DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

October 21, 2022

Administrator
Armstrong Homes Inc
7908 Oregon Avenue North
Brooklyn Park, MN 55445

RE: Project Number(s) SL36204015

Dear Administrator:

On October 14, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the August 18, 2022, evaluation were corrected. This follow-up evaluation verified that the facility is in substantial compliance.

It is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. You are encouraged to retain this document for your records.

Please feel free to call me with any questions.

Sincerely,

Jodi Johnson, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 507-344-2730 Fax: 651-215-9697

PMB

Electronically Delivered

September 6, 2022

Administrator
Armstrong Homes, Inc.
7908 Oregon Avenue North
Brooklyn Park, MN 55445

RE: Project Number(s) SL36204015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on August 18, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

The enclosed State Form documents the state licensing orders. The Department of Health documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for 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 imposed immediately with no opportunity to correct the violation first as follows:

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

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2,

9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5)(b), 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 evaluation:

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program = $500
St - 0 - 1390 - 144g.62 Subdivision 1 - Availability Of Contact Person To Staff - $3,000

The total amount you are assessed is $3,500. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

Please address your cover letter for general reconsideration requests to:
Reconsideration Unit

Free from Maltreatment reconsideration requests should be addressed to:
Reconsideration Unit

Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

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

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both.

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

Sincerely,

Casey DeVries, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-5917 Fax: 651-215-9697

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36204	A. BUILDING: _____ B. WING _____	08/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARMSTRONG HOMES INC	7908 OREGON AVENUE NORTH BROOKLYN PARK, MN 55445

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(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: SL36204015-0 On August 15, 2022, through August 18, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were two residents, both who received services under the provider's Assisted Living license. An immediate correction order was identified on August 15, 2022, issued for SL36204015-0, tag identification 1390. On August 16, 2022, the immediacy of correction order 1390 was removed, however non-compliance remained at a level 3/widespread.	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.	
0 110 SS=F	144G.10 Subdivision 1a Assisted living director license required	0 110		

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0 110	Continued From page 1 Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the licensed assisted living director (LALD) was listed as the director of record for the licensee with the Board of Executives for Long-Term Services and Support (BELTSS). This had the potential to affect all of the licensee's residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: LALD-D obtained an assisted living director license on August 4, 2021. On August 16, 2022, at 7:39 a.m., the surveyor observed the Board of Executives for Long-Term Services and Support (BELTSS) website which indicated LALD-D held a current assisted living director license but was not listed as Director of Record for the licensee. On August 15, 2022, at approximately 9:18 a.m.,	0 110		

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0 110	Continued From page 2 during the entrance conference, housing manager (HM)-C identified LALD-D as the LALD for the licensee. On August 16, 2022, at 12:10 p.m., owner (O)-G verified LALD-D was not listed as the Director of Record for the licensee. O-G stated the licensee was unaware of the Director of Record requirement. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department	0 250		

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0 250	Continued From page 3 access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required with records reviewed. This had the potential to affect all	0 250		

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0 250	Continued From page 4 residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on August 15, 2022, at approximately 9:35 a.m., housing manager (HM)-C stated the licensee's employees in charge of the facility were familiar with the assisted living regulations and the licensee provided medication and treatment management services. The licensee's Provisional Assisted Living Licensure Information and Application, section titled Official Verification of Owner or Authorized Agent, (page 17 and 18 of the application), identified, I certify I have read and understand the following: [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17. - I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th	0 250		

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0 250	Continued From page 5 Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G. - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659. - Reporting of Maltreatment of Vulnerable Adults. - Electronic Monitoring in Certain Facilities. - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all	0 250		

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0 250	Continued From page 6 data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license. - I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. - I have examined this application and all attachments and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required. - I attest to have all required policies and procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page 18 was electronically signed by owner (O)-G on February 22, 2022. The licensee had an assisted living license issued on May 25, 2022, with an expiration date of May 24, 2023. The licensee failed to ensure the following policies and procedures were developed and/or	0 250		

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0 250	Continued From page 7 implemented: - requirements in section 626.557, reporting of maltreatment of vulnerable adults; - orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; - infection control practices; - reminders for treatments; - conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; - medication and treatment management; and - supervision of unlicensed personnel performing delegated tasks. On August 16, 2022, at 1:00 p.m., HM-C, and owner (O)-G confirmed the licensee provided assisted living services but failed to implement corresponding policies and procedures, as required. As a result of this survey, the following orders were issued 0110, 0430, 0450, 0460, 0470, 0480, 0490, 0510, 0580, 0630, 0640, 0650, 0660, 0680, 0780, 0790, 0800, 0810, 0900, 0950, 0970, 1330, 1390, 1440, 1460, 1530, 1610, 1620, 1640, 1650, 1820, 1910, indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250		

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0 430	Continued From page 8	0 430		
0 430 SS=C	144G.40 Subd. 2 Uniform checklist disclosure of services (a) All assisted living facilities must provide to prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a). This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide the licensee's Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) to two of two residents (R1, R2) with records reviewed. 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 the residents).	0 430		

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0 430	Continued From page 9 The findings include: R1 R1 admitted for assisted living services on July 25, 2022. R1's Planned Services dated August 15, 2022, indicated R1 received assistance with bathing, grooming, dressing, transfer assistance, housekeeping, behavior management, symptom withdrawal, meal assistance, medication management and vital signs. R2 R2 admitted for assisted living services on January 18, 2022. R2's Service Plan Sample Form dated January 18, 2022, indicated R2 received assistance with meals, grooming, medication management, laundry, housekeeping and safety checks. R1 and R2's records lacked a uniform checklist disclosure of services to include: - a disclosure of the categories of assisted living licenses available and the category of license held by the facility; and - a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide. On August 15, 2022, at approximately 1:08 p.m., registered nurse (RN)-A verified R1, and R2's record lacked a written acknowledgement of the resident's receipt of the UDALSA. RN-A stated the staff had reviewed the UDALSA verbally with	0 430		

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0 430	Continued From page 10 the residents upon admission. The licensee's Uniform Disclosure of Assisted Living Services & Amenities policy dated July 20, 2021, indicated the licensee would provide a UDALSA to prospective residents prior to signing an assisted living contract. In addition, the licensee would obtain a written acknowledgement that the UDALSA was provided to the resident or resident representative or document the reason why an acknowledgement was not obtained. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 430		
0 450 SS=C	144G.41 Subdivision 1 Minimum requirements All assisted living facilities shall: (1) distribute to residents the assisted living bill of rights; (2) provide services in a manner that complies with the Nurse Practice Act in sections 148.171 to 148.285; (3) utilize a person-centered planning and service delivery process; (4) have and maintain a system for delegation of health care activities to unlicensed personnel by a registered nurse, including supervision and evaluation of the delegated activities as required by the Nurse Practice Act in sections 148.171 to 148.285; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide the current bill of rights (BOR) for assisted living to two of two residents	0 450		

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	36204	A. BUILDING: _____ B. WING _____	08/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARMSTRONG HOMES INC	7908 OREGON AVENUE NORTH BROOKLYN PARK, MN 55445

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0 450	Continued From page 11 (R1, R2) with records reviewed. 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: R1 and R2 admitted to the licensee for assisted living services on July 25, 2022, and January 18, 2022, respectively. R1 and R2's record lacked evidence the licensee provided R1 and R2 with the assisted living BOR. On August 15, 2022, at approximately 1:08 p.m., registered nurse (RN)-A verified R1 and R2's record lacked a written acknowledgement of the resident's receipt of the BOR. RN-A stated the staff had reviewed the BOR verbally with the residents upon admission. The licensee's Bill of Rights policy dated July 20, 2021, indicated the licensee would provide a written copy of the BOR before services were initiated to the residents. In addition, the licensee would provide a written acknowledgement of the resident's receipt of the BOR or would document why an acknowledgement was not obtained. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 450		

