Electronically Delivered

June 18, 2024

Licensee
Angel's Health & Home Care Services Inc
5833 Pearson Drive
Brooklyn Center, MN 55429

RE: Project Number(s) SL36870015

Dear Licensee:

On June 4, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the March 13, 2024, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: Jess.Schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

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Electronically Delivered

April 9, 2024

Licensee
Angel's Health & Home Care Services, Inc.
5833 Pearson Drive
Brooklyn Center, MN 55429

RE: Project Number(s) SL36870015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on March 13, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

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), MDH may impose fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. 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. 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

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a

hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. to submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

Renee L. Anderson

Renee L. Anderson, Supervisor
State Evaluation Team
Email: renee.l.anderson@state.mn.us
Telephone: 651-201-5871 Fax: 1-866-890-9290

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36870	A. BUILDING: _____ B. WING _____	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGEL'S HLTH & HOME CARE SRV	5833 PEARSON DRIVE BROOKLYN CENTER, MN 55429

(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: SL36870015-0 On March 11, 2024, to March 13, 2024, the Minnesota Department of Health conducted an initial survey at the above provider, and the following correction orders are issued. At the time of the survey, there were three (3) residents, all of whom received services under the provider's Assisted Living license. An immediate correction order was identified on March 12, 2024, issued for SL36870015-0, tag identification 0820.	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.	
0 460 SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request assistance for health and safety needs 24 hours	0 460		

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0 460	Continued From page 1 per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to provide a means for residents to request assistance for health and safety needs 24 hours a day, seven days a week, as required for three of three residents (R1, R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 March 11,	0 460		

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0 460	Continued From page 2 2024, at 10:35 a.m., director of operations (DO)-A stated they offered residents the option to have a call light or a sound bell system installed in their room to summon staff, however, R1 and R2 would yell out to staff, and R3 refused a call light or sound bell. R1 R1 was admitted June 23, 2023, and had diagnoses including end stage renal (kidney) disease, diabetes mellitus type 2, insomnia (difficulty sleeping), and restless leg syndrome. R1's individualized abuse prevention plan (IAPP) dated February 12, 2024, indicated increased weakness, generalized pain, leg pain, and unsteadiness resulting in falls, after returning from dialysis treatments. R1's IAPP indicated R1 would need help in an emergency and would not be able to evacuate without assistance. R2 R2 was admitted June 6, 2023, and had diagnoses of systemic torsion dystonia (muscle contractions cause abnormal, often repetitive movements, postures, or both), hand contractures (where thickening tissue in the palm of the hand cause fingers to curl inward), and dysphagia (swallowing difficulties). R2's IAPP dated December 19, 2023, indicated due to paralysis (inability to make voluntary muscle movements), R2 was dependent with cares and feeding, was unable to ambulate (walk) independently, or to activate an emergency call system. R2's IAPP indicated R2 would need help in an emergency and would not be able to evacuate without assistance. R3	0 460		

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0 460	Continued From page 3 R3 was admitted June 30, 2023, and had diagnoses of depression, prostate cancer, and migraine headaches. R3's IAPP dated February 4, 2024, indicated, due to pain, balance issues and unsteady gait (walking pattern), R3 would need help in an emergency situation. R3's IAPP indicated R3 would need help in an emergency and would not be able to evacuate without assistance. On March 11, 2024, at 10:35 a.m., DO-A stated the licensee lacked documentation of residents being offered or refusing the option to install a call light or a sound bell system in their room. In addition, DO-A stated the licensee would typically document resident offering and refusal of a call light or sound bell system upon intake. The licensee's Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) dated August 1, 2021, which was provided to residents upon admission, indicated on page 11, under Emergency Call System, "in case of an emergency, staff would call 911". No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 460		
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	0 480		

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0 480	Continued From page 4 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 March 13, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity	0 660		

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0 660	Continued From page 5 and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included completion of a baseline health symptom screening, and two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test, for two of two employees (unlicensed personnel (ULP)-D and clinical nurse supervisor (CNS)-B). 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's Facility TB Risk Assessment dated July 1, 2023, indicated the facility was a low risk setting for TB transmission.	0 660		

