliance.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.		
{0 250} SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a	{0 250}			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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{0 250}	Continued From page 1 result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under	{0 250}			

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{0 250}	Continued From page 2 section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: . No further action required.	{0 250}			
{0 470} SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the	{0 470}			

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{0 470}	Continued From page 3 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: No further action required.	{0 470}			
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: No further action required.	{0 480}			
{0 485} SS=C	144G.41 Subdivision 1. (13)(i)(A)and(C) Minimum Requirements (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	{0 485}			

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{0 485}	Continued From page 4 fresh vegetables. The following apply: (A) menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; and (C) the facility cannot require a resident to include and pay for meals in their contract; (ii) weekly housekeeping; (iii) weekly laundry service; This MN Requirement is not met as evidenced by: No further action required.	{0 485}			
{0 650} SS=F	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health	{0 650}			

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{0 650}	Continued From page 5 screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: No further action required.	{0 650}			
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced	{0 680}			

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{0 680}	Continued From page 6 by: No further action required.	{0 680}			
{0 700} SS=F	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced by: No further action required.	{0 700}			
{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	{0 810}			

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{0 810}	Continued From page 7 thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, 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 resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On February 20, 2024, licensed assisted living director (LALD)-D provided documents on the fire safety and evacuation plan (FSEP), fire safety	{0 810}			

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{0 810}	Continued From page 8 and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee's FSEP, titled "Fire Safety Emergency Plan", undated, 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 plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate) and P.A.S.S. (Pull, Aim, Squeeze, Sweep) but failed to include procedures for how staff are to complete each step. 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 FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation nor did it include instructions for staff to follow in case of relocation. LALD-D provided a document titled "Sample Resident Profile", but did not provide any information on any current residents. During an interview on February 22, 2024, at	{0 810}			

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{0 810}	Continued From page 9 11:00 a.m., LALD-D stated they had not had an opportunity to update the policy. LALD-D stated they understood the areas of their policy that were incomplete and would work on bringing them into compliance. TRAINING Record review indicated the licensee failed to provide evacuation training to residents at least once per year. LALD-D was unable to provide documentation showing any training offered or training scheduled for a future date for residents on the fire safety and evacuation plan. Record review indicated the licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. LALD-D was unable to provide documentation showing any training provided or training scheduled for a future date for staff on the fire safety and evacuation plan. During an interview on February 22, 2024, at 11:00 a.m., LALD-D stated they understood the requirements and would implement a training program that was compliant with statute requirements. DRILLS Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. LALD-D was unable to provide documentation showing any evacuation drills completed since licensure. During an interview on February 22, 2024, at 11:00 a.m., LALD-D stated they had not completed any evacuation drills but were developing a schedule.	{0 810}			

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{0 810}	Continued From page 10 No further information was provided.	{0 810}			
{0 970} SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: No further action required.	{0 970}			
{01060} SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date	{01060}			

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{01060}	Continued From page 11 or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: No further action required.	{01060}			
{01620} SS=F	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.	{01620}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36335	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 02/21/2024
NAME OF PROVIDER OR SUPPLIER VAIMAR SUITES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 7900 DOUGLAS DRIVE 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
{01620}	Continued From page 12 (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: No further action required.	{01620}			
{01640} SS=D	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 Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities.	{01640}			

Minnesota Department of Health

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{01640}	Continued From page 13 (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: No further action required.	{01640}			
{01730} SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel;	{01730}			

Minnesota Department of Health

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{01730}	Continued From page 14 (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: No further action required.	{01730}			
{01880} SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: No further action required.	{01880}			
{01940} SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy	{01940}			

Minnesota Department of Health

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{01940}	Continued From page 15 services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: No further action required.	{01940}			
{01960} SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the	{01960}			

Minnesota Department of Health

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{01960}	Continued From page 16 signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: No further action required.	{01960}			
{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: No further action required.	{02290}			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

December 20, 2023

Licensee

Vaimar Suites LLC

7900 Douglas Drive North

Brooklyn Park, MN 55443

RE: Project Number(s) SL36335015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on November 30, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

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.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5), the MDH may impose fine amounts of either \$1,000 or \$5,000 to licensees who are found to be responsible for maltreatment.

The MDH may impose 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 MDH 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 (b), 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, the following fines are assessed pursuant to this survey:

St - 0 - 0820 - 144g.45 Subd. 2 (g) - Fire Protection And Physical Environment - \$3,000.00

St - 0 - 0830 - 144g.45 Subd. 3 - Local Laws Apply - \$3,000.00

St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - \$3,000.00

St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - \$3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$12,000.00**. 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 the 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/HRD-Appeals-Form>

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. Requests for hearing may be emailed to: **Health.HRD.Appeals@state.mn.us**.

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.

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

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36335	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/30/2023
NAME OF PROVIDER OR SUPPLIER VAIMAR SUITES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 7900 DOUGLAS DRIVE NORTH BROOKLYN PARK, MN 55443		
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0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL36335015-0 On November 27, 2023, through November 30, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were five active residents; all of whom received services under the Assisted Living license. An immediate correction order was identified on November 27, 2023, issued for SL36335015-0, tag identification 0820. An immediate correction order was identified on November 27, 2023, issued for SL36335015-0, tag identification 1290. On November 28, 2023, the immediacy of correction order 1290 was removed, however non-compliance remained, and the scope and level remained the same.	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.		

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 000	Continued From page 1 Immediate correction orders were identified on November 29, 2023, issued for SL36335015-0, tag identification 0830 and 2310. On November 30, 2023, the immediacy of correction orders 0830 and 2310 was removed, however non-compliance remained, and the scope and level remained the same. On December 04, 2023, the immediacy of correction order 0820 was removed, however non-compliance remained at a scope and level of I.	0 000			
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department	0 250			

Minnesota Department of Health

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0 250	Continued From page 2 access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor	0 250			

Minnesota Department of Health

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0 250	Continued From page 3 developed and/or implemented current policies and procedures as required with records reviewed. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on November 27, 2023, at 10:00 a.m., licensed assisted living director (LALD)-D stated the licensee's employees in charge of the facility were familiar with the assisted living regulations and the licensee provided medication and treatment management services. The licensee's Application for Assisted Living License, section titled Official Verification of Owner or Authorized Agent, (page four and five of the application), identified, I certify I have read and understand the following: [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17.	0 250			

Minnesota Department of Health

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0 250	Continued From page 4 - I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G. - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659. - Reporting of Maltreatment of Vulnerable Adults. - Electronic Monitoring in Certain Facilities. - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat.	0 250			

Minnesota Department of Health

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0 250	Continued From page 5 sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license. - I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. - I have examined this application and all attachments and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required. - I attest to have all required policies and procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page six was electronically signed by LALD-D on December 19, 2022. The licensee had an assisted living license issued on March 1, 2023, with an expiration date of February 29, 2024.	0 250			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36335	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 11/30/2023
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0 250	Continued From page 6 The licensee failed to ensure the following policies and procedures were developed and/or implemented: - conducting and handling background studies on employees; - orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; - conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; - orientation to and implementation of the assisted living bill of rights; - reminders for medications, treatments, or exercises, if provided; and - medication and treatment management. On March 29, 2023, at 3:08 p.m., administrator (A)-B, clinical nurse supervisor (CNS)-C and LALD-D confirmed the licensee provided assisted living services but failed to implement corresponding policies and procedures, as required. As a result of this survey, the following orders were issued 0470, 0480, 0485, 0650, 0680, 0700, 0790, 0800, 0810, 0820, 0830, 0970, 1060, 1290, 1620, 1640, 1730, 1880, 1940, 1960, 2290, and 2310 indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 250			

Minnesota Department of Health

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0 250	Continued From page 7 (21) days	0 250			
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a written staffing plan that included an evaluation completed by the clinical nurse supervisor (CNS)	0 470			

