Electronically Delivered

January 2, 2025

Licensee
Safe Harbor Residential Care Home LLC
9812 Ford Circle
Saint Louis Park, MN 55426

RE: Project Number(s) SL34674015

Dear Licensee:

On November 25, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the September 5, 2024, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

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

JMD

Electronically Delivered

October 10, 2024

Licensee
Safe Harbor Residential Care Home LLC
9812 Ford Circle
Saint Louis Park, MN 55426

RE: Project Number(s) SL34674015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on September 5, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

The correction order documentation should include the following:

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

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

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

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

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

If you have any questions, please contact me.

Sincerely,

Kelly Thorson

Kelly Thorson, Supervisor
State Evaluation Team
Email: kelly.thorson@state.mn.us
Telephone: 320-223-7336 Fax: 1-866-890-9290

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34674	A. BUILDING: _____ B. WING _____	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAFE HARBOR RESIDENTIAL CARE HOME LL	9812 FORD CIRCLE SAINT LOUIS PARK, MN 55426

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL34674015 On September 3, 2024, through September 5, 2024, Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 4 residents; 4 residents receiving services under the provider's Assisted Living Facility license. An immediate correction order was identified on September 4, 2024, issued for SL34674015-0, tag identification 0820. On September 4, 2024, the immediacy of correction order 0820 was removed, however non-compliance remained at an scope and level of H.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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 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 evaluators ' 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 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated September 4, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a	0 660		

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0 660	Continued From page 2 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 maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included a two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test, for one of one employee (unlicensed personnel (ULP)-C). This practice resulted in a level two 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 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: The facility TB risk assessment completed August	0 660		

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0 660	Continued From page 3 1, 2024, indicated the facility was at a low risk for TB transmission. ULP-C began employment on February 20, 2024, to provide direct care services under the licensee's assisted living license. ULP-C's employee file included a physician's letter dated September 14, 2022, indicating a recent chest x-ray was completed, the results were normal, and there was no evidence of chronic or active tuberculosis. ULP-C's record lacked evidence indicating a TST or blood test for baseline screening had been completed prior to the chest x-ray. On September 4, 2024, at 9:17 a.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated she thought the chest x-ray met the requirements for TB testing. The licensee's 8.16 Tuberculosis Screening policy, dated August 1, 2021, indicated new staff will have an IGRA blood test or a two-step Mantoux conducted with results documented on the Baseline TB Screening Tool for HCWs (Health Care Workers). No staff will be permitted to begin work where the work involves sharing the air space with residents until the negative results of the first Mantoux are read and documented or a negative blood test result is received and documented. Staff TB screening results will be kept in each employee medical file. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		

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0 800	Continued From page 4	0 800		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On September 04, 2024, at 10:00 a.m., survey staff toured the facility with the licensed assisted living director/licensed practical nurse (LALD/LPN)-A. During the facility tour, survey staff observed the following items: It was observed outside the exit door by the kitchen that the burnt used cigarettes were being	0 800		

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0 800	Continued From page 5 disposed of without a proper disposal container, creating a possible fire hazard. In the bathroom on the lower level, it was observed that the acoustic ceiling had considerable brown stains from water damage. During the facility tour, LALD/LPN-A visually verified these deficient findings at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the	0 810		

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0 810	Continued From page 6 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 the interview and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and failed to provide the required drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, 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 September 04, 2024, at 1:00 p.m., the licensed assisted living director/licensed practical nurse (LALD/LPN)-A provided documentation on the fire safety and evacuation plan (FSEP), fire safety and evacuation training for the facility, and fire safety and evacuation drills for the facility.	0 810		

