Electronically Delivered

September 13, 2024

Licensee
Estherra Care LLC
3257 98th Circle North
Brooklyn Park, MN 55443

RE: Project Number(s) SL34948015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 31, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

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

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

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

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the

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

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

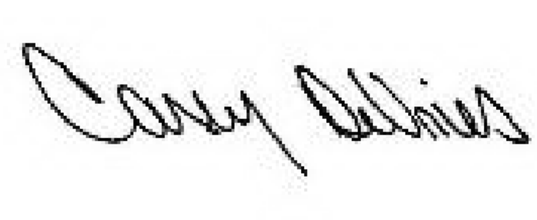
To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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

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

If you have any questions, please contact me.

Sincerely,



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

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34948	A. BUILDING: _____ B. WING _____	07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESTHERRA CARE LLC	3257 98TH CIRCLE NORTH BROOKLYN PARK, MN 55443

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL34948015-0 On July 29, 2024, through July 31, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were two individuals residing in the facility; two receiving services under the provider's Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that:	0 470		

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0 470	Continued From page 1 (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure their required staffing plan was reviewed two times per year to determine appropriate staffing levels to meet resident needs. This had the potential to affect all residents and employees. 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	0 470		

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0 470	Continued From page 2 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 July 29, 2024, at 10:45 a.m., during the entrance conference, owner and licensed assisted living director (LALD)-C stated the facility had a staffing plan developed that was evaluated and updated annually. On July 29, 2024, at 1:00 p.m., LALD-C presented the surveyor with the current staffing plan. The undated Direct Care Staffing Plan indicated the facility had the ability to serve up to four residents and that the staffing plan would be reviewed at least two times each year. The plan indicated it had been reviewed by LALD-C on February 9, 2023 and February 10, 2024. On July 29, 2024, at 2:30 p.m., LALD-C stated they did not realize the staffing plan was required to be reviewed every six months, but thought it was supposed to be annually, and that is what they had been doing. The licensee's Staffing and Scheduling policy, dated June 1, 2021, indicated licensee would assure qualified employees would be scheduled to meet operational requirements and resident needs. The clinical nurse supervisor (CNS) would be responsible to develop and implement a written staffing plan that provided an adequate number of staff to meet resident needs twenty-four hours per day seven days per week. The policy did not specify how often the plan needed to be reviewed.	0 470		

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0 470	Continued From page 3 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according 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 July 30, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.	0 480		

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0 480	Continued From page 4 TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to have a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all	0 680		

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0 680	Continued From page 5 residents, employees, 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's emergency disaster preparedness plan lacked evidence of the following required content: - quarterly review of missing resident policy; - policy and procedure for ensuring food, water, medical supplies, and pharmaceutical supplies; - policy and procedure for alternate sources of energy to maintain temperatures to protect resident health/safety, safe/sanitary storage of provisions, emergency lighting, fire detection, extinguishing, alarm systems, and sewage and waste disposal; - written communication plan that included names and contact information of staff, residents' physicians, Federal, State, tribal, State Licensing and Certification Agency, the MN Office of Ombudsman for LTC; and - conduct exercises to test the EPP at least twice per year. On July 29, 2024, at 2:30 p.m., licensed assisted living director (LALD)-C stated they reviewed the missing resident policy annually and were not aware it needed to be reviewed quarterly. On July 29, 2024, at 3:45 p.m., LALD-C stated	0 680		

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0 680	Continued From page 6 they were not aware what specific amounts of water and food resources would be needed for the facility in an emergency. LALD-C stated flashlights would be used as an alternate light source, but they would need to secure them in a central location, make sure the flashlights all worked, and that they had batteries to be prepared for an emergency. The licensee's Emergency Preparedness policy dated June 1, 2021, indicated the facility would have an identified plan in place to assure the safety and well-being of clients and staff during periods of an emergency or disaster that disrupts services. The licensee's Missing Resident policy 2.28, dated June 1, 2021, indicated the policy and any individual resident plans that pertain to elopement would be reviewed, with any changes documented, at least quarterly. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program.	0 800		