Minnesota Department of Health

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0 470	Continued From page 8 (as indicated in Minnesota Administrative Rule 4659.0180) at least twice a year. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living license. The facility was licensed for a bed capacity of five residents and had a current census of five residents. On November 27, 2023, at 10:26 a.m., during entrance conference, CNS-C stated the licensee had two shifts staffed by one unlicensed personnel (ULP) each shift to meet the needs of the residents. The surveyor inquired if they had developed and implemented a staffing plan they evaluated twice per year. CNS-C stated, "no, we do not have that written down anywhere." In addition, CNS-C stated licensed assisted living director (LALD)-D and administrator (A)-B evaluated when an increase in staff was needed to meet the needs of the residents. The licensee lacked a staffing plan lacked an evaluation conducted by the CNS, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility. No further information was provided.	0 470			

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0 470	Continued From page 9	0 470			
	TIME PERIOD FOR CORRECTION: Seven (7) days				
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated November 27, 2023, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			

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0 485 SS=C	144G.41 Subdivision 1. (13)(i)(A)and(C) Minimum Requirements (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: (A) menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; and (C) the facility cannot require a resident to include and pay for meals in their contract; (ii) weekly housekeeping; (iii) weekly laundry service; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not require any resident to include and pay for meals as a part of their assisted living package fee. This had the potential to affect all residents of the facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 485			

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0 485	Continued From page 11 The findings include: On November 28, 2023, at 12:26 p.m., licensed assisted living director (LALD)-D provided the surveyor with a blank contact and stated it was used for all resident who resided at the facility. The licensee's Assisted Living Contract page 4 included: "Subject to the Resident's needs, Vaimar Suites will provide the following services which are included in the basic monthly fee: 1. Food Service: Three (3) meals/day are served in the dining area as planned and prepared by Vaimar Suites staff at the following times: 7:00 AM Breakfast 12:00 PM Lunch 3:00 PM Snack 5:00 PM Dinner Bedtime Snack" On November 28, 2023, at 10:40 a.m., R3 stated they did not like the food provided by the licensee however, they accepted the meals provided because they paid 600.00 dollars per month. On November 29, 2023, at 1:03 p.m., LALD-D stated they were unaware of the requirement and the residents they served had financial assistance to pay for meals. In addition, LALD-D stated the licensee never had an issue with the resident not wanting the food they provided. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485			
0 650 SS=F	144G.42 Subd. 8 Employee records	0 650			

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0 650	Continued From page 12 (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records contained the required content for two of two employees (unlicensed personnel (ULP)-A, clinical nurse supervisor (CNS)-C). 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	0 650			

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0 650	Continued From page 13 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-A ULP-A was hired on December 28, 2020, to provide direct services to the residents. R1's electronic medication administration record (EMAR) dated November 1, 2023, through November 31, 2023 (sic), indicated ULP-A administered fluticasone 110 microgram (mcg) actuation inhaler on November 27, 2023, at 9:45 a.m. ULP-A's employee record lacked the following: - annual performance reviews; - orientation to assisted living regulations to include an overview of assisted living statues, handling emergencies and emergency services, assisted living bill of rights, handling of resident complaints, review or types of assisted living services the employee would provide and the providers scope of license, and principles of person-centered planning/service delivery; - annual training to include assisted living bill of rights, dementia training, review of providers policies and procedures, and principles of person-centered planning; - trainings to include communication skills that included preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; and - competency evaluation to include setting up medications for an unplanned time away from home. On November 28, 2023, at 9:00 a.m., ULP-A	0 650			

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0 650	Continued From page 14 stated they received the orientation, trainings, and competencies listed above. ULP-A stated trainings were conducted on the computer or by the nurse in person and the RN completed the competency evaluations. CNS-C CNS-C was hired on March 1, 2021, to provide supervision and oversite to unlicensed personnel and to provide direct services to residents. CNS-C's employee record contained multiple continuing education units (CEU). CNS-C employee record lacked the following: - annual performance reviews; - orientation to assisted living regulation to include overview of assisted living statues, handling emergencies and using emergency services, assisted living bill of rights, handling of residents complaints, consumer advocacy services, and principles of person-centered planning /service delivery; and - annual training to include, assisted living bill of rights, review of provider policies and procedures, principles of person-centered planning/service delivery, and dementia training. On November 27, 2023, at 2:13 p.m., CNS-C stated they received initial orientation through a consultant however, the consultant did not place the training in the employee record. In addition, CNS-C stated their employee record lacked annual training on the required topics because they were the person who provided the training to the ULP. On November 27, 2023, at 2:32 p.m., CNS-C stated the licensee provided four hours of dementia training yearly. CNS-C stated they	0 650			

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0 650	Continued From page 15 complete performance evaluations after annual staff training and reviewed items ULP needed to improve on, however, they did not document the evaluations for all employees. CNS-C stated they completed training on the new assisted living statue and annual dementia training however, the employee record was not updated to reflect this. The licensee's Personnel Records policy dated March 18, 2023, read, "At a minimum, the following documents are kept in the personnel record, as applicable to job requirements - o Evidence of current professional licensure, registration or certification - o Results of background studies - o Records of annual training and infection control training - o Documentation of orientation - o Documentation of supervision, as applicable - o Performance reviews - o Competency evaluations - o Signed job description - o Documentation of annual performance reviews identifying areas of improvement needed and training needs" No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies	0 680			

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0 680	Continued From page 16 temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a written emergency preparedness 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 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:	0 680			

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0 680	Continued From page 17 The licensee's emergency disaster preparedness plan lacked evidence of the following required content: - annual review; - hazard vulnerability risk assessment; - quarterly review of missing resident policy; - strategies for addressing facility and community-based risks including staffing surges/shortages, and back-up plans; - subsistence needs for staff and residents; - emergency lighting; - transportation; - policy and procedures for medical documents; - roles under a waiver declared by secretary; - names and contact information; - family notifications; and - emergency prep testing requirements. On November 29, 2023, at 12:40 p.m., clinical nurse supervisor (CNS)-C stated the licensee conducted fire drills with the city's fire marshal however, the licensee did not conduct an EPP exercise at the facility. In addition, CNS-C stated they reviewed the EPP quarterly at the quality management meeting, however, did not document the EPP review. Licensed assisted living director (LALD)-D verified there were areas of the EPP that were left blank on the templated document and were not filled in with information specific to the facility. In addition, LALD-D stated staff were educated during annual training on transportation and supplies needed in case of an emergency however, it was not documented in the EPP. The Emergency Preparedness policy dated March 18, 2020, indicated the licensee would have and identified plan in place to assure the safety and well-being of clients [residents] and	0 680			

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0 680	Continued From page 18 staff during periods of and emergency or disaster that disrupts services. In addition, the licensee would conduct a disaster drill at the residence at least annually and the results of the drill would be documented. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 700 SS=F	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure resident's personal health and medical information was kept private for four of four residents (R1, R3, R4, R5). 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).	0 700			

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0 700	Continued From page 19 The findings include: On November 28, 2023, from 8:09 a.m., through 8:45 a.m., the surveyor observed the licensee's open concept dining room and living room, and observed R4 in the living room watching television while unlicensed personnel (ULP)-A, clinical nurse supervisor (CNS)-C, and licensed assisted living director (LALD)-D completed tasks around the facility. The surveyor observed ULP-H complete medication administration to R1, R3, R4, and R5. ULP-H prepared medication on the living room desk, placed unused medications back into the locked file cabinet, obtained a beverage in the kitchen, walked medications to where the residents were located which included rooms on the lower level of the facility and rooms down the hallway on the upper level. ULP-H left the computer screen open in the living room with each resident's electronic medical record listed while they administered medications to residents. On November 28, 2023, at 8:46 a.m., ULP-H stated they leave the computer screen open when they administered medication because once the medications were administered, they returned right away to the desk to document. On November 29, 2023, at 12:22 p.m., CNS-C stated they trained ULP to log off or minimize the computer screen if it contained resident information when the ULP were not within eye site of the computer. The licensee's Client Confidentiality policy dated March 18, 2020, indicated clinical and billing records were kept in a locked file and not accessible to the public. No further information provided.	0 700			

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0 700	Continued From page 20	0 700			
0 790 SS=F	TIME PERIOD FOR CORRECTION: Twenty-one (21) days 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 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:	0 790			