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0 810	Continued From page 7 FIRE SAFETY AND EVACUATION PLAN The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The FSEP included the RACE (Remove, Alarm, Confine and Extinguish or Evacuate) acronym as the fire safety procedure and instructed staff to pull the nearest fire alarm in case of fire, but the facility did not have a fire alarm system. The FSEP also instructed staff to close all doors to contain the fire, but the facility did not have a fire rated door and wall assembly. Record review of the available documentation indicated that the licensee did not have fire protection procedures necessary for residents included in the fire safety and evacuation plan. During the interview on September 04, 2024, at 2:00 p.m., LALD/LPN-A stated the fire safety and evacuation plan was from a third-party provider and verified the facility needed to update the fire safety and evacuation plan, including the facility-specific fire safety protocols. LALD/LPN-A also confirmed that the facility had not developed the necessary fire protection procedures for residents. DRILLS Record review of the available documentation indicated that the licensee did not conduct evacuation drills every other month as required by statute. Provided documentation indicated that the drills were conducted on 7/1/24, 5/3/24, 1/23/24, 12/1/23, 8/15/23, and 6/15/23, with no further drills being documented for the year. During the interview on September 04, 2024, at	0 810		

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0 810	Continued From page 8 2:00 p.m., LALD/LPN-A confirmed that the licensee did not conduct evacuation drills every other month and verified there were no further documented drills for the facility for the year. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 820 SS=H	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure physical facility elements did not constitute a distinct hazard to life. The licensee failed to provide a resident bedroom with the minimum window opening meeting the minimum state standard for egress. This affected the occupied resident in bedrooms 2 and 3 on the main level. This practice resulted in a level three violation (a violation that harmed a resident's health or safety,	0 820	This immediate correction order identified on September 4, 2024, has had the immediacy lifted as of September 4, 2024, however non-compliance remained a scope and level of H.	

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0 820	Continued From page 9 not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On September 04, 2024, at 10:00 a.m., survey staff toured the facility with the licensed assisted living director/licensed practical nurse (LALD/LPN)-A. During the facility tour, survey staff observed the following items: It was observed that occupied resident bedrooms 2 and 3 on the main level did not have windows that met the minimum size requirements for egress escape. The clear openable area of the opened windows measured 43 1/2 inches in height and 19 1/4 inches in width, with a total openable area of 837 square inches. The windows did not meet the minimum requirements for opening width. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. Survey staff explained to LALD/LPN-A that at least one egress window in each bedroom must be provided to meet the minimum state standard for an egress window to be a complying bedroom for resident occupancy. LALD/LPN-A verbally confirmed the findings. On September 04, 2024, at 11:00 a.m., during the interview, survey staff explained to LALD/LPN-A	0 820		

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0 820	Continued From page 10 that an immediate correction order was issued for the above finding. LALD/LPN-A acknowledged the above finding. No Further information was provided. TIME PERIOD FOR CORRECTION: Immediate. On September 4, 2024, the immediacy of correction order 0820 was removed, however non-compliance remained at an scope and level of H.	0 820		
01290 SS=D	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study (BGS) was submitted and received in affiliation with the assisted living license for one of one employee (clinical nurse supervisor (CNS)-B).	01290		

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01290	Continued From page 11 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 finding include: On September 4, 2024, at 8:43 a.m., the surveyor compared the facility's employee list to the licensee's Minnesota Department of Human Services (DHS) NETStudy 2.0 roster and identified one employee who was not on the roster for health facility identification (HFID) number 34674. CNS-B was hired May 27, 2022, to provide direct care services to residents and supervision of staff at the assisted living facility. CNS-B's employee record contained a BGS affiliated with another facility owned by the same owner as the licensee. CNS-B's employee record lacked evidence of current, cleared background study affiliated with the licensee's current assisted living HFID 34674. On September 4, 2024, at 8:50 a.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated CNS-C was affiliated with one of three of their locations. LALD/LPN-A stated she overlooked the requirement to have CNS-C affiliated with all three (3) locations. The licensee's 4.02 Background Studies policy	01290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34674	A. BUILDING: _____ B. WING _____	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAFE HARBOR RESIDENTIAL CARE HOME LL	9812 FORD CIRCLE SAINT LOUIS PARK, MN 55426