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0 660	Continued From page 6 ULP-D ULP-D was hired February 8, 2022, and provided direct care services to the licensee's residents. ULP-D's employee record contained a Baseline TB Screening Tool for Healthcare Workers, dated May 9, 2023. The record included a QuantiFERON-TB Gold Plus test dated January 13, 2024. ULP-D's record lacked documentation of baseline health symptoms screening and TB testing prior to providing care to residents. CNS-B CNS-B was hired December 12, 2018, and provided direct care services to the licensee's residents. CNS-B's employee record contained a Baseline TB Screening Tool for Healthcare Workers, dated May 21, 2022. The record included a QuantiFERON-TB Gold Plus test dated March 27, 2020. CNS-B's record lacked documentation of baseline health symptoms screening and TB testing prior to providing care to residents. On March 13, 2024, at 3:30 p.m., director of operations (DO)-A stated ULP-D and CNS-B lacked TB screening and TB testing upon hire. DO-A further stated the licensee's office manager was responsible for ensuring employees completed TB symptom screening and TB testing upon hire, however, CNS-B was in charge of the TB program. DO-A stated ULP-D did not start working directly with residents until June 2023. The Minnesota Department of Health (MDH) guidelines, "Regulations for Tuberculosis Control in Minnesota Health Care Settings", dated July 2013, and based on CDC guidelines, indicated a TB infection control program should include the	0 660		

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0 660	Continued From page 7 following: a team responsible for TB infection control; a facility TB risk assessment; written TB infection control procedures; and HCW education. The guidelines also indicate an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW starts working with patients. Baseline TB screening should be documented in the employee's record. The licensee's undated "Tuberculosis Screening/Prevention" policy indicated each employee having direct contact with residents would receive baseline health symptom screening, and TB skin testing prior to providing care to residents. Furthermore, testing for the presence of infection with M. tuberculosis by either TST (2 step) or IGRA would be conducted, and if employees had written documentation of a positive TST or IRGA, employee's would need to provide written documentation of the results of a chest x-ray indicating no active TB disease, that was dated after the date of the positive TST or IRGA result, and if an employee did not have written documentation from above, the employee must have received a chest x-ray to exclude a diagnosis of infectious TB disease prior to having direct contact with residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness	0 680		

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0 680	Continued From page 8 (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to have a written emergency preparedness plan (EP) with all required content as defined in Appendix Z and failed to post an EP plan prominently. This had the potential to affect all three (3) residents receiving assisted living services, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 680		

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0 680	Continued From page 9 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 March 11, 2024, at 11:10 a.m., the surveyor did not observe an EP plan accessible to staff, residents, and visitors, and therefore, requested the licensee's EP plan. Surveyor observed director of operations (DO)-A opening the cabinets, in the hallway, on the first floor of the facility, however, DO-A was unable to locate the EP plan. DO-A stated the EP binder may be located at the off-site corporate office. On March 12, 2024, at 9:02 a.m., DO-A provided the licensee's EP plan, which was later reviewed by DO-A and surveyor. The licensee's EP plan, dated August 2021, lacked the following required content: -development of all policies/procedures, based on assessment; and additional policies for: -annual review/update of EP plan; -annual review/update of EP policies; -hazard vulnerability and risk assessment; -handling and use of volunteers; -arrangement with other facilities (including sister facilities); -strategies for addressing facility and community-based risk, including evacuation plans, staffing; surges/shortages, and back-up plans; -subsistence needs for staff and patients specific to the facility;	0 680		

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0 680	Continued From page 10 -accessibility to staff, residents and visitors; -primary evacuation location; -roles under a waiver declared by secretary; -EP training and testing program; -EP training program for staff (including documentation of training provided); and -annual EP testing requirements. On March 12, 2024, at 10:12 a.m., DO-A stated the EP plan lacked the required information noted above. DO-A further stated, due to a fire on June 30, 2023, the EP plan had been brought to the off-site corporate office for review. In addition, DO-A stated some of the documents within the EP plan had been given to the property management, and licensee had not been given some of the documents within in the EP plan back. The licensee's Emergency Preparedness policy dated August 1, 2021, indicated the licensee would have an identified EP plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts service, and the EP plan would be reviewed and updated annually. Furthermore, licensee would post the EP plan prominently on each floor of the facility. In addition, licensee would conduct fire drills at the residence every other month, including at least two (2) drills for each shift for a total of six (6) fire drills annually, and a disaster drill, at the residence at least annually, with documentation of drill results. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36870	A. BUILDING: _____ B. WING _____	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGEL'S HLTH & HOME CARE SRV	5833 PEARSON DRIVE BROOKLYN CENTER, MN 55429