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0 790	Continued From page 21 On November 27, 2023, from 1:30 p.m. to 2:30 p.m., survey staff toured the facility with licensed assisted living director (LALD)-D. During the tour, survey staff observed both portable fire extinguishers in the facility lacked any tag or documentation showing the required monthly visual inspections to date. During interview on November 27, 2023 at 1:30 p.m., LALD-D stated he did not know a monthly inspection was required. LALD-D acknowledged the deficiency and stated he would start completing the monthly visual inspections. TIME PERIOD FOR CORRECTION: Twenty-one (21) 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 had the potential to affect all residents, staff, and visitors.	0 800			

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0 800	Continued From page 22 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 a facility tour on November 27, 2023, from 1:30 p.m. to 2:30 p.m., survey staff toured the facility with licensed assisted living director (LALD)-D. It was observed the ceiling in the laundry room had signs of water damage adjacent to the electrical panel. The ceiling tiles were stained, warped, and starting to fall off the ceiling structure. On November 27, 2023, at 1:30 p.m., LALD-D stated he did not know what caused the damage. It was observed the ceiling and walls in the lower level bathroom had signs of water damage adjacent to the sink area. The ceiling was stained brown above the bathroom vanity and a portion of the ceiling in the corner was broken and falling off the ceiling structure. The wallpaper was stained brown and black in some areas and was peeling off the walls in the corner to the right of the sink area. On November 27, 2023, at 1:30 p.m., LALD-D stated that he did not know what caused the damage, but would get it repaired. LALD-D stated that he understood the above deficiencies and would work to resolve them.	0 800			

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0 800	Continued From page 23	0 800			
0 810 SS=F	TIME PERIOD FOR CORRECTION: Twenty-One (21) days. 144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.	0 810			

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0 810	Continued From page 24 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 resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On November 27, 2023, at 8:36 a.m., the surveyor emailed licensed assisted living director (LALD)-D requesting documentation of the fire safety and evacuation plan (FSEP), training, and drills. LALD-D did not respond to the request. During a phone call on November 27, 2023, at 3:17 p.m. survey staff requested the FSEP documentation for the second time. LALD-D stated he was working on it and would send it as soon as possible. LALD-D did not provide documentation that day. During a video interview on November 28, 2023, at 12:30 p.m. survey staff requested the FSEP documentation for the third time. LALD-D stated he had not collected and scanned the FSEP documentation yet but would send it as soon as	0 810			

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0 810	Continued From page 25 possible. LALD-D did not provide documentation that day. During a phone call on November 29, 2023, at 11:40 a.m. survey staff requested the FSEP documentation for the fourth time. LALD-D stated he would send it as soon as possible. LALD-D did not provide documentation that day. The surveyor emailed LALD-D on November 30, 2023, at 11:00 a.m. requesting the FSEP documentation for the fifth time. LALD-D did not respond the the request. During a video interview on November 30, 2023, at 11:30 a.m., survey staff requested the documentation of the FSEP for the sixth time. LALD-D stated they were at a different location than the survey site and would need to go back to the facility to get the paperwork and scan it into the computer to send to the survey staff. Survey staff agreed to a 2:00 p.m. deadline on November 30, 2023, to submit the FSEP paperwork for review. The surveyor emailed LALD-D on November 30, 2023, at 12:00 p.m., a reminder of the agreed-upon deadline for 2:00 p.m. on November 30, 2023. At 12:05 p.m., LALD-D responded to the email and replied that the FSEP documentation would be provided. On November 30, 2023, at 3:25 p.m. no records had been received for the FSEP, training, and drills. During the exit interview on November 30, 2023, at 3:25 p.m., LALD-D stated they were having	0 810			

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0 810	Continued From page 26 trouble with the scanner and had to find another machine to scan the documents and stated they would send the documentation as soon as possible. Survey staff explained that they had missed the final deadline and the survey was over. No documentation would be received or reviewed after the exit interview was complete. TIME PERIOD OF CORRECTION: Twenty-One (21) Days	0 810			
0 820 SS=I	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure physical facility elements did not constitute a distinct hazard to life. The licensee failed to provide resident bedrooms with the minimum window opening meeting the minimum state standard for egress. This affected all the residents in all four occupied bedrooms.	0 820	This immediate correction order identified on November 27, 2023, has had the immediacy lifted as of December 04, 2023 by assigning a fire watch for the facility. This was confirmed by the licensee via email and approved by evaluation supervisor.		

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0 820	Continued From page 27 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: On November 27, 2023, from 12:30 p.m. to 1:00 p.m., survey staff toured the facility with the licensed assisted living director (LALD)-D. Survey staff asked LALD-D to open the windows in occupied resident bedroom #1 for measurement. LALD-D opened the window and the survey staff measured the clear opening to be 36.5 inches in height and 21 inches in width with a total openable area of 766 square inches. The hardware for each window obstructed the window from opening completely and would require special knowledge of the window to be able to disassemble the window hardware to open the window completely. Survey staff attempted to get a minimum 20-inch width when the windowpane was in different positions of open, but at no point could the clear opening meet the 20-inch minimum width. Survey staff asked LALD-D to open the windows in occupied resident bedroom #2 for measurement. LALD-D opened the first window and the survey staff measured the clear opening to be 36.5 inches in height and 25.75 inches in width with a total openable area of 940 square inches. The hardware for each window obstructed the window from opening completely and would require special knowledge of the window to be	0 820			

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0 820	Continued From page 28 able to disassemble the window hardware to open the window completely. Survey staff attempted to get a minimum 20-inch width when the windowpane was in different positions of open, but at no point could the clear opening meet the 20-inch minimum width. Survey staff asked LALD-D to open the window in occupied resident bedroom #3 for measurement. LALD-D opened the window and the survey staff measured the clear opening to be 36.5 inches in height and 21.25 inches in width with a total openable area of 777 square inches. The hardware for the window obstructed the window from opening completely and would require special knowledge of the window to be able to disassemble the window hardware to open the window completely. Survey staff attempted to get a minimum 20-inch width when the windowpane was in different positions of open, but at no point could the clear opening meet the 20-inch minimum width. Survey staff asked LALD-D to open the windows in occupied resident bedroom #4 for measurement. LALD-D opened the windows and the survey staff measured the clear opening to be 36.5 inches in height and 16.75 inches in width with a total openable area of 611 square inches. The windows did not meet the minimum requirements for opening width and did not meet the minimum requirements for total openable area. The hardware for each window obstructed the window from opening completely and would require special knowledge of the window to be able to disassemble the window hardware to open the window completely. Survey staff attempted to get a minimum 20-inch width when the windowpane was in different positions of open, but at no point could the clear opening	0 820			

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0 820	Continued From page 29 meet the 20-inch minimum width. Survey staff asked LALD-D to open the windows in occupied resident bedroom #5 for measurement. LALD-D opened the windows and the survey staff measured the clear opening to be 36.5 inches in height and 17 inches in width with a total openable area of 621 square inches. The windows did not meet the minimum requirements for opening width and did not meet the minimum requirements for total openable area. The hardware for each window obstructed the window from opening completely and would require special knowledge of the window to be able to disassemble the window hardware to open the window completely. Survey staff attempted to get a minimum 20-inch width when the windowpane was in different positions of open, but at no point could the clear opening meet the 20-inch minimum width. Survey staff explained to LALD-D that at least one window in each bedroom in a state-licensed facility must meet the minimum state fire code standard for an egress window to be a complying bedroom for resident occupancy. LALD-D verbally confirmed the findings. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. On November 27, 2023, survey staff explained to LALD-D that an immediate correction order was issued for the above finding. LALD-D acknowledged the above finding. No Further information was provided.	0 820			

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0 820	Continued From page 30	0 820		
0 830 SS=I	144G.45 Subd. 3 Local laws apply Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to follow applicable state and local laws, regulations, standards, ordinances, and codes related to smoking for one of one resident (R3). 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 the potential to affect a large portion or all of the residents). The findings include: On November 27, 2023, at 10:50 a.m., during the facility tour, the surveyor observed a split-level home that contained three occupied bedrooms on the upper level, two occupied bedrooms on the lower level, and a porch on the upper level surrounded with windows and one door leading to steps to the outdoor space of the facility. The surveyor smelled a cigarette smoke odor on the	0 830	On November 30, 2023, the immediacy of correction order 0830 was removed, however non-compliance remained, and the scope and level remained the same.	