(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
01290	Continued From page 12 dated August 1, 2021, indicated [licensee] will conduct a Minnesota Department of Human Services Background Study on all employees and volunteers and contractors. No employee may provide direct services and have independent direct contact with any residents until acceptable result of the background study have been received. No further information was provided. TIME PERIOD OF CORRECTION: Two (2) days	01290		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (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.	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34674	A. BUILDING: _____ B. WING _____	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAFE HARBOR RESIDENTIAL CARE HOME LL	9812 FORD CIRCLE SAINT LOUIS PARK, MN 55426

(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
01640	Continued From page 13 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a written service plan was revised to reflect the current services provided for one of two residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on September 3, 2024, at 10:28 a.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated the licensee was aware of minimum assisted living regulations. R1 was admitted to the assisted living facility on September 13, 2023. R1's Service Plan dated September 20, 2023, indicated R1 received services including activity assistance, bathing reminders, housekeeping, laundry, behavior management, and medication administration daily. R1's Medication Administration Summary dated August 2024, indicated R1 received medication administration three times daily and as needed. R1's service plan lacked revision to reflect R1 medication administration increased to three	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34674	A. BUILDING: _____ B. WING _____	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAFE HARBOR RESIDENTIAL CARE HOME LL	9812 FORD CIRCLE SAINT LOUIS PARK, MN 55426

(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
01640	Continued From page 14 times daily and as needed. On September 4, 2024, at 12:40 a.m., LALD/LPN-A stated the residents' service plans should be updated when any changes were made to the service schedule and LALD/LPN-A was unsure why this had not been done. The licensee's 6.10 Service Plan Modification policy dated August 1, 2021, indicated when a resident at [licensee] receives assisted living services and a change(s) to the service plan occurs, the service plan must be amended in writing and signed by the resident or the resident's designated representative. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01820 SS=D	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 maintain current medication orders for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34674	A. BUILDING: _____ B. WING _____	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAFE HARBOR RESIDENTIAL CARE HOME LL	9812 FORD CIRCLE SAINT LOUIS PARK, MN 55426

(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 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: On September 4, 2024, at 8:33 a.m., the surveyor observed unlicensed personnel (ULP)-C administer medications to R1. R1's Service Plan (Waiver) - Addendum to Contract dated September 20, 2023, indicated R1 received medication administration services. R1 had diagnoses including anxiety, attention deficit hyperactivity disorder (ADHD), gender dysphoria, major depressive disorder, and panic disorder. R1's August 2024, Med Admin Summary - Actual - Month list included the following scheduled medications: -amphetamine / dextroamphetamine (attention-deficit hyperactivity disorder) 15 milligrams (mg) daily; -bupropion (depression) 300 mg daily; -citalopram (depression) 40 mg daily; -lamotrigine (seizure) 200 mg daily; -topiramate (migraine headache) 25mg twice daily; -Syeda (birth control) 3-0.03 mg daily; -ondansetron (for nausea and vomiting) 4mg every 8 hours as needed; and -trazodone (Insomnia) 50 mg, take1/2 tab to 3 tabs every night as needed. R1's record lacked current, signed prescriber orders for medications managed by the licensee.	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34674	A. BUILDING: _____ B. WING _____	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAFE HARBOR RESIDENTIAL CARE HOME LL	9812 FORD CIRCLE SAINT LOUIS PARK, MN 55426

(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 16 On September 4, 2024, at 11:46 a.m., clinical nurse supervisor (CNS)-B stated she was aware that current medication orders were required, and she was working on obtaining the orders. The licensee's 7.20 Medication and Treatment Orders policy dated August 1, 2021, indicated the RN (registered nurse) was responsible for assuring that current, authorized prescriber orders for medications or treatments administered by the staff are kept on file in the residents' records. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01820		
01830 SS=D	144G.71 Subd. 14 Renewal of prescriptions Prescriptions must be renewed at least every 12 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter 152. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to renew prescriptions at least every 12 months for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	01830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34674	A. BUILDING: _____ B. WING _____	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAFE HARBOR RESIDENTIAL CARE HOME LL	9812 FORD CIRCLE SAINT LOUIS PARK, MN 55426