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0 800	Continued From page 7 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment of the facility in a continuous state of good repair and operation. This has the potential to directly affect the health, safety, and well-being of the residents and staff. 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: On July 30, 2024, from approximately, 1:00 p.m. to 2:00 p.m., survey staff toured the home with licensed assisted living director (LALD)-C. During the home tour, survey staff observed the following: -The resident sleeping room egress windows were not maintained for easy operation as the LALD-C had difficulty opening them. In addition, the windowsills were dirty. LALD-C agreed and stated that they needed to spend some time cleaning the windows. -The exhaust fan cover in the lower-level bathroom was covered with thick dust. The above deficient findings were verbally and/or visually verified by LALD-C at the time of discovery.	0 800		

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0 800	Continued From page 8 During an interview, survey staff explained the above deficient findings to LALD-C. LALD-C understood and acknowledged the findings. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=C	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	0 810		

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0 810	Continued From page 9 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 the document and record review and interview, the licensee failed to provide the minimum required training of staff on the fire safety and evacuation plan. This has the potential to directly affect the safety of visitors, staff, and all 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 potential to affect a large portion or all of the residents). The findings include: On July 30, 2024, at approximately 2:15 p.m., document review and interview with licensed assisted living director (LALD)-C, on the home's fire safety and evacuation plan and related training policies, procedures, and records indicated the following: -Record review of available documentation indicated the licensee lacked or provided incomplete employee training on the fire safety and evacuation plan twice per year after the initial hire training. The available records for review showed employee training on fire safety and	0 810		

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0 810	Continued From page 10 evacuation consisted of one employee training for the year 2022 (July 30, 2022) and one for the year 2023 (July 30, 2023). Survey staff commented that the licensee was in compliance for the year 2024 since the record review of the year 2024 indicated that they had performed one employee training on fire safety and evacuation and would have the remaining 2024 to complete another training to fulfill the minimum requirement of twice a year. The above deficient findings were verified by LALD-C during the interview. On July 30, 2024, at approximately 2:45 p.m.,during the exit interview, survey staff explained the above deficient findings to LALD-C. LALD-C understood and acknowledged the findings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
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	01060		

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01060	Continued From page 11 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: (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 required content for an emergency relocation for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01060		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01060	Continued From page 12 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: R2 was admitted to the licensee and began receiving assisted living services on June 23, 2023. R2's diagnoses included major depressive disorder, generalized anxiety disorder, gender dysphoria, borderline personality disorder, and post traumatic stress disorder. R2's Service Plan (Waiver)- Addendum to Contract, dated November 1, 2023, indicated R2 received services including assistance with medication administration, grooming, housekeeping, behavior management, and safety checks. R2's record included an After Visit Summary, dated May 9, 2024, which indicated R2 was inpatient at a hospital beginning on May 5, 2024, and was discharged from the hospital on May 9, 2024. R2's Resident Notes, included a note from clinical nurse supervisor (CNS)-A, dated May 9, 2024, at 4:15 p.m., indicating R2 had returned to the facility that day following an inpatient hospitalization. R2's record lacked a written notice delivered to the resident or designated representative that	01060		

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	34948	A. BUILDING: _____ B. WING _____	07/31/2024

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01060	Continued From page 13 contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the Office of the Ombudsman for Long Term Care (OOLTC); - 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 - 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. On July 30, 2024, at 3:20 p.m., clinical nurse supervisor (CNS)-A stated they had not been completing emergency relocation forms for residents who had been hospitalized. CNS-A stated they thought emergency relocation was for after a resident had been inpatient at another facility at least three days. CNS-A stated they were not aware of the need for ombudsman notification after four days. The licensee's Emergency Relocation policy, dated June 1, 2021, indicated in the event of an emergency relocation, the facility would provide a written notice that contained: - the reason for the relocation; - name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the OOLTC; - 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	01060		

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01060	Continued From page 14 that a return date is not currently known; and - a statement that, if the facility refuses to provide housing or services after a relocation, the resident had the right to appeal. The policy further indicated the notice would be delivered as soon as practicable to the resident, legal representative, designated representative, and the resident's case manager. In addition, the policy indicated the facility would notify the OOLTC if the resident had not returned to the facility within four days. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment;	01500		