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0 830	Continued From page 31 main level of the facility, including the upper-level resident rooms. R3 admitted to the facility on September 22, 2023, and resided on the upper level of the facility. R3's diagnoses included cluster b personality (mental disorder characterized by a problem with impulse control and emotional regulation) and cerebrovascular accident (stroke). R3's service plan dated October 6, 2023, indicated R3 received assistance with dressing, transfers, wheelchair mobility, meals, medication assistance, and behavior management. R3's undated, Resident Evaluation indicated R3 used to smoke and vape. R3's record lacked a smoking assessment. On November 28, 2023, at 2:29 p.m., the surveyor observed R3 smoking in the attached porch with multiple windows opened. On November 29, 2023, at 9:38 a.m., clinical nurse supervisor (CNS)-C stated four of the five residents in the facility smoke. CNS-C stated the designated smoking areas were on the driveway by the garage and out on the porch with the window slide opened. In addition, CNS-C stated they assessed residents initially and weekly to ensure they were safe to continue to smoke; however, documentation only indicated there was no change to the resident's normal routine and did not specifically document on smoking safety. The licensee's [Licensee name] Smoking Policy dated June 6, 2020, indicated smoking was	0 830			

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0 830	Continued From page 32 prohibited in all common areas, assisted living facility rooms, hallways, stairs, kitchens, lounges, restrooms, motor vehicles owned or leased by the assisted living facility, and any other enclosed areas. In addition, for everyone's safety smoking locations were at the end of the driveway, and the porch room with open windows, for residents whose mobility put them at risk of falling with frequent movement up and down the stairs. The Minnesota Department of Health's Minnesota Clean Indoor Air Act (MCIAA) amendment effective on August 1, 2019, noted smoking was prohibited in health care facilities and clinics. In addition, an indoor area meant a space between a floor and a ceiling that is at least half enclosed by walls, doorways or windows (opened or closed) around the perimeter. A wall included retractable dividers, garage doors, plastic sheeting or any other temporary or permanent physical barrier. Minnesota State Statute 144.414 Prohibitions; Subdivision 3 dated 2022, indicated under a section titled Health care facilities and clinics. (a) Smoking is prohibited in any area of a hospital, health care clinic, doctor's office, licensed residential facility for children, or other health care-related facility, except that a patient or resident in a nursing home, boarding care facility, or licensed residential facility for adults may smoke in a designated separate, enclosed room maintained in accordance with applicable state and federal laws. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	0 830			

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NAME OF PROVIDER OR SUPPLIER VAIMAR SUITES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 7900 DOUGLAS DRIVE 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
0 970	Continued From page 33	0 970			
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property of a resident. This had the potential to affect all residents living within the assisted living facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On November 28, 2023, at 12:26 p.m., licensed assisted living director (LALD)-D provided the surveyor with a blank contract and stated it was used for all resident who resided at the facility. The blank Assisted Living Contract included the following section which contained language waving the licensee's liability for health, safety, or	0 970			

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0 970	Continued From page 34 personal property of a resident: Page 13: Miscellaneous Provisions "The resident agrees that Vaimar Suites will not be liable to the resident for any personal injury or property damage (including, without limitation, damage to, or loss or theft of, automobiles or personal property of resident) suffered by the resident or the resident's agents, guests or invitees, unless and to the extent that the injury or damage is caused by the negligence of Vaimar Suites or its employees or agents. The resident hereby releases Vaimar Suites from liability for any personal injury or property damage suffered by the resident or the resident's agents, guests, or invitees, unless caused by the negligence of Vaimar Suites or its employees or agents." Page 15: Indemnification "Vaimar Suites shall not be liable for any damage or injury to the resident, or any other person, or to any property, occurring on the premises, or any part thereof, or in common areas thereof, and the resident agrees to hold Vaimar Suites harmless from any claims or damages unless caused solely by negligence of Vaimar Suites." Page 15: Liability "The resident agrees to be liable and responsible for all obligations herein referenced, monetary and otherwise, of the resident and where this Contract has been executed by a party designated below. Or where a separate Responsible Party Agreement has been executed by a third party, said third party and the resident shall be jointly and severally liable and responsible for all obligations, monetary and otherwise, of the resident herein referenced." On November 29, 2023, at 1:00 p.m., LALD-D	0 970			

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0 970	Continued From page 35 stated they were unaware the contract could not contain language for waiving the facility's liability. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970			
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to:	01060			

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01060	Continued From page 36 (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for a resident's emergency relocation to the resident, legal representative, or designated representative, and failed to provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC) of the emergency relocation greater than four days, for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: R1 admitted to the licensee on July 20, 2022, and began receiving assisted living services.	01060			

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01060	Continued From page 37 R1's service plan signed July 20, 2022, indicated R1 received assistance with dressing, oral care, hair care, bathing, toileting, transfers, assistance with wheelchair mobility as needed, meals, and medication management. R1's nursing progress notes dated January 14, 2023, to November 28, 2023, indicated R1 was hospitalized on the following dates: January 14, 2023, to January 17, 2023, for flank pain and hematuria; January 31, 2023, to February 3, 2023, for shortness of breath and back pain; April 16, 2023, to April 19, 2023, for plural effusion; July 6, 2023, to July 8, 2023, for syncope; July 22, 2023, to July 28, 2023, post dialysis; September 9, 2023, to September 11, 2023, for fall; October 19, 2023, to October 20, 2023, for fall; and November 16, 2023, to November 19, 2023, for abdominal pain, dark urine, and loose stool. R1's record lacked evidence the licensee provided the resident or resident's representative a written emergency relocation notice. The record also lacked evidence to indicate the licensee provided the notification to the OOLTC of the emergency relocation greater than four days as required. On November 28, 2023, clinical nurse supervisor (CNS)-C stated the licensee did not provide any resident who had been hospitalized an emergency relocation notice. CNS-C stated they were unfamiliar with the regulation and stated, "I know it from a nursing home perspective, but I did not know it from a group home perspective."	01060			

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01060	Continued From page 38 In addition, CNS-C stated the licensee did not provide notification to OOLTC of the emergency relocation however, updated the resident's guardian or case worker. The licensee's Discharge and Transfer of Residents policy dated August 1, 2021, read, "25. In the event of an emergency relocation, the facility will, as soon as possible, provide written notice of Emergency Relocation to the following: a. The resident b. The resident's legal representative c. The resident's designated representative d. If the resident receives home and community-based services, the resident's case manager e. If the resident has been relocated and not returned to Vaimar Suites within four (4) days, the Office of Ombudsman for Long-Term Care." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060			
01290 SS=I	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 an employee in good faith	01290			

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01290	Continued From page 39 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 was submitted and received in affiliation with the assisted living license for four of four employees (unlicensed personnel (ULP)-A, ULP-E, ULP-F, ULP-G). 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: ULP-A ULP-A began employment with licensee on December 28, 2020, to provide direct cares and services to residents. ULP-A's employee record included a background study clearance dated December 23, 2020, affiliated to the licensee's former comprehensive license health facility identification (HFID) #35968, and was no longer an active or accessible license through the Minnesota Department of Human Services NETStudy 2.0 (web-based system used to submit background study requests). In addition, NETStudy indicated	01290	On November 28, 2023, the immediacy of correction order 1290 was removed, however non-compliance remained, and the scope and level remained the same.	