(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
01830	Continued From page 17 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: During the entrance conference on September 3, 2024, at 10:27 a.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated the licensee provided medication management services to residents at the facility. R1 was admitted and began receiving services on September 13, 2023. On September 4, at 8:33 a.m., the surveyor observed unlicensed personnel (ULP)-C administer medications to R1. R1's Service Plan (Waiver) - Addendum to Contract dated September 20, 2023, indicated R1 received services including activity assistance, bathing reminders, housekeeping, laundry, behavior management, and medication administration. R1's record lacked prescriber orders renewed at least every 12 months for the following medications: -amphetamine/dextroamphetamine (attention-deficit hyperactivity disorder) 15 milligrams (mg) daily -bupropion (depression) 300 mg daily -citalopram (depression) 40 mg daily -lamotrigine (seizure) 200 mg daily -topiramate (migraine headache) 25mg twice daily -Syeda (birth control) 3-0.03 mg daily -ondansetron (for nausea and vomiting) 4mg	01830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34674	A. BUILDING: _____ B. WING _____	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAFE HARBOR RESIDENTIAL CARE HOME LL	9812 FORD CIRCLE SAINT LOUIS PARK, MN 55426

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01830	Continued From page 18 every 8 hours as needed -trazodone (Insomnia) 50 mg, take1/2 tab to 3 tabs every night as needed On September 4, 2024, at 1:28 p.m., LALD/LPN-A stated they were aware that all medications orders must be renewed yearly, the residents' current orders were expired, and needed to be renewed. The licensee's 7.18 Medications and Treatment Orders - Renewal policy dated August 1, 2021, indicated residents who receive medication management services by [licensee] will have current physician prescribed medication or treatment / therapy orders on record. Medication and treatment orders must be renewed at least every 12 months or more frequently as required. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01830		

Minnesota Department of Health
Food, Pools, and Lodging Services
625 Robert Street North
St. Paul
6512014500

Type: Follow-Up
Date: *09/27/24*
Time: 10:43:46
Report: 1029241332

Food and Beverage Establishment Inspection Report

Location:

Safe Harbor Residential Care
9812 Ford Circle
St Louis Park, MN55426
Hennepin County, 27

Establishment Info:

ID #: 0039291
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 9524519469
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.

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

HOT WATER: = at 180 Degrees Fahrenheit
Location: DISHWASHER
Violation Issued: No

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

ALL PREVIOUSLY ISSUED CORRECTION ORDERS CORRECTED.

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1029241332 of 09/27/24.

Certified Food Protection Manager: MEEKA SINGH

Certification Number: FM122419 Expires: 04/05/27

Inspection report reviewed with person in charge and emailed.

Signed: _____
MEEKA SINGH
LALD

Signed: Trevor McCliment
Trevor McCliment
Public Health Sanitarian
Metro District Office
651-201-3957
trevor.mccliment@state.mn.us

Minnesota Department of Health
Food, Pools, and Lodging Services
625 Robert Street North
St. Paul
6512014500

Type: Full
Date: *09/04/24*
Time: 11:20:15
Report: 1029241299

Food and Beverage Establishment Inspection Report

Location:
Safe Harbor Residential Care
9812 Ford Circle
St Louis Park, MN55426
Hennepin County, 27

Establishment Info:
ID #: 0039291
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 9524519469
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.

3-100 Food Characteristics: unadulterated

3-101.11 ***** Priority 1 *****

MN Rule 4626.0125 Remove all unsafe and adulterated foods from the premises.

TCS ITEMS IN REFRIGERATOR PAST EXPIRATION DATES ON PACKAGES. ITEMS DISCARDED BY OPERATOR.

Comply By: 09/04/24

4-700 Sanitizing Equipment and Utensils

4-702.11 ***** Priority 1 *****

MN Rule 4626.0900 Sanitize utensils and food contact surfaces of equipment before use, after cleaning.

NSF/ANSI 184 DISHWASHER NOT REACHING SANITIZING TEMPS. OPERATOR PLACED SERVICE ORDER FOR REPAIR AND WILL USE ONLY SINGLE-USE DISPOSABLE UTENSILS AND EQUIPMENT AS A SHORT TERM FIX UNTIL DISHWASHER IS ABLE TO SANITIZE AGAIN IN THE NEXT 24-48 HOURS.