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01500	Continued From page 15 disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure all employees that	01500		

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01500	Continued From page 16 performed direct services completed all required training components for each twelve months of employment for one of one employee (clinical nurse supervisor (CNS)-A). 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). CNS-A had a hire date of July 29, 2021. CNS-A provided supervision of staff and direct services to residents. On July 29, 2024, at 10:30 a.m., during the entrance conference, CNS-A stated they completed employee training and resident assessments as part of their role with the facility. CNS-A's employee record lacked training for the following required topics: - review of provider policies and procedures for 2022, 2023, and 2024. On July 30, 2024, at 3:06 p.m., licensed assisted living director (LALD)-C stated employees completed training on their policies and procedures at time of hire but they had not been completing this training annually with any employee. The licensee's Annual Required Staff Training policy 5.06, dated June 1, 2021, indicated all staff that perform direct care services would complete at least eight hours of annual training for each	01500		

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01500	Continued From page 17 twelve months of employment with the facility. The policy specified training must include review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures. The facility would retain a confirmation of training in each employee record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
01750 SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide specific written instructions for medication administration when delegated to unlicensed personnel (ULP) for one of two residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01750		

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01750	Continued From page 18 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 R1 was admitted to the licensee and began receiving assisted living services on March 26, 2021. R1's diagnoses included anxiety, major depressive disorder, social phobia, hypogonadism, and vitamin D insufficiency. R1's Service Plan (Waiver)- Addendum to Contract, dated January 1, 2024, indicated R1 received services including assistance with medication administration, bathing reminders, housekeeping, laundry, behavior management, and safety checks. On July 30, 2024, at 9:04 a.m., the surveyor observed ULP-B prepare and administer medications to R1. R1's Assessment, dated May 6, 2024, completed by clinical nurse supervisor (CNS)-A in the category of rest and sleep indicated R1 preferred to go to bed at 11:45 p.m. and wake up between 9:00 a.m. and 10:00 a.m. in the morning. No additional information was noted about sleep habits, insomnia, or sleep interventions. R1's signed MD (medical doctor) Orders, dated July 24, 2024, indicated R1 received trazodone	01750		

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01750	Continued From page 19 50 milligram (mg) one-half to two tablets (25 mg to 100 mg) by mouth at bedtime as needed for sleep/ insomnia. R1's Medication Administration Record (MAR) dated July 1 through July 29, 2024, indicated R1 received trazodone 50 mg for insomnia on ten out of twenty-eight evenings. On July 8, 15, and 17, 2024, ULP-E and ULP-F documented results after administration of trazodone 50 mg were that R1 was sleeping. On July 7, 2024, ULP-F documented they followed up after administering the trazodone 50 mg but did not indicate if R1 was sleeping or still awake. R1's MAR dated July 1 through 29, 2024 indicated R1 received trazodone 50 mg for insomnia without relief on the following dates: - On July 2, 2024, at 11:28 p.m., ULP-E administered trazodone 50 mg to R1 and documented a response at 12:31 a.m., that R1 was still awake. - On July 3, 2024, at 10:24 p.m., ULP-E administered trazodone 50 mg to R1 and documented a response at 10:51 p.m., that R1 was still awake. - On July 7, 2024, at 11:34 p.m., ULP-E administered trazodone 50 mg to R1. On July 8, 2024, at 6:49 a.m., ULP-E documented that R1 was awake until 3:00 a.m. - On July 9, 2024, at 11:57 p.m., ULP-E administered trazodone 50 mg to R1 and documented a response at 12:28 a.m., that R1 was still awake and watching television in R1's room. - On July 16, 2024, at 11:46 p.m., ULP-E administered 50 mg trazodone to R1 and documented a response at 1:07 a.m., that R1 was still awake watching television.	01750		