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01290	Continued From page 40 ULP-A separated from the licensee on April 7, 2022. ULP-A's record lacked evidence the licensee submitted a background study for ULP-A under the current assisted living license and affiliated to the current HFID number. On November 27, 2023, at 2:15 p.m. the surveyor observed ULP-A working independently and prepared food for residents at the facility in the kitchen. ULP-E ULP-E began employment with the licensee on June 6, 2020, to provide direct cares and services to residents. ULP-E's employee record included a background study clearance dated December 30, 2019, affiliated to the licensee's former comprehensive license HFID #33143, and was no longer an active or accessible license through the Minnesota Department of Human Services NETStudy 2.0. In addition, NETStudy 2.0 indicated ULP-E separated from the licensee on April 7, 2022. ULP-E's record lacked evidence the licensee submitted a background study for ULP-E under the current assisted living license and affiliated to the current HFID number. ULP-F ULP-F began employment with licensee on March 10, 2021, to provide direct cares and services to residents. ULP-F employee record included a background study clearance March 13, 2021, affiliated to the licensee's former comprehensive license HFID #35968, and was no longer an active or accessible license through the Minnesota Department of Human Services NETStudy 2.0. In	01290			

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01290	Continued From page 41 addition, NETStudy 2.0 indicated ULP-F separated from the licensee on April 7, 2022. ULP-F's record lacked evidence the licensee submitted a background study for ULP-F under the current assisted living license and affiliated to the current HFID number. ULP-G ULP-G began employment with licensee on March 10, 2021, to provide direct cares and services to residents. ULP-G's employee record included a background study clearance dated March 23, 2021, affiliated to the licensee's former comprehensive license HFID #35968, and was no longer an active or accessible license through the Minnesota Department of Human Services NETStudy 2.0. In addition, NETStudy 2.0 indicated ULP-G separated from licensee on April 7, 2022. ULP-G's record lacked evidence the licensee submitted a background study for ULP-G under the current assisted living license and affiliated to the current HFID number. On November 27, 2023, at 3:12 p.m., the surveyor requested to see the licensee's current roster on NETStudy 2.0 from licensed assisted living director (LALD)-D. The surveyor observed ULP-A, ULP-E, ULP-F, and ULP-G were not affiliated with the licensee's current HFID #36335. LALD-D stated there was a mistake with the roster and they were going to look at the information. On November 27, 2023, at 10:26 a.m. during entrance conference, clinical nursing supervisor (CNS)-C stated one ULP worked per shift in the facility and 12 hour shifts from 7:00 a.m. to 7:00 p.m. and 7:00 p.m. to 7:00 a.m.	01290			

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01290	Continued From page 42 On November 27, 2023, at 3:25 p.m., licensed assisted living director stated they were unable to find a current background study for ULP-F and they would have to conduct a new background study. On November 27, 2023, at 3:45 p.m. LALD-D stated they conducted a background study on all employees prior to direct cares being served. In addition, LALD-D stated a ULP can provide direct care to residents if they had been cleared by the parent company. On November 27, 2023, at 4:26 p.m. LALD-D stated "I don't know what happened they kicked them out." The licensee's Recruitment and Hiring policy dated March 18, 2020, indicated background checks would be conducted and the result would be obtained before a potential team member may begin employment or engagement with licensee. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	01290			
01620 SS=F	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	01620			

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01620	Continued From page 43 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 observation, interview, and record review, the licensee failed to complete a change of condition reassessment when a resident presented with new or changed symptoms for one of one resident (R1). In addition, the licensee failed to complete a smoking assessment for one of one resident (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 the residents). The findings include: CHANGE OF CONDITION R1 admitted to the licensee on July 20, 2022, and	01620		

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01620	Continued From page 44 began receiving assisted living services. R1's diagnoses included end stage renal failure, diabetes, and hypertension. R1's service plan signed July 20, 2022, indicated R1 received assistance with dressing, oral care, hair care, bathing, toileting, transfers, assistance with wheelchair mobility as needed, meals, and medication management. R1's nursing progress notes dated January 14, 2023, to November 28, 2023, indicated R1 was hospitalized on the following dates: January 14, 2023, to January 17, 2023, for flank pain and hematuria; January 31, 2023, to February 3, 2023, for shortness of breath and back pain; April 16, 2023, to April 19, 2023, for plural effusion; July 6, 2023, to July 8, 2023, for syncope; July 22, 2023, to July 28, 2023, post dialysis; September 9, 2023, to September 11, 2023, for fall; October 19, 2023, to October 20, 2023, for fall; and November 16, 2023, to November 19, 2023, for abdominal pain, dark urine, and loose stool. R1's record contained nursing assessments completed on January 18, 2023, April 16, 2023, April 19, 2023, July 15, 2023, September 11, 2023, October 20, 2023, and November 19, 2023. R1's record lacked a change of condition assessment for the following returns from the hospital February 3, 2023, or July 28, 2023. On November 30, 2023, at 12:10 p.m., clinical nurse supervisor (CNS)-C stated the license would conduct a change of condition assessment	01620			

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01620	Continued From page 45 when there was a change to a resident's behavior or activities of daily living. In addition, CNS-C stated a change of condition assessment would be completed post hospitalization. The surveyor inquired if a change of condition assessment was completed on R1 on the dates listed above. CNS-C stated they believed they were completed by their private contracted on call nurse however, they were unable to locate the paperwork. The licensee Assessment-Comprehensive Services policy dated December 2, 2019, indicated ongoing client [resident] monitoring and reassessment must be conducted as needed based on changes in the needs of the client [resident], but cannot exceed 90 days from the last date of assessment. SMOKING ASSESSMENT R3 admitted to the facility on September 22, 2023, and resided on the upper level of the facility. R3's diagnoses included cluster b personality (mental disorder characterized by a problem with impulse control and emotional regulation) and cerebrovascular accident (stroke). R3's service plan dated October 6, 2023, indicated R3 received assistance with dressing, transfers, wheelchair mobility, meals, medication assistance, and behavior management. On November 28, 2023, at 2:29 p.m., the surveyor observed R3 smoking in the attached porch. R3's undated, Resident Evaluation indicated R3 used to smoke and vape.	01620			

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NAME OF PROVIDER OR SUPPLIER VAIMAR SUITES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 7900 DOUGLAS DRIVE NORTH BROOKLYN PARK, MN 55443		
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01620	Continued From page 46 R3's record lacked a smoking assessment as required by Minnesota Administrative Rule 4659.0150 Subpart 2 (M) (8), a uniform assessment tool element, to evaluate the resident's ability to smoke without causing burns or injury to the resident or others, or damage to property. On November 29, 2023, at 9:38 a.m., CNS-C stated R1, R2, R3 and R5 smoked on the facility grounds. On November 29, 2023, at 10:07 a.m., CNS-C stated the licensee did not have a smoking assessment documented for any of the residents listed above. In addition, CNS-C stated they monitored residents weekly to ensure they were still able to smoke safely however, had no documentation. The licensee Assessment-Comprehensive Services policy dated December 2, 2019, indicated the registered nurse (RN) would conduct a comprehensive assessment including vulnerability assessment, and a home safety checklist if it was appropriate. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620			
01640 SS=D	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	01640			

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01640	Continued From page 47 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 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 observation, interview, and record review, the licensee failed to ensure the current service plan included all services to be provided for one of three residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: R1 admitted to the licensee on July 20, 2022, and began receiving assisted living services.	01640		

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01640	Continued From page 48 R1's diagnoses included end stage renal failure, diabetes, and hypertension. R1's service plan signed July 20, 2022, indicated R1 received assistance with dressing, oral care, hair care, bathing, toileting, transfers, assistance with wheelchair mobility as needed, meals, and medication management. R1's service plan lacked identification of a service for blood glucose monitoring, oxygen management, and Miami J cervical collar cares. On November 27, 2023, at approximately 10:50 a.m., during facility tour, the surveyor observed R1 utilized 2 liters (L) of oxygen (O2). On November 29, 2023, at 10:40 a.m., the surveyor observed a Miami J cervical collar on R1. R1's provider orders dated April 19, 2023, indicated R1 received insulin aspart 0 - 6 units three times per day based on blood glucose level and if R1's blood glucose was greater than 501 the provider should be notified. In addition, R1 received 2 L of O2 continuously to keep oxygen saturation levels above 88 percent (%). R1's provider orders dated November 21, 2023, indicated R1 should wear the Miami J neck brace at all times until follow up with neurosurgeon on October 16, 2023. R1's electronic medication administration record (EMAR) dated November 1, 2023, through November 31, 2023 (sic), included the following: - blood glucose monitoring three times per day and as needed. Check the insulin sliding scale and administer insulin as per corresponding blood	01640			