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0 460	Continued From page 12	0 460		
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 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 observation, interview and record review the licensee failed to provide a mean for residents to request assistance for health and safety needs 24 hours a day, seven days a week. 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 the residents).	0 460		

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0 460	Continued From page 13 The findings include: On August 15, 2022, at approximately 9:52 a.m., housing manager (HM)-C stated residents would "yell out our name" if assistance was needed or find a staff member to assist with a request. In addition, HM-C stated the licensee had ordered a call light system that would be installed when it arrived. On August 15, 2022, at approximately 10:52 a.m., during a facility tour, the surveyor observed no system in place for residents to request staff assistance when needed 24 hours a day. On August 15, 2022, at 2:05 p.m., HM-C stated the licensee had not ordered the call light system however, they had placed an order today. HM-C then handed the surveyor a receipt of purchase made on August 15, 2022, and stated it would be the system the licensee would use for residents to request assistance. The licensee's 24-Hour Emergency Response policy dated July 20, 2021, indicated residents would press a button or pull and emergency response cord that would activate the response system which would notify a designated staff person. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 460		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470		

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0 470	Continued From page 14 determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a staffing plan to determine staffing levels to meet the needs of all residents. This had the potential to affect all residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	0 470		

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0 470	Continued From page 15 cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living facility license. The facility was licensed for a bed capacity of six residents and had a current census of two residents. The licensee failed to develop and implement a staffing plan for determining its staffing level that included the following: - an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; - ensured 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 - ensured 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. On August 16, 2022, at 12:23 p.m., registered nurse (RN)-A stated the licensee had not created a staffing plan, however, the licensee used one staff member per shift as listed on the white board. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		

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0 480	Continued From page 16	0 480		
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: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared according to the Minnesota Food Code. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	0 480		

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0 480	Continued From page 17 Please refer to the additional documentation included in the Food and Beverage Establishment Inspection Reports, dated August 15, 2022. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 490 SS=F	144G.41 Subd 1 (13) (ii)-(vii) Minimum requirements (ii) weekly housekeeping; (iii) weekly laundry service; (iv) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for providing this assistance; (v) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance; (vi) provide culturally sensitive programs; and (vii) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record	0 490		

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0 490	Continued From page 18 review, the licensee failed to have a daily program of social and recreational activities based on individual and group interests, physical, mental, and psychosocial needs, that create opportunities for active participation in the community at large. This had the potential to affect all residents who received services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On August 15, 2022, through August 16, 2022, the surveyor did not observe any activities planned or offered to the residents. Residents remained in their rooms most of the day and went outdoors to smoke. On August 16, 2022, at 12:24 p.m., registered nurse (RN)-A stated the licensee did not provide a daily program of social and recreational activity however, when staff were available, they would ask residents if they would like to go out for an activity. In addition, RN-A stated if a resident asked to go somewhere the staff would attempt to accommodate. On August 16, 2022, at approximately 12:25 p.m., owner (O)-G stated the licensee had games available for residents and staff would play if a resident requested.	0 490		

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0 490	Continued From page 19 The licensee's Activity Programming policy dated July 20, 2021, indicated the licensee would provide activities and social recreation for its residents on a regular basis. In addition, the licensee would provide a monthly activity calendar that would be available to all residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 490		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and record review the licensee failed to establish and maintain an effective infection control program to comply with accepted health care, medical, and nursing standards for infection control related to current recommendations for Coronavirus (COVID-19). This practice had the potential to affect all of the licensee's residents, staff and visitors.	0 510		

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0 510	Continued From page 20 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On August 15, 2022, at approximately 9:00 a.m., staff of the licensee took the surveyor's temperature, however, did not screen the surveyor for COVID-19 symptoms. In addition, the surveyor observed unlicensed personnel (ULP)-E in the common area without a mask present. On August 16, 2022, at approximately 8:50 a.m., staff of the licensee did not take the surveyor's temperature and did not screen the surveyor for COVID-19 symptoms. On August 16, 2022, at approximately 12:00 p.m., the surveyor observed owner (O)-G within six feet of R1 without a mask or eyewear. August 16, 2022, at 12:05 p.m., registered nurse (RN)-A stated staff were supposed to screen visitors by asking questions related to COVID-19 symptoms and take visitor's temperatures. In addition, RN-A stated all visitors and staff members were required to wear a mask within the facility. The surveyor inquired why screening was not completed on the surveyor. RN-A stated they were unsure why the licensee protocol was not followed.	0 510		

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0 510	Continued From page 21 The licensee's Infection Control policy dated July 20, 2021, indicated the licensee's infection control program would be consistent with current guidelines from the CDC for prevention control in long-term care facilities, where applicable in assisted living facilities. The CDC COVID Data Tracker indicated Hennepin County community transmission level were high on August 10, 2022, to August 16, 2022. The CDC COVID-19 PPE and Source Control Grids dated April 7, 2022, indicated when a community transmission level is high, staff working with residents without COVID-19 should wear a face mask and eye protection. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 510		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal.	0 580		

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0 580	Continued From page 22 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to implement and maintain a quality management program (QMP) appropriate to the size of the facility and relevant to the type of services provided. This had the potential to affect all residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 August 15, 2022, at approximately 10:20 a.m., housing manager (HM)-C stated the licensee did not have a QMP. In addition, HM-C stated the licensee was working on getting the "business up and running" and the licensee had created a binder for the future QMP. The surveyor inquired if the licensee had documented any minutes on what they were attempting to improve in facility from change of ownership. HM-C stated the licensee had kept no record. The licensee's Quality Management Project policy dated July 20, 2021, indicated the licensee would have one documented quality management project in place at all times, and retain records of such projects for two years. No further information provided.	0 580		

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0 580	Continued From page 23 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 580		
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to update an individual abuse prevention plan (IAPP) to include the person's risk of abusing others and identify specific measures to be taken to minimize the risk of abuse to other vulnerable adults for one of two residents (R1) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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).	0 630		

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0 630	Continued From page 24 The findings include: R1 admitted for assisted living services on July 25, 2022. R1's diagnosis included depression, anxiety and chronic pain. R1's Planned Services dated August 15, 2022, indicated R1 received assistance with bathing, grooming, dressing, transfer assistance, housekeeping, behavior management, symptom withdrawal, meal assistance, medication management and vital signs. On August 16, 2022, at approximately 11:30 a.m., the surveyor observed R1 verbalize a racial comment to the other MDH surveyor. On August 16, 2022, at 12:40 p.m., the surveyor observed R1 use profanity towards staff members. R1's Assessment dated July 26, 2022, indicated R1 was not at risk of abusing others. R1's IAPP lacked the following: - the person's risk of abusing other vulnerable adults; and -statements of the specific measures to be taken to minimize the risk of abuse to other vulnerable adults. On August 16, 2022, at 12:44 p.m., the surveyor inquired if R1 was verbally abusive towards others. Registered nurse (RN)-A stated R1 was verbally abusive towards others. The surveyor inquired why R1's abuse prevention plan did not reflect this. RN-A stated they would update the IAPP.	0 630		

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0 630	Continued From page 25 The licensee's Individual Abuse Prevention Plan policy dated July 20, 2022, indicated the IAPP would contain an individualized review or assessment of the person's risk of abusing other vulnerable adults and would include statements of specific measures to be taken to minimize the risk of abuse to other vulnerable adults. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post the 911 emergency number in common areas and near telephones provided by the assisted living facility. This had the potential to affect all residents, staff and visitors. This practice resulted in a level two violation (a	0 640		