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01750	Continued From page 20 - On July 24, 2024, at 12:12 a.m., ULP-E administered trazodone 50 mg to R1 and documented a response at 1:51 a.m., that R1 was still awake but stated they were going to bed soon. R1's record lacked notes of any additional follow up measures taken by ULPs on their shifts when trazodone was not effective for R1's insomnia. The record lacked documentation of communication from ULPs with nursing. On July 30, 2024, at 3:20 p.m., director of nursing (DON)-D, stated R1 directed how many mg of trazodone they wanted to take when R1 had trouble sleeping. DON-D stated they had not provided ULPs with any additional direction other than what was indicated on the MAR. DON-D did not recall ULPs raising any issue in July or making any calls to nursing about trazodone not working. DON-D stated they had talked with R1 about trazodone effectiveness in the past. DON-D stated R1 was aware they could talk to nursing about making adjustments if needed. DON-D stated they had also talked with R1 about drinking less caffeine to promote better sleep. DON-D was not aware of R1's caffeine intake on the nights the trazodone did not work. R1's record lacked specific written instructions for ULPs to determine what measures should be taken when trazodone ordered as a range of 25 to 100 mg was not working at the dose administered. The licensee's Delegation of Assisted Living Services policy, dated June 1, 2021, indicated when medication management was delegated to a ULP, the registered nurse would provide specific instructions for each resident and	01750		

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01750	Continued From page 21 document those instructions in the resident's record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to provide documentation in the resident's record regarding the disposition of medication to include all of the required items for three of three discharged residents (R3, R4, and	01910		

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01910	Continued From page 22 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: R3 R3's diagnoses included schizoaffective disorder, depression, anxiety, history of alcohol abuse, history of suicidal ideation, and asthma. R3 discharged from the licensee on July 11, 2024. R3's Discharge Care Plan, dated July 11, 2024, indicated the following medications were sent with R3 to their new apartment: -oxycodone fifteen tablets; -clonazepam eighteen tablets; - senna thirteen tablets; - ibuprofen eight tablets; - diphenhydramine four tablets; and - all scheduled medications for July 11, 2024, through August 11, 2024. A medication administration list, dated July 11, 2024, was signed by director of nursing (DON)-D and R3. The document included fifty-four pages, and indicated the facility was sending the medications listed with R3 to be administered by R3 or a responsible party after R3 left the facility. The document included dates of July 11, 2024,	01910		

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01910	Continued From page 23 through August 11, 2024, with scheduled medications for 9:00 a.m., 2:00 p.m., 8:00 p.m., and as needed listed for each day. The medications listed included: 9:00 a.m. scheduled medications - acetaminophen 325 milligram (mg) three tablets by mouth twice daily; - benztropine 0.5 mg one tablet by mouth twice daily; - clonazepam 1 mg one tablet by mouth twice daily; - fluphenazine 5 mg two tablets by mouth twice daily; - propranolol extended release (ER) one capsule by mouth daily; and -senna 8.6 mg one tablet by mouth twice daily. 2:00 p.m. scheduled medications - acetaminophen 325 milligram (mg) three tablets by mouth twice daily; 8:00 p.m. scheduled medications - acetaminophen 325 milligram (mg) three tablets by mouth twice daily; - benztropine 0.5 mg one tablet by mouth twice daily; - clonazepam 1 mg one tablet by mouth twice daily; - fluphenazine 5 mg two tablets by mouth twice daily; - mirtazapine 15 mg one tablet by mouth at bedtime; -olanzapine 5 mg one tablet by mouth at bedtime; - senna 8.6 mg one tablet by mouth twice daily; and - sodium fluoride 5000 pls cream to apply after brushing with normal toothpaste and let dry. As needed medications listed -ibuprofen 800 mg one tablet every six to eight hours as needed for pain once daily; and -oxycodone 5 mg one tablet by mouth every four hours as needed for pain.	01910		