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01640	Continued From page 49 glucose reading; - 2 L of O2 per nasal cannula to keep sats (oxygen saturation levels) above 88 percent. Check oxygen levels each shift; and - cervical collar neck brace the neck brace on at all times. Check skin under the collar brace twice per day when providing cares that will need removal of brace, removing should be done while resident is lying flat on the bed without any pillow underneath. On November 29, 2023, at 12:12 p.m., clinical nurse supervisor (CNS)-C stated if a resident had a change in service, they would update the service plan and obtain a signature from the resident or resident's representative on the agreed upon services. The surveyor inquired why R1's service plan lacked the services listed above. CNS-C stated they added the information to the EMAR however, they did not understand those services would need to be written on R1's service plan. The licensee's Service Plan policy dated December 2, 2019, indicated the service plan would include a description of the home care [assisted living] services to be provided and must be revised, if needed, based on the client [resident] review or reassessment. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01640			
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication	01730			

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01730	Continued From page 50 management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management.	01730			

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01730	Continued From page 51 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and maintain a current individualized medication management record for each resident to include all required content for two of residents two (R1, R5). 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: R1 R1 admitted to the licensee on July 20, 2022, and began receiving assisted living services. R1's diagnoses included end stage renal failure, diabetes, and hypertension. R1's service plan signed July 20, 2022, indicated R1 received assistance with dressing, oral care, hair care, bathing, toileting, transfers, assistance with wheelchair mobility as needed, meals, and medication management. The service plan lacked inclusion of oxygen management, and blood glucose monitoring. R1's Medication Management Plan dated, July 20, 2022, included staff administration of medication, monitoring was completed by caregiver, licensed practical nurse (LPN), and	01730			

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01730	Continued From page 52 registered nurse (RN), storage by the facility, and to notify a RN with missed medication, side effects, medication refusal. R1's medication management plan comprised of multiple documents lacked the following: - medication management tasks that may be delegated to unlicensed personnel (ULP). R5 R5 admitted to the licensee on October 16, 2023, and began receiving assisted living services. R5's diagnoses included schizoaffective disorder (mental disorder in which a person experiences a combination of symptoms of schizophrenia (mental disorder characterized by delusions, hallucinations, disorganized thoughts, speech, and behavior) and mood disorder), and asthma. R5's service plan signed October 30, 2023, indicated R5 received assistance with medication administration. In addition, R5's Service Plan Part 4 - Medication Management Plan indicated R5's medication was administered by staff, monitoring was completed by caregiver, LPN, and RN, and notify a nurse for change in resident condition, low supply of equipment or medications. R5's Medication Assessment dated November 20, 2023, indicated medications were stored in a medication cabinet. R5's electronic medication administration record (EMAR) dated November 1, 2023, through November 31, 2023 (sic), included acetaminophen 500 milligrams (mg) mg tablet take one to two tablets by mouth every six hours as needed for pain, albuterol inhaler 90 micrograms (mcg)/ actuation inhaler take one to	01730			

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01730	Continued From page 53 two puffs into the nostrils every four hours as needed for wheezing. The document lacked specific resident instruction on when R5 would receive 500 mg vs 1000 mg of acetaminophen and when R5 would receive one puff vs two puffs of the albuterol inhaler. In addition, R5's EMAR included an intramuscular injection (IM) administered every 28 days and read "Paliperidone Palmitate ER 234 mg / 1.5 ml (milliliter) injection OK to administer in the group home, Give IM 1.5 MLS into the muscle every 28 days See Drug Leaflet." The instruction did not indicate who could administer the medication. R5's medication management plan comprised of multiple documents lacked the following: - specific written instructions for resident medication administration; and - medication management tasks that may be delegated to ULP. On November 29, 2023, at 12:12 p.m., clinical nurse supervisor (CNS)-C stated all medication management plans would lack medication management tasks that may be delegated to a ULP however, they locked the medication administered by the nurse in a different location so the ULP could not administer the medication to the residents. CNS-C stated the RN reviewed with the ULP which medications would be administered by the ULP prior to delegating the task of medication administration. In addition, CNS-C stated they have been attempting to get parameters for medications, however, were having difficulty obtaining the clarification from the provider. The licensee's undated Medication Management Program policy, indicated the medication management program was at the discretion of the	01730			

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01730	Continued From page 54 RN and based on a professional face-to-face nursing assessment that included the following elements: - client [resident]/caregiver ability in medication self-management; - come environment: safety and sanitation; - storage/security of medications; - coordination/communication with prescriber and other providers involved with medication management; and - medication reconciliation. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730			
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to store prescription medication securely to permit only authorized personnel to have access. In addition, the licensee failed to maintain refrigerated medication per manufacturer's instructions. This had the potential to affect all residents with refrigerated medications. 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	01880			

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01880	Continued From page 55 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: UNSECURED MEDICATIONS On November 27, 2023, at 10:50 a.m., the surveyor observed the facility's medication refrigerator located in a shared kitchen. The medication refrigerator was unlocked and unsecured and contained an unopened box of five Novolog FlexPens for R1. The medication refrigerator had no locking mechanism to secure the medication. On November 28, 2023, at 8:30a.m., the surveyor observed one unknown pill fall out of a prepackaged box onto the computer desk in the living room while ULP-H prepared the medication for R1. ULP-H acknowledged the dropped pill on the computer desk, put away the remaining medications for R1 in the medication file cabinet excluding the dropped medication, and began to walk to R1's room. The surveyor intervened and inquired what ULP-H was going to do with the dropped medication. ULP-H said they left it on the computer desk to give to the nurse. ULP-H picked up the medication and provided the unknown pill to the nurse. On November 28, 2023, at 8:35 a.m., the surveyor observed two medication file cabinets in the dining room. One of the two medication file cabinets which contained four resident's medications was observed unlocked and unsecured while ULP-H administered medication	01880			

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01880	Continued From page 56 in R2's room and R4 was sitting in the connected open concept living room. On November 28, 2023, at 8:46 a.m., ULP-H stated they were trained to keep the medication file cabinet locked at all times and accidentally left the medication file cabinet opened. On November 29, 2023, at 12:20 p.m., clinical nurse supervisor (CNS)-C stated the medication file cabinet should remained locked unless the medication file cabinet was in eye site of the ULP. In addition, CNS-C stated they trained ULP to placed dropped medication in the medication file cabinet and notify a nurse. MEDICATION REFRIGERATOR TEMPERATURES On November 27, 2023, at 10:50 a.m., the surveyor observed the facility's medication refrigerator. The medication refrigerator temperature was 32 degrees Fahrenheit (F) and contained an unopened box of five Novolog FlexPens for R1. The licensee's Vaimar Suite Medication Fridge Temperature Log 2023, indicated between July 1, 2023, and November 27, 2023, the licensee's medication refrigerator ranged between 26 degrees and 31 degrees F. The licensee's Medication Fridge Temperature Log indicated the medication refrigerator was too cold and out of range evey day between the dates listed above. On November 27, 2023, at 12:23 p.m., CNS-C stated they trained staff to monitor the temperature on the medication refrigerator daily and if the temperature was out of range the ULP would adjust the temperature.	01880			

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01880	Continued From page 57 The manufactures instructions for Novolog FlexPen dated March 15, 2023, recommended unopened Novolog FlexPens to be refrigerated with the refrigerator temperature set between 36 degrees and 46 degrees. The licensee's Storage/Control of Medications policy dated March 26, 2020, indicated storage of medications outside of the clients private living space were securely locked in substantial constructed compartments according to the manufacturer's directions. In addition, medication requiring refrigeration were stored in a refrigerator maintained between 35 and 40 degrees. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880			
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that	01940			

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01940	Continued From page 58 will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: R1 admitted to the licensee on July 20, 2022, and began receiving assisted living services. R1's diagnoses included end stage renal failure, diabetes, and hypertension.	01940			