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0 640	Continued From page 26 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On August 15, 2022, at approximately 10:52 a.m., during a facility tour, the surveyor observed a 911 emergency number on a white board in stair well. In addition, the surveyor observed two phones in basement and one phone in kitchen area which all lacked the required posting of the 911 emergency number. On August 15, 2022, at approximately 11:00 a.m., housing manager (HM)-C verified the telephones lacked the required posting of 911 emergency number. HM-C stated the licensee did not know about the requirement and would post 911 emergency number by phones. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640		
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure,	0 650		

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0 650	Continued From page 27 registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure employee records included all required content for one of one employee (unlicensed personnel (ULP)-B) with employee record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a	0 650		

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0 650	Continued From page 28 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 included: ULP-B started employment with licensee January 18, 2022. On August 16, 2022, at approximately 11:20 a.m., the surveyor observed ULP-B assist R1 to access the licensee's backyard with a wheelchair. ULP-B's record lacked a current job description to include qualification, responsibilities, and identification of staff persons providing supervision. On August 16, 2022, at approximately 11:40 a.m., house manager (HM)-C acknowledged ULP-B's employee record lacked a current job description. In addition, HM-C stated every employee needed to have a currently dated and signed job description. Licensee's Employee Records policy dated July 20, 2021, indicated licensee will keep an employee record for all paid employees. Employee records will be kept up-to-date and confidential. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control	0 660		

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0 660	Continued From page 29 (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on 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 documentation of a completed TB Facility Risk Assessment and the licensee failed to ensure TB screening and training was completed for one of two employees (unlicensed personnel (ULP)-B) with employee records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	0 660		

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0 660	Continued From page 30 The findings included: TB RISK ASSESSMENT The licensee failed to complete a TB risk assessment, including designating and documenting a qualified person or team with primary responsibility for the TB infection control program. On August 16, 2022, at approximately 12:10 p.m., house manager (HM)-C acknowledged the licensee had not established a TB prevention program. SCREENING AND TRAINING ULP-B started employment with licensee January 18, 2022. ULP-B's record included a baseline screening (tuberculin skin test (TST)) first step completed on February 5, 2022, with the results read on February 7, 2022. The record lacked a second step TST. In addition, ULP-B's record lacked documentation for TB history and symptom screen and TB training completed at hire. On August 16, 2022, at approximately 12:40 p.m., HM-C acknowledged the findings above and stated licensee was aware the documents were missing, and would ask registered nurse (RN)-A to establish a tuberculosis (TB) prevention program and complete ULP-B's TB screening and training. Licensee's Infection Control Policy dated July 20, 2021, indicated licensee has a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases.	0 660		

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0 660	Continued From page 31 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 (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency	0 680		

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0 680	Continued From page 32 disaster preparedness plan with all required content. This had the potential to affect the licensee's two residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On August 16, 2022, at approximately 10:38 a.m., the surveyor requested to view the licensee's emergency preparedness plan (EPP). On August 16, 2022, at approximately 10:39 a.m., house manager (HM)-C stated licensee had not started an emergency preparedness program. Licensee lacked EPP to include the following content: - Establishment of the Emergency Program (EP); - Develop and Maintain EP Program; - Maintain and Annual EP Updates; - EP Program Patient Population; - Process for EP Collaboration; - Development of EP Policies and Procedures; - Subsistence Needs for Staff and Patients; - Procedures for Tracking of Staff and Patients; - Policies and Procedures Including Evacuation; - Policies and Procedures for Sheltering; - Policies and Procedures for Medical Documents; - Policies and Procedures for Volunteers; - Arrangement with Other Facilities;	0 680		

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0 680	Continued From page 33 - Roles under a Waiver Declared by Secretary; - Development of Communication Plan; - Names and Contact Information; - Emergency Officials Contact Information; - Primary/Alternate Means for Communication; - Methods for Sharing Information; - Sharing Information on Occupancy/Needs; - LTC Family Notifications; - Emergency Prep Training and Testing; - Emergency Prep Training Program; - Emergency Prep Testing Requirements; - LTC Emergency Power (Typically ENGINEERING); and - Integrated Health Systems. On August 16, 2022, at approximately 10:42 a.m., HM-C acknowledged licensee had not implemented an emergency preparedness program to include above content. Licensee's Emergency Preparedness Plan - Appendix Z Compliance policy dated July 20, 2021, indicated licensee has in place an effective and compliant Emergency Preparedness Plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code:	0 780		

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0 780	Continued From page 34 (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure smoke alarms are interconnected so that actuation of one alarm causes all alarms in the dwelling to actuate as required. 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, but was not likely to cause serious injury, impairment, or death), and 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 residents). The findings include:	0 780		

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0 780	Continued From page 35 On August 18, 2022, between 11:50 a.m. and 1:00 p.m., survey staff toured the facility with the unlicensed professional (ULP)-B. During the facility tour, survey staff observed the smoke alarms were not interconnected. When each test button was pushed, only the local alarm sounded. ULP-B verbally confirmed survey staff observations during the facility tour. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 780		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the installation and maintenance of portable fire extinguishers at the facility. This had the potential to directly affect all residents, staff, and visitors.	0 790		

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0 790	Continued From page 36 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 residents). The findings include: On August 18, 2022, between 11:50 a.m. and 1:00 p.m., survey staff toured the facility with the unlicensed professional (ULP)-B. During the facility tour, survey staff observed the installed portable fire extinguisher was size 5:BC. The fire extinguisher also lacked records to show the required monthly visual inspections were performed or recorded. ULP-B verbally confirmed survey staff observations during the facility tour. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program.	0 800		

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0 800	Continued From page 37 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. 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 the potential to affect a large portion or all residents). The findings include: On August 18, 2022, between 11:50 a.m. and 1:00 p.m., survey staff toured the facility with the unlicensed professional (ULP)-B. During the facility tour, survey staff observed the following: 1. The wall of the basement bedroom on the hallway side had been damaged. 2. The closet in bedroom #2 had broken bi-fold door hardware and would not stay in the track. ULP-B verbally confirmed survey staff observations during the facility tour. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		

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0 810	Continued From page 38	0 810		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and	0 810		

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ARMSTRONG HOMES INC	7908 OREGON AVENUE NORTH BROOKLYN PARK, MN 55445

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 810	Continued From page 39	0 810		

maintain fire safety and evacuation plans, failed to provide required training to residents and employees for fire safety and evacuation, and failed to conduct required employee evacuation drills. This had the potential to affect all current residents, staff, and visitors to the facility.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 the potential to affect a large portion or all residents).

The findings include:

On August 18, 2022, between 11:50 a.m. and 1:00 p.m., survey staff toured the facility with the unlicensed professional (ULP)-B. During the facility tour, survey staff observed that the evacuation plans were not posted in the facility. ULP-B verbally confirmed survey staff observations during the facility tour.

During a phone interview on August 18, 2022, at 1:00 p.m., the house manager (HM)-C stated they did not have the policy on site and he would send it to the survey staff by end of the day. He also stated that they had not done any of the required trainings for staff or residents and had not done any of the required evacuation drills.