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 790	Continued From page 11	0 790		
0 790 SS=C	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide or maintain fire extinguishers as required throughout the facility. This deficient condition had the ability to affect all staff, visitors, and residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On a facility tour on March 13, 2024, at 1:00 p.m., with director of operations (DO)-A, the surveyor observed the required fire extinguisher was provided and serviced annually but the monthly	0 790		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36870	A. BUILDING: _____ B. WING _____	03/13/2024

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0 790	Continued From page 12 required inspections were not documented. At least one fire extinguisher with minimum 2-A:10-B:C rating is required to be provided, mounted, maintained, and located within 75 feet of travel throughout the facility. Fire extinguishers are required to be mounted at least 4 inches off the floor and not higher than 60 inches from the floor to the top of the extinguisher. Documentation is required to demonstrate fire extinguishers have been inspected by facility personnel monthly, and annually replaced with a new extinguisher (of current year manufacture date) or serviced by a certified technician. During interview on March 13, 2024, at 1:05 p.m., DO-A, verified this deficient finding. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 790		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or	0 810		

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0 810	Continued From page 13 evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop the fire safety and evacuation plan with required content, make the plan readily available, provide required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	0 810		

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0 810	Continued From page 14 During an interview on March 13, 2024, at 1:15 p.m., director of operations (DO)-A, stated the fire safety and evacuation plan was not located in a central location within the facility and was located at the corporate office so it could be updated. The FSEP is required to be always kept in the facility and available for reference by employees and occupants. On March 13, 2024, at 1:20 p.m., DO-A, provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee FSEP dated January 1, 2023, failed to include the following: The FSEP included one of the primary evacuation routes leading through the garage as an exit. The garage is a higher hazard occupancy than the assisted living and shall not be used as a exit route for occupants of the assisted living. 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 failed to include procedures employees are required perform specific to this facility in the event of a fire or similar emergency. The plan inappropriately included information including, the doors automatically closing when the fire alarm system is activated, and the fire department will be automatically notified. During an interview on March 13, 2024, at 1:30 p.m.,	0 810		

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0 810	Continued From page 15 DO-A, stated the facility does not have a fire alarms system, automatic closing doors and automatic notification of the fire department. The FSEP did not identify specific fire protection actions for residents evident by not including in writing, specific procedures residents are required to perform in the event of a fire or similar emergency. During an interview on March 13, 2024, at 1:45 p.m., DO-A, stated the FSEP documentation listed above was not available. TRAINING On March 11, 2024, at 8:37 a.m., and 12:38 a.m., and March 13, 2024, at 7:30 a.m., survey staff requested training documentation from DO-A by email. On March 13, 2024, at 8:34 a.m., and 12:02 p.m., survey requested training documentation from DO-A by telephone. No training documentation was provided for employees or residents. Record review indicated the licensee failed to provided evacuation training to residents at least once per year as evident by not providing documentation the residents were offered training of the facility FSEP procedures. Record review indicated the licensee failed to provide training to employees on the FSEP upon hire and at least twice per year as evident by not providing written documentation training was provided to employees. During an interview on March 13, 2024, at 1:50 p.m., DO-A, stated they would send training documentation by email. No further	0 810		

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0 810	Continued From page 16 documentation was provided. DRILLS On March 11, 2024, at 8:37 a.m., and 12:38 a.m., and March 13, 2024, at 7:30 a.m., survey staff requested evacuation drill documentation from DO-A by email. On March 13, 2024, at 8:34 a.m., and 12:02 p.m., survey requested evacuation drill documentation from DO-A by telephone. No evacuation drill documentation was provided. During an interview on March 13, 2024, at 2:00 p.m., DO-A, stated they would send evacuation drill documentation by email. No further documentation was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 820 SS=H	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.	0 820		

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0 820	Continued From page 17 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide facilities that were not a distinct hazard to life. This had the potential to directly affect more than a limited number of the residents and staff. 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). Findings include: On a facility tour on March 12, 2024, at 12:30 p.m., with director of operations (DO)-A, the surveyor observed that compliant emergency escape and rescue openings were not provided in resident sleeping rooms number 1, 2, and 3. Occupied Resident Rooms Resident sleeping room 2, occupied by R1, emergency escape and rescue clear window opening measurements are 16 inches wide, 29 inches in height and 464 square inches in openable area. The window was measured with DO-A, and survey staff present. The window did not meet the minimum requirements for clear opening minimum width and minimum clear opening area. Resident sleeping room 3, occupied by R2, emergency escape and rescue clear window	0 820		