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01910	Continued From page 24 The document included the medication name, strength, date of disposition, signature of resident, and signature of staff involved, but lacked quantity and prescription numbers. On July 29, 2024, at 4:00 p.m., clinical nurse supervisor (CNS)-A stated they were aware the form used for disposition of medications did not contain all of the required information in a readable format. CNS-A stated the electronic medical record used by facility did not have a document that met the facility's needs related to disposition of medications. CNS-A stated they had talked about getting something different in place but had not done so yet. R4 R4's diagnoses included bipolar disorder, dissociative identity disorder, general anxiety disorder, gender dysphoria, diabetes, and sleep apnea. R4 discharged from the licensee on May 26, 2023. R4's Medication Administration Record (MAR) dated May 2023 indicated R4 received the following medications: - Fiasp 100 units per milliliters (ml) daily for use with insulin pump; - lamotrigine 100 mg one tablet by mouth daily; - linzess 145 micrograms (mcg) one capsule by mouth daily; - naltrexone 25 mg one half tablet by mouth twice daily; - omeprazole 20 mg one capsule by mouth daily; - omnipod dash pod one omnipod on insulin pump every forty-eight hours; - promethazine 25 mg two tablets by mouth four	01910		

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01910	Continued From page 25 times daily; - Ventolin hydrofluoroalkane (hfa) 90 mcg per actuation aerosol two puffs by mouth inhalation twice daily; - ariprazole 30 mg one tablet by mouth daily; - gabapentin 300 mg one capsule by mouth three times daily; - levetiracetam 500 mg one tablet by mouth twice daily; - lithium carbonate 300 mg two tablets twice daily; - metoprolol succinate ER 25 mg one tablet by mouth twice daily; - metoprolol succinate ER 50 mg one tablet by mouth twice daily; - motegrity 2 mg one tablet by mouth daily; - polyethylene glycol 3350 seventeen grams (gm) powder mixed with 4 to 8 ounces (oz) of liquid one daily; - estradiol transdermal system 0.1 mg per 24-hour period apply two patches to skin twice weekly; - mirtazapine 15 mg one tablet by mouth at bedtime; - gabapentin 300 mg three capsules three times daily as needed in addition to scheduled gabapentin; - glucagon inject 1 mg under skin as needed for blood glucose under 50 mg/ deciliter (dl); - hydroxyzine hydrochloride (hcl) 50 mg one to two tablets by mouth twice daily as needed; - meclizine hcl 25 mg three times daily as needed; - metoprolol tartrate one tablet by mouth every twelve hours as needed for racing heart; - mirtazapine 7.5 mg one tablet by mouth at bedtime as needed for sleep; - ondansetron one tablet by mouth every twelve hours as needed; - polyvinyl Al 1.4 percent (%) ophthalmic solution one to two drops into each eye daily as needed;	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34948	A. BUILDING: _____ B. WING _____	07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESTHERRA CARE LLC	3257 98TH CIRCLE 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
01910	Continued From page 26 - risperidone dissolve one tablet by mouth once daily as needed; - albuterol 0.083% solution one vial nebulized and inhaled every four hours as needed; - baclofen one tablet by mouth three times daily as needed; and - clonazepam 0.5 mg one tablet by mouth daily as needed for severe anxiety. R4's Discharge/ Transfer Summary, dated May 26, 2023, lacked any information about medication disposition. R4's Resident Notes, dated May 26, 2023, indicated the facility and R4 were planning for a discharge date of June 1, 2023, but that R4's case manager sent an email on May 26, 2023 at 11:55 a.m. notifying facility that R4 was moving on that same day. The note indicated DON-D authorized the unlicensed personnel working to provide R4 with his medications. DON-D's note indicated discharge without nursing present was not safe and medications might be missed, that it was R4's decision to leave and the facility, "would not accept any responsibility". DON-D's note further indicated, "the discharge process and medication count should be performed by a licensed RN". On July 30, 2024, at 3:20 p.m., DON-D stated they had communicated via telephone with R4 on the day R4 was discharged. DON-D stated R4 was not willing to wait for DON-D and CNS-A to arrive at the facility and provide proper discharge plans and medication education. DON-D stated they had the unlicensed personnel (ULP) that was working provide R4 with all of his medications and that no medication disposition was completed.	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34948	A. BUILDING: _____ B. WING _____	07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESTHERRA CARE LLC	3257 98TH CIRCLE NORTH BROOKLYN PARK, MN 55443