Comply By: 09/05/24

3-500C Microbial Control: date marking

3-501.17B ***** Priority 2 *****

MN Rule 4626.0400B Mark the refrigerated, ready-to-eat, TCS food prepared and packaged in a processing plant and opened and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded. The date must not exceed the manufacturer's use-by-date.

DATEMARKING ABSENT FROM OPENED DELI MEATS AND SALAD MIX. OPERATOR INSTRUCTED TO DATE MARK REQUIRED ITEMS. REQUIRED ITEMS AND DATEMARKING PROCEDURES DISCUSSED. ITEMS DISCARDED BY OPERATOR.

Comply By: 09/04/24

4-300 Equipment Numbers and Capacities

4-301.12D

MN Rule 4626.0680D Mechanical warewashing equipment in lieu of a 3-compartment sink may be allowed as long as the warewashing equipment is large enough to accommodate the largest piece of equipment to be washed, rinsed and sanitized.

DISHWASHER NO LONGER REACHING SANITIZING TEMPS. OPERATOR ELECTED TO REPAIR DISHWASHER TO REACH REQUIRED SANITIZING TEMPS.

Comply By: 09/13/24

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.

INTERIORS OF MICROWAVE AND OVEN ENCRUSTED WITH DEBRIS AND GRIME. OPERATOR INSTRUCTED TO CLEAN AND MAINTAIN CLEAN.

Comply By: 09/04/24

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

NO HANDWASHING NOTIFICATION SIGN NEAR HANDWASHING SINK. OPERATOR INSTRUCTED TO PROVIDE HANDWASHING SIGN.

Comply By: 09/04/24

Surface and Equipment Sanitizers

HOT WATER: = at <150 Degrees Fahrenheit
Location: DISHWASHER
Violation Issued: Yes

Food and Equipment Temperatures

Process/Item: MILK
Temperature: 36 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: No

Process/Item: DELI MEAT
Temperature: 39 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: No

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

Establishment's kitchen is residential in nature with tile floors, granite-like countertops, tile walls behind sink and counter, smooth painted walls, textured but cleanable ceiling, and wood/composite-wood drawers and cabinetry. Laminate covering missing from some interior drawers and cabinet holding surfaces. Establishment has NSF/ANSI 184 standard dishwasher to sanitize utensils and equipment and Taylor TempRite thermal stickers to verify maximum water temperatures.

Food and Beverage Establishment Inspection Report

All identified issues addressed with operator. Discussed employee illness reporting and exclusion procedures, vomit/fecal matter cleanup, temperature control, sanitizing by heat and by chemical, employee hygiene, signs of contamination and spoilage, Clostridium botulinum, and other food safety topics and foodborne illness risk factors.

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1029241299 of 09/04/24.

Certified Food Protection Manager: MEEKA D. SINGH

Certification Number: FM122419 Expires: 04/05/27

Inspection report reviewed with person in charge and emailed.

Signed: _____

MEEKA SINGH
LALD

Signed: Trevor McCliment

Trevor McCliment
Public Health Sanitarian
Metro District Office
651-201-3957
trevor.mccliment@state.mn.us

Report #: 1029241299

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Food, Pools, and Lodging Services
625 Robert Street North
St. Paul

No. of RF/PHI Categories Out	4	Date	09/04/24
No. of Repeat RF/PHI Categories Out	0	Time In	11:20:15
Legal Authority MN Rules Chapter 4626		Time Out	

Safe Harbor Residential Care	Address: 9812 Ford Circle	City/State: St Louis Park, MN	Zip Code: 55426	Telephone: 9524519469
License/Permit #: 0039291	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

		Safe Food and Water	COS	R
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		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		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

		Proper Use of Utensils	COS	R
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		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48	X	Warewashing facilities: installed, maintained, & used; test strips		
49		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:** 09/05/24

Inspector (Signature) Trevor McCliment