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01940	Continued From page 59 R1's service plan signed July 20, 2022, indicated R1 received assistance with dressing, oral care, hair care, bathing, toileting, transfers, assistance with wheelchair mobility as needed, meals, and medication management. The service plan lacked oxygen management, and blood glucose monitoring. On November 27, 2023, at approximately 10:50 a.m., during facility tour, the surveyor observed R1 utilized 2 liters (L) of oxygen (O2). R1's provider orders dated April 19, 2023, indicated R1 received insulin asapt 0-6 units three times per day based on blood glucose level and if R1's blood glucose was greater than 501 the provider should be notified. In addition, R1 received 2 L of O2 continuously to keep oxygen levels above 88 percent (%). R1's electronic medication administration record (EMAR) dated November 1, 2023, through November 31, 2023 (sic), included the following orders: - blood glucose monitoring three times per day and as needed. Check the insulin sliding scale and administer insulin as per corresponding blood glucose reading; and - 2 L of O2 per nasal cannula to keep sats (oxygen saturation level) above 88 percent. Check oxygen levels each shift. R1's EMAR lacked when to contact a health care professional if blood glucose and oxygen levels were low. R1's individualized treatment management plan comprised of multiple records lacked the following required content: - procedures to notify a registered nurse (RN) or	01940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36335	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/30/2023
NAME OF PROVIDER OR SUPPLIER VAIMAR SUITES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 7900 DOUGLAS DRIVE NORTH BROOKLYN PARK, MN 55443		
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01940	Continued From page 60 other licensed health professional when problems arose with treatment or therapies. On November 29, 2023, at 12:25 p.m., clinical nursing supervisor (CNS)-C stated staff were trained in person on when to contact a health professional for blood glucose monitoring and oxygen. CNS-C stated the ULP would contact the nurse for a low blood glucose or oxygen saturation reading because it was a "change in condition" in the resident. The surveyor inquired if when to contact a health professional would be located in the resident's chart. CNS-C stated it was not located within the record. The Treatment and Therapy Management policy Dated March 18, 2020, indicated the RN or licensed profession would prepare and individualized treatment or therapy management plan for each client [resident] who received ordered treatments or therapy services to include: - type of service to be provided; - procedures for documenting treatments or therapies; - procedures for monitoring treatments or therapies to prevent possible complications or adverse reactions; - identification of treatment or therapy tasks delegated to unlicensed personnel; and - procedures for notifying the RN or licensed health professional when a problem arises related to the treatment or therapy service. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940			

Minnesota Department of Health

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01960	Continued From page 61	01960			
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to document treatment administration for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: R1 admitted to the licensee on July 20, 2022, and began receiving assisted living services. R1's diagnoses included end stage renal failure, diabetes, and hypertension. R1's service plan signed July 20, 2022, indicated	01960			

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01960	Continued From page 62 R1 received assistance with dressing, oral care, hair care, bathing, toileting, transfers, assistance with wheelchair mobility as needed, meals, and medication management. The service plan lacked oxygen management, Miami J cervical collar, and blood glucose monitoring. R1's provider orders dated November 21, 2023, indicated R1 should wear the Miami J neck brace at all times until follow up with neurosurgeon on October 16, 2023. On November 27, 2023, through November 28, 2023, the surveyor observed no Miami J cervical collar on R1. On November 29, 2023, at 10:40 a.m., the surveyor observed a Miami J cervical collar on R1. R1's electronic medication administration record (EMAR) dated November 1, 2023, through November 31, 2023 (sic), included the following order to be documented on twice per day, cervical collar neck brace the neck brace on at all times. Check skin under the collar brace when providing cares that will need removal of brace, removing should be done while resident is lying flat on the bed without any pillow underneath. The EMAR lacked documentation on the cervical collar twice per day for the month of November 2023. On November 28, 2023, at 10:12 a.m., the surveyor inquired if R1 still wore their Miami J cervical collar. Clinical nurse supervisor (CNS)-C stated R1 refused to wear their cervical brace a majority of the time and they were going to update the provider of R1's refusals at the next scheduled appointment. CNS-C stated R1 had	01960			

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01960	Continued From page 63 been educated on the refusal on not wearing the cervical brace however, R1 continued to refuse the cervical collar. CNS-C stated documentation of the device should be located on the EMAR. The surveyor showed CNS-C the lack of documentation in the EMAR. CNS-C stated they were unaware of why ULP did not document R1's refusals. The licensee's Treatment and Therapy Management plan policy dated March 18, 2020, indicated each staff member who administered a treatment or therapy was responsible for documenting this in the clinical record. In addition, when a treatment or therapy was not administered as ordered or prescribed, staff would document the reason why it was not administered and any follow- up procedures provided to meet the client's [resident's] needs. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960			
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 observation, interview, and record review, the licensee limited the rights of one of one resident (R1) who smoked when the licensee	02290			

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02290	Continued From page 64 required smoking material be stored by the licensee when not in use. 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: R1 admitted to the licensee on July 20, 2022, and began receiving assisted living services. R1's diagnoses included end stage renal failure, diabetes, and hypertension. R1's Assisted Living Contract was signed by R1 on July 20, 2022. R1's service plan signed July 20, 2022, indicated R1 received assistance with dressing, oral care, hair care, bathing, toileting, transfers, assistance with wheelchair mobility as needed, meals, and medication management. The service plan lacked oxygen management, Miami J cervical collar, and blood glucose monitoring. R1's record lacked a smoking assessment and R1 was not assessed to be unsafe with smoking materials. R1's care plan dated July 21, 2022, indicated R1 was told and was agreeable to Vaimar Suites' smoking policy, staff were to keep all cigarettes and lighters in the cabinet and give it to R1 when they were ready to go out and smoke, and any	02290			

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02290	Continued From page 65 violation of the smoking policy should be reported to the administrator. On November 29, 2023, at 9:38 a.m., clinical nurse supervisor (CNS)-C stated R1, R2, R3 and R5 smoked on the facility grounds and the licensee kept lighter and cigarettes of the four residents when they were not smoking. CNS-C stated three of the four residents were their own responsible party, and one had a guardian. CNS-C stated they follow the licensee's policy for smoking. On November 29, 2023, at 10:07 a.m., CNS-C stated the licensee did not have a smoking assessment documented for any of the residents listed above to include an assessment if residents were or were not safe with smoking materials. On November 29, 2023, at 10:40 a.m., the surveyor inquired with R1 if they had their smoking materials. R1 stated no. The surveyor did not observe any smoking materials in R1's room. R1 stated the licensee kept their smoking material. R1 stated, "I just give it to them when I get back in, I don't mind." The licensee's Vaimar Suites Smoking Policy dated June 6, 2020, read, "Staff will keep the lighter locked and provided to residents while going out to smoke." In addition, "Failure to follow the smoking regulation will result in written warning and may result in termination of contract of stay." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02290			

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02310	Continued From page 66	02310		
02310 SS=I	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 ensure the care and services were provided according to acceptable health care and medical, or nursing standards for the licensee's one resident (R1) that utilized an assistive device (consumer bed rail). 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 the potential to affect a large portion or all of the residents). The findings include: R1 admitted to the licensee on July 20, 2022, and began receiving assisted living services. R1's diagnoses included end stage renal failure, diabetes, and hypertension. R1's service plan signed July 20, 2022, indicated R1 received assistance with dressing, oral care, hair care, bathing, toileting, transfers, assistance	02310	On November 30, 2023, the immediacy of correction order 2310 was removed, however non-compliance remained, and the scope and level remained the same.	

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02310	Continued From page 67 with wheelchair mobility as needed, meals, and medication management. On November 28, 2023, at 10:44 a.m., the surveyor observed R1's queen sized bed had a bedside extendable bed rail assist handle (consumer bed rail), at the top of the bed on the right side. The bed rail moved slightly up and down the bed when pressure was applied. The bed rail was attached to the left side of the frame with a black strap and was not wrapped around the box spring. R1's record included a Side-Rail Use Assessment Form completed January 17, 2023, signed by clinical nurse supervisor (CNS)-C and R1. Information on the form included a bed rail assessment for appropriate use, residence preference on bed rail use, and risk and benefit. The assessment lacked identification of which type of device would be used, physical inspection of the consumer bed rail, and documentation of installation per manufacturer's guidelines/instructions. R1's ongoing assessments identified by CNS-C as the 90-day assessments titled, Nurse Reassessment Visit dated April 16, 2023, July 15, 2023, and October 13, 2023, included areas to review R1's body systems (neurosensory, cardiovascular, musculoskeletal, etc.), and an area to review equipment. The assessments all had a hand-written check mark next to the equipment line indicating no change "NC". Next to the check mark was a line to write in a note. Two of the three on-going assessments included a hand-written description of equipment such as oxygen and wheelchair (April 16, 2023, and October 13, 2023, respectively), the assessment dated July 15, 2023, did not include a description	02310			