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01910	Continued From page 27 R5 R5's diagnoses included bipolar disorder, anxiety, diabetes, hypertension, hypothyroidism, and chronic obstructive pulmonary disease (COPD). R5 discharged from the licensee on September 5, 2023. On July 30, 2024, at 4:15 p.m., DON-D stated they did not have any documentation on medication disposition because R5 transferred internally to another one of the facilities owned by the same company. The surveyor stated the other facility held a separate health facility identification number (HFID) and a medication disposition was required. The licensee's Medication Disposal policy 7.23, dated June 1, 2021, indicated medications managed by the facility would be given to the resident or the resident's representative when the resident's medications were no longer managed by the facility, or the medication had been discontinued by the prescriber. Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. In addition, the policy indicated any unused controlled· substances remaining when the resident's medications were no longer managed by the facility must be disposed of in accordance with accepted practices of the Minnesota Board of Pharmacy. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34948	A. BUILDING: _____ B. WING _____	07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESTHERRA CARE LLC	3257 98TH CIRCLE 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
01910	Continued From page 28 days	01910		

DEPARTMENT OF HEALTH

Type: Full
Date: *07/30/24*
Time: 15:22:00
Report: 1036241141

Food and Beverage Establishment Inspection Report

Location:
Estherra Care Llc
3257 98th Circle North
Brooklyn Park, MN55443
Hennepin County, 27

Establishment Info:
ID #: 0039005
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 9526887164
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.

4-300 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 WERE AVAILABLE FOR MEASURING THE SANITIZER CONCENTRATION. MDH PROVIDED ESTABLISHMENT WITH A FEW TEST STRIPS UNTIL SOME CAN BE OBTAINED.

Comply By: 08/20/24

4-100 Equipment Construction Materials

4-101.17

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

OBSERVED SEVERAL WOODEN UTENSILS IN DRAWERS. ITEMS WERE REMOVED FROM KITCHEN. ISSUE CORRECTED ON SITE.

Comply By: 08/20/24

4-500 Equipment Maintenance and Operation

4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

OBSERVED A DAMAGED GASKET SEAL ON THE CHEST FREEZER. REPLACE AND MAINTAIN.

Comply By: 08/20/24

Surface and Equipment Sanitizers

UTENSIL SURFACE TEMP: = at 180 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Chlorine: = 100PPM at Degrees Fahrenheit
Location: SANITIZER SPRAY BOTTLE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Ambient Temp
Temperature: 40 Degrees Fahrenheit - Location: FRIDGE
Violation Issued: No

Process/Item: Ambient Temp
Temperature: -10 Degrees Fahrenheit - Location: FREEZER
Violation Issued: No

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

THIS INSPECTION WAS CONDUCTED IN CONJUNCTION WITH MDH HEALTH REGULATORY DIVISION (HRD) SURVEY. SURVEYOR FROM HRD WAS PEGGY ANDERSON. INSPECTION CONDUCTED IN PRESENCE OF ESTHER WAKO, THE PERSON IN CHARGE. AT TIME OF INSPECTION, ESTABLISHMENT HAD TWO RESIDENTS. ALL VIOLATIONS WERE DISCUSSED WITH THE PERSON IN CHARGE AND SURVEYOR 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 ALL ORDERS ON SITE IN ADDITION TO THE FOLLOWING WITH
THE PERSON IN CHARGE:
- EMPLOYEE ILLNESS LOG AND EXCLUSION POLICY.
- HAND WASHING POLICY AND REVIEW.
- PROPER FOOD STORAGE.
- GLOVE USAGE.
- THERMOMETER USE AND CALIBRATION.
- SANITIZER USE AND TEST KITS.
- DATE MARKING.
- PEST CONTROL.
- FULLY COOKING FOOD FOR HIGH RISK POPULATIONS.
- ANSI 184 STANDARD FOR RESIDENTIAL DISH WASHER.

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

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

Type: Full
Date: *07/30/24*
Time: 15:22:00
Report: 1036241141
Estherra Care Llc

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the inspection report number 1036241141 of 07/30/24.

Certified Food Protection Manager: BOUTHONG THONGSAVANH

Certification Number: FM118402 Expires: 04/24/26

Inspection report reviewed with person in charge and emailed.

Signed: _____
ESTHER WAKO
PERSON IN CHARGE

Signed: _____
Jeff Johanson