Review of the fire policy showed the following:

1. No evacuation plan or documentation on specific procedures for the residents including procedures for their movements, and relocation

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0 810	Continued From page 40 during a fire or similar emergency. No written instructions for addressing any unique situation during an evacuation, especially for residents who are wheelchair-bound and need assistance during an evacuation. The policy was a basic policy from a third-party provider and had not been edited or updated to fit the facility. 2. No record of required employee evacuation drills. 3. No schedule or records on the training of employees on fire safety and evacuation; on proper actions to take in the event of a fire or emergency for the safety of residents including movement, evacuation, or relocation. 4. No schedule or records on the training of residents who are capable of assisting in their evacuation; on proper actions to take in the event of a fire or emergency for their safety including movement, evacuation, or relocation. 5. No fire safety and evacuation plan that showed the location and number of resident rooms. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 900 SS=D	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms	0 900		

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0 900	Continued From page 41 concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to execute a written contract with the required content for one of two residents (R1) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 900		

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0 900	Continued From page 42 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 admitted for assisted living services on July 25, 2022. R1's Planned Services dated August 15, 2022, indicated R1 received assistance with bathing, grooming, dressing, transfer assistance, housekeeping, behavior management, symptom withdrawal, meal assistance, medication management and vital signs. On August 16, 2022, at approximately 9:30 a.m., the surveyor observed unlicensed personnel (ULP)-B administer oral medications to R1. R1's record lacked a written contract with the following required content: - housing; - assisted living services, whether provided directly by the facility or by management agreement or other agreement; and - the resident's service plan, if applicable. In addition, the resident records lacked evidence the contract had been fully executed as the facility must: - offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; - give a complete copy of any signed contract and any addendums, and all supporting documents	0 900		

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0 900	Continued From page 43 and attachments, to the resident promptly after a contract and any addendum has been signed; and - the facility must offer the resident the opportunity to identify a designated representative. On August 15, 2022, at 3:14 p.m., housing manager (HM)-C verified R1's record lacked a written contract. HM-C stated the previous nurse verbalized R1's written contract was completed. In addition, HM-C stated, "she probably told me but did not complete it." The licensee's Signing an Assisted Living Contract policy dated July 20, 2021, indicated when a resident decided to move into the facility an assisted living contract would be signed. In addition, one copy of the assisted living contract would be provided to the resident and the other copy would be retained in the resident's record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 900		
0 950 SS=D	144.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES.	0 950		

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0 950	Continued From page 44 You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to offer the resident the opportunity to identify a designated representative in writing with the required statutory language for one of two residents (R2) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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:	0 950		

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0 950	Continued From page 45 R2 admitted for assisted living services on January 18, 2022. R2's Assisted Living Contract was signed on January 18, 2022. R2's Assisted Living Contract lacked the opportunity to designate a representative and the verbatim "right to designate a representative for certain purposes" notice. On August 16, 2022, at approximately 12:12 p.m., registered nurse (RN)-A, and owner (O)-G verified R2's contract lacked opportunity to designate a representative and the verbatim "right to designate a representative for certain purposes" notice. RN-A the stated staff asked R2 if they wanted to designate a representative and R2 said no. (O)-G stated if a resident wanted a representative, it would be listed on the face sheet in the resident's chart. The licensee's Designated Representative policy dated July 20, 2021, indicated the licensee would offer residents the opportunity to identify a designated representative in writing. In addition, a signed Designated Representative form would be completed, and the form would be kept in the resident's record. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 950		
0 970 SS=F	144.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility	0 970		

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0 970	Continued From page 46	0 970		

liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property of a resident for one of two residents (R2) with records reviewed.

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

The findings include:

R2 admitted for assisted living services on January 18, 2022.

R2's Assisted Living Contract was signed on January 18, 2022.

R2's Assisted Living Contract, included two sections titled insurance liability release, and indemnification. The sections indicated the resident would waive the facility's liability for injury, death or property damage occurring on the

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0 970	Continued From page 47 providers premises unless caused solely by negligence of licensee. On August 16, 2022, at approximately 12:12 p.m., owner (O)-G verified all contracts contained waivers of liability. O-G stated the licensee is responsible for what occurred in the facility. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		
01330 SS=F	144G.60 Subd. 4 (b) Unlicensed personnel (b) Unlicensed personnel performing delegated nursing tasks in an assisted living facility must: (1) have successfully completed training and demonstrated competency by successfully completing a written or oral test of the topics in section 144G.61, subdivision 2, paragraphs (a) and (b), and a practical skills test on tasks listed in section 144G.61, subdivision 2, paragraphs (a), clauses (5) and (7), and (b), clauses (3), (5), (6), and (7), and all the delegated tasks they will perform; (2) satisfy the current requirements of Medicare for training or competency of home health aides or nursing assistants, as provided by Code of Federal Regulations, title 42, section 483 or 484.36; or (3) have, before April 19, 1993, completed a training course for nursing assistants that was approved by the commissioner. This MN Requirement is not met as evidenced by: Based on observation, interview and record	01330		

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01330	Continued From page 48 review the licensee failed to ensure the unlicensed personnel performing delegated nursing task in the assisted living facility completed training and demonstrated competency in all required areas for one of one employee (unlicensed personnel (ULP)-B) with employee record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings included: ULP-B started employment with licensee January 18, 2022. On August 16, 2022, at approximately 11:20 a.m., the surveyor observed ULP-B assist R1 to access the licensee's backyard with a wheelchair. ULP-B's record lacked training and competency evaluations completed to include the following: - documentation requirements for all services provided; - reports of changes in the resident's condition to the supervisor designated by the facility; - basic infection control, including blood-borne pathogens; - maintenance of a clean and safe environment; hair care and bathing; care of teeth, gums, and oral prosthetic devices; care and use of hearing aids; and dressing and assisting with toileting; - training on the prevention of falls; - standby assistance techniques and how to	01330		

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01330	Continued From page 49 perform them; - medication, exercise, and treatment reminders; - basic nutrition, meal preparation, food safety, and assistance with eating; - preparation of modified diets as ordered by a licensed health professional; - communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; - awareness of confidentiality and privacy; - understanding appropriate boundaries between staff and residents and the resident's family; - procedures to use in handling various emergency situations; and - awareness of commonly used health technology equipment and assistive devices. - observing, reporting, and documenting resident status; - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; - reading and recording temperature, pulse, and respirations of the resident; - recognizing physical, emotional, cognitive, and developmental needs of the resident; - safe transfer techniques and ambulation; - range of motioning and positioning; and - administering medications or treatments as required. On August 16, 2022, at approximately 11:20 a.m., house manager (HM)-C acknowledged ULP-B's record was missing all training and competency evaluations noted above. In addition, HM-C stated ULP-B was verbally trained but had not completed skills test or been checked off by RN-A. HM-C also stated all licensee's ULPs had gone through the same training and their records	01330		

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01330	Continued From page 50 would be missing the content above. Licensee was not able to provide evidence of the training completed. Licensee's Training Records policy dated July 20, 2022, indicated licensee will maintain a record of staff training and competency required, but lacked verbiage to include the content of the training. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01330		
01390 SS=I	144G.62 Subdivision 1 Availability of contact person to staff (a) Assisted living facilities must have a registered nurse available for consultation by staff performing delegated nursing tasks and must have an appropriate licensed health professional available if performing other delegated services such as therapies. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a registered nurse ((RN)-A) was readily available for consultation to the staff performing delegated nursing tasks and services. This had the potential to affect all residents and staff of the facility. The licensee hired RN-A to perform all nursing tasks. RN-A simultaneously held a nursing position working a 0.7 schedule (or 56 hours every two weeks) at a hospital which would not allow them to be available 24 hours per day, 7 days per week, to address facility emergencies or concerns.	01390	On August 16, 2022, the immediacy of correction order 1390 was removed, however non-compliance remained at a level 3/widespread.	