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02310	Continued From page 68 of equipment. None of the three assessments addressed bed rails or contained information on bed rails. R1's nursing progress notes dated January 14, 2023, to November 28, 2023, indicated R1 was hospitalized on the following dates: January 14, 2023, to January 17, 2023, for flank pain and hematuria; January 31, 2023, to February 3, 2023, for shortness of breath and back pain; April 16, 2023, to April 19, 2023, for plural effusion; July 6, 2023, to July 8, 2023, for syncope; July 22, 2023, to July 28, 2023, post dialysis; September 9, 2023, to September 11, 2023, for fall; October 19, 2023, to October 20, 2023, for fall; and November 16, 2023, to November 19, 2023, for abdominal pain, dark urine, and loose stool. R1's record included change of condition assessments dated January 18, 2023, April 19, 2023, July 15, 2023, September 11, 2023, October 20, 2023, and November 19, 2023. The change of condition assessments lacked inclusion of a re-assessment of R1 for the on-going use of a bed rail. There were no change of condition assessments in R1's record following return from the hospital on February 3, 2023, or July 28, 2023, including no re-assessment for the on-going use of a bed rail. R1's record lacked: - documentation of physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; - documentation of installation and use according to manufacturer's guidelines; and	02310			

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02310	Continued From page 69 - ongoing assessments related to the appropriate use of bed rails. Additionally, despite R1's multiple changes of condition and re-assessments on R1, the licensee failed to continue to document re-assessment of the bed rail, whether R1 continued to be appropriate for use of the bed rail, and lacked documentation that bed rail was installed per manufacturer's instructions. On November 28, 2023, at 11:49 a.m., CNS-C stated the licensee completed a bed rail assessment and completed education on the risks and benefits of bed rail use prior to a grab bar installation on a resident's bed. The surveyor inquired how the licensee would know if a consumer bed rail was installed correctly. CNS-C stated it would be placed under the mattress or box spring and flush with the mattress. The surveyor asked for manufacturer's instructions for R1's consumer bed rail. CNS-C stated they did not have them; however, stated they had looked them up online when they were installed. CNS-C stated they performed a bed rail inspection every 90 days in person with the ongoing assessment by making sure there was not a gap between the consumer rail and mattress and checking that it is secured to the bed. The surveyor inquired how this was documented on the assessments. CNS-C stated under the equipment section, it would state N/C (no change). The surveyor inquired how someone would know what equipment was in use as a bed rail was not listed under equipment. CNS-C stated, "they would have to go to the plan of care and see if there is no changes on those." On November 28, 2023, at 1:07 p.m., CNS-C stated they observed the resident while they used	02310			

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02310	Continued From page 70 the bed rail to determine if they were appropriate to use the device. In addition, CNS-C stated they assessed their cognitive and physical abilities, and if they were unable to utilize the bed rail appropriately, they would deem them inappropriate for bed rail use. On November 29, 2023, at 10:43 a.m. CNS-C stated they were unable to locate the other change of condition assessments because they were out of town, and the other private contract nurse worked. The Food and Drug Administration's (FDA), Recommendations for Health Care Providers Using Adult Portable Bed Rails dated February 27, 2023, indicated adult portable bed rail use or removal should be made based on the individual patient or resident assessments. In addition, follow the health care facility's procedures and manufacturer's recommendations and specifications for installing and maintaining bed rails for the particular bed and bed rails used. The FDA guidance 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)	02310			

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02310	Continued From page 71 website, Assisted Living Resources & Frequently-Asked Questions (FAQs) 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 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 bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Installation and use according to manufacturer's guidelines; - 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". The licensee's Side Rail Use policy dated March 18, 2020, indicated the registered nurse (RN) was responsible to ensure the side rails in use were of a safe designed and properly maintained. Side rails would be used consistent with the manufacturer's recommendations and if the recommendations were not available, the RN	02310			

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02310	Continued From page 72 would use appropriate nursing judgement related to the implementation of the side rails. In addition, side rails would be reassessed and documented as needed, but not less than every 90 days. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	02310			

Type: Full
Date: 11/27/23
Time: 10:27:17
Report: 1036231299

Food and Beverage Establishment Inspection Report

Page 1

Location:

Vaimar Suites Llc
7900 Douglas Drive North
Brooklyn Park, MN55443
Hennepin County, 27

Establishment Info:

ID #: 0037845
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 9522217318
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 at the specific request of the regulatory authority.

NO EMPLOYEE ILLNESS LOG ON SITE. MDH PROVIDED AND EXPLAINED AN ILLNESS LOG DURING INSPECTION.

Comply By: 11/27/23

3-500D Microbial Control: disposition of food

3-501.18A

**** Priority 1 ****

MN Rule 4626.0405A Discard all TCS food prepared in the establishment or opened commercially packaged food when the time exceeds 7 days from the preparation or opening date or if the container or package is not marked.

OBSERVED A CONTAINER OF CHICKEN AND CONTAINER OF GREEN BEANS WITH NO DATE LABEL. ITEMS DISCARDED ON SITE.

Comply By: 11/27/23

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. INSTRUCTIONS FOR TAKING A FOOD SAFETY

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CLASS AND OBTAINING A CFPM CERTIFICATE SENT ALONG WITH REPORT.

Comply By: 12/18/23

3-300B Protection from Contamination: cross-contamination, eggs

3-302.12

MN Rule 4626.0240 Properly label all working containers holding food or food ingredients that are removed from original packages with the common name of the food. Label the food in English and any other languages used by employees who handle food.

OBSERVED SECONDARY FOOD CONTAINER WITH NO LABEL. PER STAFF, THE ITEM WAS SUGAR. CONTAINER WAS LABELED ACCORDINGLY. ISSUE CORRECTED ON SITE.

Comply By: 11/27/23

Surface and Equipment Sanitizers

UTENSIL SURFACE TEMP: = at 170 Degrees Fahrenheit

Location: DISH MACHINE

Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Hold/MILK

Temperature: 36 Degrees Fahrenheit - Location: GE FRIDGE

Violation Issued: No

Process/Item: Ambient Temp

Temperature: 35 Degrees Fahrenheit - Location: GE FRIDGE

Violation Issued: No

Process/Item: Ambient Temp

Temperature: -5 Degrees Fahrenheit - Location: GE FREEZER

Violation Issued: No

Process/Item: Ambient Temp

Temperature: 36 Degrees Fahrenheit - Location: SUNBEAM FRIDGE

Violation Issued: No

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

THIS INSPECTION WAS CONDUCTED IN CONJUNCTION WITH MDH HEALTH REGULATORY DIVISION (HRD) SURVEY. SURVEYOR FROM HRD WAS ASHLEY CREWS. INSPECTION CONDUCTED IN PRESENCE OF VIOLET MUMBUWA, THE PERSON IN CHARGE. ALL VIOLATIONS WERE DISCUSSED WITH THE PERSON IN CHARGE AND HRD EVALUATOR DURING INSPECTION.

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.

DISCUSSED THE FOLLOWING:

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- EMPLOYEE ILLNESS POLICY AND LOG
- REPORTABLE DISEASES
- COOKING TEMPERATURES
- PROPER SANITIZING OF UTENSILS AND DISHWARE
- THERMOMETER USE AND CALIBRATION
- DATE MARKING
- PEST MANAGEMENT
- PROPER FOOD STORAGE
- HANDWASHING PROCEDURES
- GLOVE USE
- NO BARE HAND CONTACT WITH RTE FOODS
- RESTRICTIONS CONCERNING SERVING A SUSCEPTIBLE POPULATION
- ALL VIOLATIONS ON THIS REPORT

FLOOR AND CABINETS ARE WOOD WITH HOLLOW BASE, AND CEILING IS TEXTURED. ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT SUCH A TIME THEY ARE FOUND TO BE A CONCERN OR RISK OF CONTAMINATION, THEY WILL BE ORDERED TO BE REPLACED AND BROUGHT UP TO CODE.

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.**

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 1036231299 of 11/27/23.

Certified Food Protection Manager: _____

Certification Number: _____ Expires: ____ / ____ / ____

Inspection report reviewed with person in charge and emailed.

Signed: _____

VIOLET MUMBUWA
PERSON IN CHARGE

Signed: _____

Jeff Johanson