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0 820	Continued From page 18 opening measurements are 16 inches wide, 29 inches in height and 464 square inches in openable area. The window was measured with DO-A, and survey staff present. The window did not meet the minimum requirements for clear opening width and minimum clear opening area. Unoccupied Room Resident sleeping room number 1, unoccupied, emergency escape and rescue clear window opening measurements are 16 inches wide, 29 inches in height and 464 square inches in openable area. The window was measured with DO-A, and survey staff present. The window did not meet the minimum requirements for clear opening width and minimum clear opening area. It was explained to DO-A that at least one compliant emergency escape and rescue opening is required within each resident sleeping room. Existing emergency escape and rescue openings are required to meet a minimum clear opening area of 648 square inches and have a minimum dimension of 20 inches in height and a minimum dimension of 20 inches in width. And have a windowsill height from the floor to the clear opening of not more than 48 inches. These deficient conditions were visually verified by DO-A, accompanying on the tour. Survey staff explained that an immediate correction order was issued for the above findings. TIME PERIOD FOR CORRECTION: Immediate. On March 13, 2024, at 3:18 p.m., immediacy of the citation has been lifted; however, the deficient condition does still exist.	0 820		

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01530	Continued From page 19	01530		
01530 SS=D	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the required eight hours of dementia care training was completed within 160 hours of the employment start date for one of two employees (unlicensed personnel (ULP)-D). This practice resulted in a level two violation (a	01530		

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01530	Continued From page 20 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: ULP-D was hired by licensee on February 8, 2022, to provide assisted living services to the licensee's residents, and had a signed Home Health Aide job description dated June 12, 2022. ULP-D's employee record included documentation of training completed on February 8, 2022. The documentation included five hours of dementia training on the following topics: -introduction and overview; -communication; -activities of daily living; -behaviors vs symptoms; and -the journey. ULP-D's employee record lacked documentation of training on person-centered planning, and service delivery, and a total of eight hours of dementia care training within 160 hours of the employment start date. On March 12, 2024, at 1:15 p.m., director of operations (DO)-A stated no additional documentation of training was available. The licensee's Dementia Training policy dated July 1, 2021, indicated direct care employees would complete eight (8) hours of initial training within 80 hours of employment start date.	01530		

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01530	Continued From page 21 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		

Minnesota Department of Health
Division of Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *03/13/24*
Time: 10:06:09
Report: 8044241062

Food and Beverage Establishment Inspection Report

Location:
Angel'S Hlth & Home Care Srv
5833 Pearson Drive
Brooklyn Center, MN55429
Hennepin County, 27

Establishment Info:
ID #: 0037981
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7632705771
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.

4-500 Equipment Maintenance and Operation

4-501.114A ***** Priority 1 *****

MN Rule 4626.0805A Use the approved sanitizer according to the rule and the EPA approved manufacturer's label.

Clorox wipes used for counter are not safe for food contact surfaces.

Comply By: 03/13/24

4-300 Equipment Numbers and Capacities

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

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

No stem thermometer for checking food temperatures.

Comply By: 03/14/24

4-300 Equipment Numbers and Capacities

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

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

No stickers or thermometer for dishwasher.

Comply By: 03/27/24

Type: Full
Date: *03/13/24*
Time: 10:06:09
Report: 8044241062
Angel'S Hlth & Home Care Srv

Food and Beverage Establishment Inspection Report

4-300 Equipment Numbers and Capacities

4-302.14 ***** Priority 2 *****

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

No chlorine test strips.

Comply By: 03/20/24

Surface and Equipment Sanitizers

Hot Water: = at 160.0 Degrees Fahrenheit
Location: Dishwasher
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 40.8 Degrees Fahrenheit - Location: Mayo in refrigerator
Violation Issued: No

Process/Item: Cold Holding
Temperature: 40.0 Degrees Fahrenheit - Location: Refrigerator
Violation Issued: No

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

HRD inspection conducted with nurse evaluator Rhonda Makela. Inspection report reviewed on site with Director of Operations, Solomon Akwaka.

Domestic kitchen consists of wooden floors, painted gypsum walls and ceilings, wooden cupboards and domestic equipment, incluiding a dishwasher with sanitizing cycle.

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 8044241062 of 03/13/24.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Signed:_____
Inspector signed for Solomon

Signed:_____

Michael DeMars, RS
Public Health Sanitarian III
Rochester District Office
507-216-1096
michael.demars@state.mn.us