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01390	Continued From page 51 This resulted in an immediate correction order on August 15, 2022, at approximately 1:45 p.m. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On August 15, 2022, at 9:45 a.m., at the entrance conference, housing manager (HM)-C verified RN-A was the only employed nurse working at the facility. HM-C indicated RN-A worked at the assisted living facility (ALF) every Monday and Friday from 10:00 a.m., to 12:00 p.m., and remained on-call at all other times. On August 15, 2022, at 9:53 a.m., RN-A stated they held another nursing position as a floor nurse in a hospital where they worked a 0.7 schedule. RN-A further stated they had the capability to look at their cell phone and were able to step away during their hospital shifts to take phone calls and would return to the floor. On August 15, 2022, at 10:47 a.m., RN-A verified the previously discussed hospital work schedule. The surveyor asked RN-A if they would be able to leave if an emergency occurred at the ALF. RN-A stated they would be able to leave their hospital shifts if there was an emergency by using family sick leave or personal leave.	01390		

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01390	Continued From page 52 On August 15, 2022, at 11:48 a.m., the surveyor asked RN-A if his sick or personal leave exhausted, would they be able to leave the hospital shift. RN-A stated they did not know if the hospital would allow him to leave the hospital shift. The licensee's Emergency Contacts for Staff policy dated July 20, 2021, indicated in the event of a medical emergency staff were to contact 911 or the clinical nurse supervisor. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01390		
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and	01440		

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01440	Continued From page 53 thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a registered nurse ((RN)-A) conducted supervision of unlicensed staff as required for one of one unlicensed personnel ((ULP)-B) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings included: ULP-B started employment with licensee January 18, 2022. ULP-B's employee record lacked evidence RN-A conducted direct supervision of the employee performing delegated tasks within 30 days the employee had first performed the delegated task for residents and thereafter as needed based on performance. On August 16, 2022, at approximately 11:50 a.m., house manager (HM)-C acknowledged ULP-B's record lacked a supervisory assessment completed within 30 days after the date ULP-B first performed delegated tasks for the residents. In addition, HM-C stated licensee was not aware of the supervision requirement and therefore	01440		

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01440	Continued From page 54 none of the licensee's ULPs would have the supervisory documentation. Licensee's Supervision of Staff - Delegated Services policy dated July 20, 2021, indicated staff who provide delegated nursing or therapy tasks to residents will be supervised by an RN or appropriate licensed health professional where the services are being provided to verify that work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Also, the policy indicated supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working and first performs the delegated tasks for residents and thereafter as needed based on performance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		
01460 SS=F	144G.63 Subdivision 1 Orientation of staff and supervisors All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility. This MN Requirement is not met as evidenced by:	01460		

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01460	Continued From page 55 Based on interview and record review, the licensee failed to ensure staff providing services completed an orientation to assisted living facility licensing requirements and regulations before providing services for one of one unlicensed personnel ((ULP)-B) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings included: ULP-B started employment with licensee January 18, 2022. ULP-B's employee record lacked evidence the employee had received orientation to assisted living requirements to include the following topics: - an overview of assisted living statutes; - an introduction and review of the licensee's policies and procedures related to the provision of assisted living services by the individual staff person; - the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; - handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; - consumer advocacy services of the Office of	01460		

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01460	Continued From page 56 Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and - a review of the types of assisted living services the employee will be providing and the licensee's category of licensure. On August 16, 2022, at approximately 12:20 p.m., housing manager (HM)-C acknowledged ULP-B's record was missing orientation to assisted living requirements noted above. In addition, HM-C stated all the licensee's ULP's were trained the same, however, the licensee was not able to provide evidence of the training completed. Licensee's Orientation & Training - Training Records policy dated July 20, 2022, indicated licensee will maintain a record of staff training and competency required, but lacked verbiage to include the content for orientation to assisted living requirements training. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01460		
01530 SS=F	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	01530		

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01530	Continued From page 57 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 direct care staff received the required amount of dementia care training in the required time frame for one of one employee (unlicensed personnel (ULP)-B) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a 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).	01530		

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01530	Continued From page 58 The findings included: ULP-B started employment with licensee January 18, 2022. ULP-B's employee record lacked documentation of the required eight (8) hours of dementia training within 160 hours of the employment start date. On August 16, 2022, at approximately 12:45 p.m., house manager (HM)-C acknowledged ULP-B's employment record lacked the required 8 hours of dementia training within 160 hours of the employment start date. In addition, HM-C stated only RN-A had the required 8 hours of dementia training, all other staff had only two hours of dementia training. Licensee's Dementia Training policy dated July 20, 2021, indicated all staff are required to complete dementia training at the time of hire and annually thereafter. In addition, the policy indicated direct care employees will complete eight (8) hours of initial training within 160 hours of the employment start date. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01610 SS=F	144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a	01610		

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01610	Continued From page 59 nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed an initial comprehensive nursing assessment prior to signing the assisted living contract/providing services for two of two residents (R1, R2) as required, with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 admitted for assisted living services on July 25, 2022.	01610		

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01610	Continued From page 60 R1's diagnosis included depression, anxiety and chronic pain. R1's Planned Services dated August 15, 2022, indicated R1 received assistance with bathing, grooming, dressing, transfer assistance, housekeeping, behavior management, symptom withdrawal, meal assistance, medication management and vital signs. R1's record indicated the RN completed an initial assessment on July 26, 2022, which indicated one day had passed since start of services. R2 R2 admitted for assisted living services on January 18, 2022. R2's diagnosis included degenerative joint disease (DJD), chronic pain, bipolar (mental illness characterized by extreme mood swings), depression and degenerative arthritis. R2's Service Plan Sample Form dated January 18, 2022, indicated R2 received assistance with meals, grooming, medication management, laundry, housekeeping and safety checks. R2's record indicated the RN completed an admission assessment on June 11, 2022, which indicated 144 days had passed since start of services. On August 15, 2022, at approximately 10:02 a.m., RN-A stated the licensee's process was to complete an assessment on the residents prior to admission to make a temporary care plan and to also complete an admission assessment upon move into the facility.	01610		

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01610	Continued From page 61 On August 16, 2022, at approximately 11:49 a.m., RN-A stated they were not employed with licensee when R2 admitted to the facility and did not have information on R2's initial assessments. On August 18, 2022, at approximately 10:08 a.m., housing manager (HM)-C stated the licensee had contacted the previous owner who indicated there may be some files in a storage. The surveyor was not provided with further documents. The licensee's Assessments, Reviews & Monitoring policy, dated July 15, 2021, indicated the licensee would conduct a nursing assessment by an RN of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which the prospective resident executes a contract with a facility or the date on which a resident moves in. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01610		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs	01620		

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01620	Continued From page 62 and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive reassessment no later than 14 days after services initiation to two of two residents (R1, R2) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 admitted for assisted living services on July 25, 2022. R1's diagnosis included depression, anxiety and chronic pain.	01620		

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01620	Continued From page 63 R1's Planned Services dated August 15, 2022, indicated R1 received assistance with bathing, grooming, dressing, transfer assistance, housekeeping, behavior management, symptom withdrawal, meal assistance, medication management and vital signs. R1's record indicated the RN completed an admission assessment on July 26, 2022, and a 14-day assessment on August 15, 2022, which indicated 20 days had passed between assessments. R2 R2 admitted for assisted living services on January 18, 2022. R2's diagnosis included degenerative joint disease (DJD), chronic pain, bipolar (mental illness characterized by extreme mood swings), depression and degenerative arthritis. R2's Service Plan Sample Form dated January 18, 2022, indicated R2 received assistance with meals, grooming, medication management, laundry, housekeeping and safety checks. R2's record indicated the RN completed an admission assessment on June 11, 2022, 14-day assessment on July 6, 2022, and an ongoing assessment on August 15, 2022, which indicated the first assessment was completed 144 days after admission. On August 16, 2022, at approximately 11:49 a.m., RN-A stated the licensee's process was to conduct assessments upon admission, day 14, every 90-days and with change of condition. In addition, RN-A stated R1's assessment was overdue because they did not complete	01620		

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01620	Continued From page 64 assessment until August 15, 2022. RN-A stated they were not employed with licensee when R2 admitted to the facility and did not have information on R2's assessments. On August 18, 2022, at approximately 10:08 a.m., housing manager (HM)-C stated the licensee had contacted the previous owner who indicated there may be some files in a storage. The surveyor was not provided with further documents. The licensee's Assessments, Reviews & Monitoring policy, dated July 15, 2021, indicated the initial review would be completed within 30 calendar days of the start of services and resident reassessment and monitoring would be conducted no more than 14 calendar days after initiation of services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services	01640		

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01640	Continued From page 65 and how to contact the Office of Ombudsman for Long-Term Care. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the service plan included a signature or other authentication by the resident and the facility to document agreement on the services to be provided to one of two residents (R1) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 admitted for assisted living services on July 25,2022. On August 15, 2022, at 12:20 p.m., registered nurse (RN)-A provided the surveyor with a document titled Planned Services dated August 15, 2022, which RN-A indicated was the service	01640		

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01640	Continued From page 66 plan for R1. R1's Planned Services, dated as printed August 15, 2022, lacked a signature or other authentication by the resident or by the facility, documenting agreement on the services to be provided. On August 16, 2022, at approximately 9:30 a.m., the surveyor observed unlicensed personnel (ULP)-B administer oral medications to R1. On August 16, 2021, at approximately 12:48 p.m., registered nurse (RN)-A verified R1's record lacked a signed service plan. RN-A stated the licensee developed the service plans in the computer, which documented RN-A's name. RN-A stated they were unaware of the requirement but would have the resident sign the service plan. The licensee's Service Plan policy dated July 20, 2021, indicated a written plan between resident or resident representative and the licensee about the services that would be provided to resident. No further information was provided. TIME PERIOD TO CORRECT: Twenty-one (21) days	01640		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences;	01650		

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01650	Continued From page 67 (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plan included the required content for two of two residents (R1, R2) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a 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).	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36204	A. BUILDING: _____ B. WING _____	08/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARMSTRONG HOMES INC	7908 OREGON AVENUE NORTH BROOKLYN PARK, MN 55445

(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
01650	Continued From page 68 The findings include: R1's diagnosis included depression, anxiety and chronic pain. On August 15, 2022, at 12:20 p.m., registered nurse (RN)-A provided the surveyor with a document titled Planned Services dated August 15, 2022, which RN-A indicated was the service plan for R1. R1's Planned Services dated August 15, 2022, indicated R1 received assistance with bathing, grooming, dressing, transfer assistance, housekeeping, behavior management, symptom withdrawal, meal assistance, medication management and vital signs. R1's service plan lacked the following required content: - the fees for services; - the identification of staff or categories of staff who will provide the services; - the schedule and methods of monitoring assessments of the resident; - the schedule and methods of monitoring staff providing services; and - a contingency plan that includes: - the action to be taken if the scheduled service cannot be provided; - information and a method to contact the facility; - the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and - the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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ARMSTRONG HOMES INC	7908 OREGON AVENUE NORTH BROOKLYN PARK, MN 55445

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01650	Continued From page 69 by the resident under those chapters. On August 15, 2022, at approximately 3:14 p.m., housing manager (HM)-C stated fees for service were located on the "6790" form for waivered services. R2 R2 diagnosis included degenerative joint disease (DJD), chronic pain, bipolar (mental illness characterized by extreme mood swings), depression and degenerative arthritis. R2's Service Plan Sample Form dated January 18, 2022, indicated R2 received assistance with meals, grooming, medication management, laundry, housekeeping and safety checks. R2's service plan lacked the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. On August 16, 2022, at approximately 11:56 a.m., RN-A verified R2's service plan lacked the content above because content was not filled in by licensee. In addition, RN-A verified R1's service plan lacked the above content. The licensee's Service Plan policy dated July 20, 2021, indicated the service plan would include the content listed above. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36204	A. BUILDING: _____ B. WING _____	08/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARMSTRONG HOMES INC	7908 OREGON AVENUE NORTH BROOKLYN PARK, MN 55445

(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
01820	Continued From page 70	01820		
01820 SS=F	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure a current written or electronically recorded prescription was obtained for all medications the provider managed to two of two residents (R1, R2) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 R1 admitted for assisted living services on July 25, 2022. R1's diagnosis included depression, anxiety and chronic pain. R1's Planned Services dated August 15, 2022, indicated R1 received assistance with bathing, grooming, dressing, transfer assistance, housekeeping, behavior management, symptom	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36204	A. BUILDING: _____ B. WING _____	08/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARMSTRONG HOMES INC	7908 OREGON AVENUE NORTH BROOKLYN PARK, MN 55445

(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
01820	Continued From page 71 withdrawal, meal assistance, medication management and vital signs. On August 16, 2022, at approximately 9:30 a.m., the surveyor observed unlicensed personnel (ULP)-B administer oral medications to R1. R1's Medication Administration Record (MAR), dated August 2022, listed the medications, times to administer, and staff initials to indicate the medications had been administered. The medications included baclofen 10 milligrams (mg) three times per day, buspirone 15 mg three times per day, Certavite one tablet one time per day, ferrous sulfate 325 mg two times per day, Vitamin D3 1000 units (IU) one time per day, aspirin 162 mg one time per day, pantoprazole 40 mg one time per day, pregabalin 100 mg, three times per day, prazosin 5mg one time per day, cyclobenzaprine 5mg two time per day as needed (PRN), diphenhydramine 25 mg three times a day PRN, hydroxyzine 50 mg every 4 hours as needed max four doses in 24- hours, loperamide 2 mg two times per day PRN, simethicone 80 mg four times per day PRN, Tylenol arthritis 650 mg three times per day PRN, senna 8.6 mg two times per day PRN, and ondansetron 4 mg two time per day PRN. R2 R2 admitted for services on January 18, 2022, and began receiving assisted living services. R2 diagnosis included degenerative joint disease (DJD), chronic pain, bipolar (mental illness characterized by extreme mood swings), depression and degenerative arthritis. R2's Service Plan Sample Form dated January 18, 2022, indicated R2 received assistance with	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36204	A. BUILDING: _____ B. WING _____	08/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARMSTRONG HOMES INC	7908 OREGON AVENUE NORTH BROOKLYN PARK, MN 55445

(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
01820	Continued From page 72 meals, grooming, medication management, laundry, housekeeping and safety checks. On August 16, 2022, at approximately 9:10 a.m., the surveyor observed unlicensed personnel (ULP)-B administer oral medication to R2. R2's MAR, dated August 2022, listed the medication, times to administer, and staff initials to indicate the medications had been administered. The medication included atorvastatin calcium 20 mg one time per day. R1 and R2's record lacked signed prescriber orders for medications to be administered by the licensee. On August 15, 2022, at approximately 12:49 p.m., registered nurse (RN)-A stated the licensee did not have any signed provider orders for R1 or R2. RN-A stated the licensee had reached out to the pharmacy however, the pharmacy had not provided the licensee with the medication orders. In addition, RN-A stated the licensee was attempting to collaborate with a new pharmacy who would be able to provide electronic prescriptions to the licensee. The surveyor inquired how the staff knew they were administering the correct medication. RN-A stated the pharmacy sends medication to the facility and the pharmacy would not fill a medication without a provider's order. On August 16, 2022, at approximately 12:00 p.m., RN-A stated the licensee sends paperwork with residents to medical appointments to have providers sign for medication orders. In addition, RN-A stated the licensee had attempted to have residents go to medical appointments however, residents canceled the appointments.	01820		

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	36204	A. BUILDING: _____ B. WING _____	08/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARMSTRONG HOMES INC	7908 OREGON AVENUE NORTH BROOKLYN PARK, MN 55445

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01820	Continued From page 73 The licensee's Medication & Treatment policy dated July 20, 2021, indicated all orders for medications would be dated and signed by the prescriber and must be current and consistent with the nursing assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
01910 SS=D	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	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01910	Continued From page 74 licensee failed to provide documentation in the resident's record regarding the disposition of medication to include the medication name, medication strength, prescription number, quantity, and to whom the medications were given for one of one discharged resident (R3) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: R3 discharged from the facility on July 15, 2022. R3's Medications Current dated August 15, 2022, included amlodipine 10 milligrams (mg), aripiprazole 20 mg, clonidine 0.1 mg, divalproex extended release (ER) 250 mg, lisinopril 20 mg, metformin ER 500 mg, pantoprazole 40 mg, albuterol sulfate 108 micrograms (mcg), haloperidol 2 mg, hydroxyzine 25 mg, and trazodone 50 mg. R3's record contained an untitled document dated July 22, 2022, which contained name of the staff involved in disposition and date of disposition. R3's record lacked evidence of documentation of R3's disposition of medication to include medication name, medication strength, prescription number, quantity, and to whom the medications were given.	01910		

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01910	Continued From page 75 On August 15, 2022, at 1:18 p.m., housing manger (HM)-C verified R3's record lacked the content listed above. HM-C stated an unlicensed personnel (ULP) released the medication to another facility after discharge and did not document all the required information. The licensee's Medication Disposal policy dated July 20, 2021, indicated the licensee would document in the resident record the disposition of medication including the medication's names, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in disposition. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		

DEPARTMENT OF HEALTH

Environmental Health
Food, Pools, and Lodging
625 Robert St. N
St. Paul
651-201-5000

Type: Full
Date: *08/15/22*
Time: 11:30:00
Report: 1031221109

Food and Beverage Establishment Inspection Report

Location:
Armstrong Homes Inc
7908 Oregon Avenue North
Brooklyn Park, MN55445
Hennepin County, 27

Establishment Info:
ID #: 0038940
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6513543080
ID #:

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

The following orders were issued during this inspection.

2-200 Employee Health

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

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

ESTABLISHMENT DOES NOT HAVE ILLNESS LOG ON SITE. COPY OF LOG SENT WITH REPORT. KEEP ILLNESS LOG ON SITE AND UP TO DATE.

Comply By: 08/15/22

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

3-302.11A(1) ***** Priority 1 *****

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

RAW SHELL EGGS FOUND ABOVE LETTUCE AND OTHER FOODS. BACON FOUND IN REFRIGERATOR DRAWER NEXT TO SLAW AND CHEESE. ***REFRIGERATOR REARRANGED TO ACCOMMODATE ALL RAW ITEMS ON BOTTOM SHELF. KEEP READY-TO-EAT FOODS ABOVE RAW. INFORMATION SENT WITH REPORT.

Comply By: 08/15/22

3-500B Microbial Control: hot and cold holding

3-501.16A2 ***** Priority 1 *****

MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

MASHED POTATOES, 2% MILK, AND SLAW FOUND IN REFRIGERATOR (UPSTAIRS) MEASURED 44-47F. ALL ITEMS HAVE BEEN STORED IN REFRIGERATOR OVERNIGHT.

ALL ITEMS DISCARDED REFRIGERATOR TEMPERATURE ADJUSTED DOWN. MONITOR TEMPERATURES.

Comply By: 08/15/22

7-200 Toxic Supplies and Applications

7-201.11A ***** Priority 1 *****

MN Rule 4626.1600A Separate poisonous or toxic materials from food, equipment, utensils, linens, and single-service and single-use articles by spacing or partitioning.

LYSOL SPRAY FOUND ON TOP OF REFRIGERATOR (UPSTAIRS) NEXT TO BREAD. ***STAFF REMOVED CHEMICAL FROM AREA AND STORED WITH CHEMICALS.***

Comply By: 08/15/22

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.

ESTABLISHMENT DOES NOT HAVE A THIN PROBE THERMOMETER.

Comply By: 08/17/22

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.

ESTABLISHMENT DOES NOT HAVE SANITIER TESTING KIT ON SITE. PROVIDE AND USE TEST KIT TO CHECK SANITIZER CONCENTRATION.

Comply By: 08/16/22

4-600 Cleaning Equipment and Utensils

4-601.11A ***** Priority 2 *****

MN Rule 4626.0840A Equipment food-contact surfaces and utensils must be clean to sight and touch.

CAN OPENER BLADE HAS DRIED FOOD DEBRIS ON IT. CLEAN AND MAINTAIN CLEAN ALL FOOD CONTACT SURFACES.

Comply By: 08/16/22

2-100 Supervision

2-102.12AMN

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

ESTABLISHMENT DOES NOT HAVE A CERTIFIED FOOD PROTECTION MANAGER (CFPM).

Comply By: 08/15/22

3-300C Protection from Contamination: equipment/utensils, consumers

3-304.14B

MN Rule 4626.0285B Wiping cloths used for wiping counters and other equipment surfaces must be held in an approved sanitizing solution and laundered daily.

WET WIPING CLOTH FOUND ON EDGE OF 2-COMP SINK. STORE WIPING CLOTH AS DESCRIBED ABOVE.

Comply By: 08/16/22

4-100 Equipment Construction Materials

4-101.11BCDE

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

SPATULA WITH PLASTIC DETATCHING FROM FOOD CONTACT SURFACE FOUND IN UTENSIL DRAWER. ***SPATULA DISCARDED*** REMOVE FROM SERVICE ALL DAMAGED UTENSILS THAT ARE UNCLEANABLE OR MAY CAUSE PHYSICAL CONTAMINATION.

Comply By: 08/15/22

4-200 Equipment Design and Construction

4-204.112A

MN Rule 4626.0620A Provide a temperature measuring device located in the warmest part of mechanically refrigerated units and coolest part of hot food storage units that are capable of measuring air temperature or a simulated product temperature.

BOTH REFRIGERATORS MISSING INTERIOR THERMOMETERS.

Comply By: 08/18/22

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.

REFRIGERATOR (UPSTAIRS) BOTTOM DRAWER HAS GLASS THAT IS DETACHED. REATTACH GLASS OR REPLACE REFRIGERATOR COMPONENT. DO NOT JUST REMOVE GLASS. REFRIGERATOR (DOWNSTAIRS) MISSING BULB. REPLACE BULB. LOWER KITCHEN CUPBOARDS ROUGH. REFINISH OR CONTACT PAPER.

Comply By: 08/19/22

4-500 Equipment Maintenance and Operation

4-501.12

MN Rule 4626.0740 Resurface scratched or scored cutting blocks and boards or discard if they can no longer be effectively cleaned and sanitized or resurfaced.

WOOD CUTTING BOARD (COUNTER PULL-OUT) SCRATCHED DEEPLY EXPOSING RAW WOOD. ***DISCONTINUE USE OF CUTTING BOARD*** REPLACE CUTTING BOARD.

Comply By: 08/16/22

4-600 Cleaning Equipment and Utensils

4-602.12

MN Rule 4626.0850 Clean the food contact surfaces of cooking and baking equipment and interior cavities of microwave ovens at least every 24 hours.

INTERIOR OF MICROWAVE HAS SPLATTERS OF FOOD DEBRIS. CLEAN AND MAINTAIN CLEAN.

Comply By: 08/17/22

4-600 Cleaning Equipment and Utensils

4-602.13

MN Rule 4626.0855 Clean all non-food-contact surfaces of equipment at a frequency necessary to preclude accumulation of soil residues.

AIR FRYER AND STOVE HAS FOOD/OIL/GREASE ON SURFACE. REFRIGERATOR (DOWNSTAIRS) HAS FOOD AND SPILLS INSIDE CABINET. CLEAN AND MAINTAIN CLEAN.

Comply By: 08/18/22

6-300 Physical Facility Numbers and Capacities

6-301.14A

MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands

LEFT SIDE OF 2-COMP SINK IS MISSING HANDWASH REMINDER SIGN.

Comply By: 08/18/22

Food and Equipment Temperatures

Process/Item: Cold Hold/2% Milk
Temperature: 47 Degrees Fahrenheit - Location: Refrigerator (upstairs)
Violation Issued: Yes

Process/Item: Cold Hold/Meatballs
Temperature: 47 Degrees Fahrenheit - Location: Refrigerator (upstairs)
Violation Issued: Yes

Process/Item: Cold Hold/Slaw
Temperature: 46 Degrees Fahrenheit - Location: Refrigerator (upstairs)
Violation Issued: Yes

Process/Item: Cold Hold/Juice
Temperature: 41 Degrees Fahrenheit - Location: Refrigerator (downstairs)
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	4	3	9

Inspection conducted by Chris F, in the presence of Fuad A.

All violations discussed with Fuad during the inspection.

NOTES:

- Establishment has a residential kitchen (4626.0506(G)(2)) Same-day service only. No saving and reheating of foods or preparation of foods the day prior to eating. Any remaining food from meals to be removed/discarded at end of day.

- Staff must prepare sanitizer bucket and store their wiping rag in it daily. Check concentration of sanitizer throughout day with test strips. Dump and replace sanitizer solution as needed.

- Make sure to date mark any prepared cold items that are kept in refrigerator.

- Employee food needs to be labeled and separated from residents food.

- Staff and residents should be washing hands every time they prepare foods in kitchen.

- Gloves should be used for single-purpose only; switch gloves whenever leaving kitchen to do other work.

- Cutting boards should be utilized as food contact surfaces and not counters or plates.

- Extra care needs to be taken when cleaning behind cabinet hardware so debris does not build up.

- Establishment does not have 3-comp sink or commercial dishwasher - can use dishwasher to wash and rinse, but will need to use bus tub or sink basin to sanitize and air dry dishes, as discussed during inspection. DO NOT USE TOWELS IN DRYING OF DISHES.

- 2-Comp sink has left basin designated for handwashing and the other for product washing/prep sink.

- When preparing food, make sure to use a thin-probe thermometer to check temperatures.

- Keep tools and cleaning supplies separate from food and cookware. Do not place these items on food counters.

- When preparing food from raw, make sure to use a thermometer to check temperatures.

- Keep as few items on counters as possible. Store items (like air fryer) when not needed.

- Lower kitchen shelving needs contact paper prior to using for storage.

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 Environmental Health inspection report number 1031221109 of 08/15/22.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Inspection report reviewed with person in charge and emailed.

Signed:_____
Fuad Ahmed
Person in Charge

Signed:_____
Chris Foster
Public Health Sanitarian I
Freeman Office Building
651-983-8760
chris.j.foster@state.mn.us

Report #: 1031221109

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Environmental Health
Food, Pools, and Lodging
625 Robert St. N
St. Paul

No. of RF/PHI Categories Out	6	Date	08/15/22
No. of Repeat RF/PHI Categories Out	0	Time In	11:30:00
Legal Authority MN Rules Chapter 4626		Time Out	

Armstrong Homes Inc	Address: 7908 Oregon Avenue North	City/State: Brooklyn Park, MN	Zip Code: 55445	Telephone: 6513543080

License/Permit #: 0038940	Permit Holder	Purpose of Inspection: Full	Est Type	Risk Category

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item — Mark "X" in appropriate box for COS and/or R

IN= in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

	Compliance Status		COS	R
	Supervision			
1	IN OUT	PIC knowledgeable; duties & oversight		
2	IN OUT N/A	Certified food protection manager, duties		
	Employee Health			
3	IN OUT	Mgmt/Staff;knowledge,responsibilities&reporting		
4	IN OUT	Proper use of reporting, restriction & exclusion		
5	IN OUT	Procedures for responding to vomiting & diarrheal events		
	Good Hygenic Practices			
6	IN OUT N/O	Proper eating, tasting, drinking, or tobacco use		
7	IN OUT N/O	No discharge from eyes, nose, & mouth		
	Preventing Contamination by Hands			
8	IN OUT N/O	Hands clean & properly washed		
9	IN OUT N/A N/O	No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10	IN OUT	Adequate handwashing sinks supplied/accessible		
	Approved Source			
11	IN OUT	Food obtained from approved source		
12	IN OUT N/A N/O	Food received at proper temperature		
13	IN OUT	Food in good condition, safe, & unadulterated		
14	IN OUT N/A N/O	Required records available; shellstock tags, parasite destruction		
	Protection from Contamination			
15	IN OUT N/A N/O	Food separated and protected		
16	IN OUT N/A	Food contact surfaces: cleaned & sanitized		
17	IN OUT	Proper disposition of returned, previously served, reconditioned, & unsafe food		

	Compliance Status		COS	R
	Time/Temperature Control for Safety			
18	IN OUT N/A N/O	Proper cooking time & temperature		
19	IN OUT N/A N/O	Proper reheating procedures for hot holding		
20	IN OUT N/A N/O	Proper cooling time & temperature		
21	IN OUT N/A N/O	Proper hot holding temperatures		
22	IN OUT N/A	Proper cold holding temperatures		
23	IN OUT N/A N/O	Proper date marking & disposition		
24	IN OUT N/A N/O	Time as a public health control: procedures & records		
	Consumer Advisory			
25	IN OUT N/A	Consumer advisory provided for raw/undercooked food		
	Highly Susceptible Populations			
26	IN OUT N/A	Pasteurized foods used; prohibited foods not offered		
	Food and Color Additives and Toxic Substances			
27	IN OUT N/A	Food additives: approved & properly used		
28	IN OUT	Toxic substances properly identified, stored, & used		
	Conformance with Approved Procedures			
29	IN OUT N/A	Compliance with variance/specialized process/HACCP		

Risk factors (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is **not** in compliance — Mark "X" in appropriate box for COS and/or R — **COS=** corrected on-site during inspection **R=** repeat violation

			COS	R
		Safe Food and Water		
30	IN OUT N/A	Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32	IN OUT N/A	Variance obtained for specialized processing methods		
		Food Temperature Control		
33		Proper cooling methods used; adequate equipment for temperature control		
34	IN OUT N/A N/O	Plant food properly cooked for hot holding		
35	IN OUT N/A N/O	Approved thawing methods used		
36	X	Thermometers provided & accurate		
		Food Identification		
37		Food properly labled; original container		
		Prevention of Food Contamination		
38		Insects, rodents, & animals not present		
39		Contamination prevented during food prep, storage & display		
40		Personal cleanliness		
41	X	Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
		Proper Use of Utensils		
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
		Utensil Equipment and Vending		
47	X	Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48	X	Warewashing facilities: installed, maintained, & used; test strips		
49	X	Non-food contact surfaces clean		
		Physical Facilities		
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) **Date:** 08/15/22

Inspector (Signature)