Electronically Delivered

January 16, 2025

Licensee
Topcare Health Services LLC
9665 Thomas Avenue North
Brooklyn Park, MN 55444

RE: Project Number(s) SL36725015

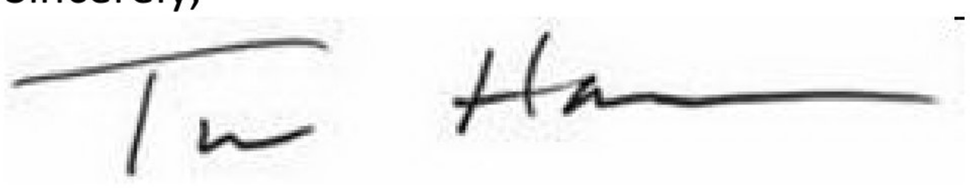
Dear Licensee:

On December 24, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the September 25, 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,



Tim Hanna, Supervisor
State Engineering Services Section
Email: Tim.Hanna@state.mn.us
Telephone: 507-208-8982 Fax: 1-866-890-9290

HHH

Electronically Delivered

October 23, 2024

Licensee
Topcare Health Services LLC
9665 Thomas Avenue North
Brooklyn Park, MN 55444

RE: Project Number(s) SL36725015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on September 25, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

The correction order documentation should include the following:

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

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

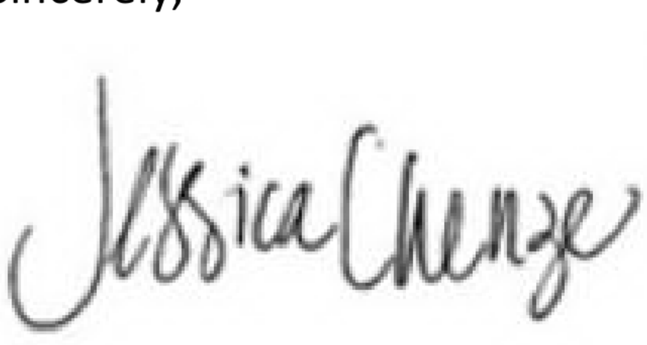
To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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

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

If you have any questions, please contact me.

Sincerely,



Jessie Chenze, Supervisor
State Evaluation Team
Email: Jessie.Chenze@state.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36725	A. BUILDING: _____ B. WING _____	09/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOPCARE HEALTH SERVICES LLC	9665 THOMAS AVENUE NORTH BROOKLYN PARK, MN 55444

(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: SL36725015-0 On September 23, 2024, through September 25, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 2 residents; 2 receiving services under the Assisted Living license.	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 23, 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		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's	0 730		

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0 730	Continued From page 2 name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation,	0 730		

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0 730	Continued From page 3 when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to complete and provide to the resident, or their representative, or case worker, a discharge summary with the required contents for one of one discharged resident (R2). 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: R2 was discharged from the facility on April 25, 2024. R2's diagnoses included generalized anxiety disorder, major depressive disorder, and post-traumatic stress disorder (PTSD). R2's Discharge Summary signed and dated April 25, 2024, included diagnoses, dates of assessments, healthcare provider information and medication disposition. The discharge summary indicated discharge paperwork was sent to the case manager, medications were given to R2, who was moving into her own apartment.	0 730		

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0 730	Continued From page 4 R2's discharge note dated April 25, 2024, written by care coordinator (CC)-D, indicated "The resident was discharged from the facility by 11:30 a.m., and all her belongings were handed over to her. The resident's medications were also handed over to her and she was educated about her medications. The residents case manager picked the resident up and a moving company assisted with moving the resident. The resident said her goodbye to other residents, and the staff. The staff received a phone call from her psychiatric doctor who is trying to schedule a follow-up appointment with her, and the writer forwarded her current number to them. They called about two hours later to inform and ask for another way to contact the resident since she was not picking up her calls. The writer also called and informed the resident to reach out to her provider." R2's Discharge Summary lacked the following required content: - a summary of the residents stay that included courses of illnesses, allergies, treatments, and therapies, and pertinent lab, radiology, and consultation results; - a final summary of the resident's status from the latest assessment or review under Minnesota Statutes, section 144G.70, if applicable, which included the resident status, including baseline and current mental, behavioral, and functional status; and - post discharge care plan that was developed with the resident and, with the resident's consent, the resident's representatives, which would help the resident adjust to a new living environment. The post discharge care plan must indicate where the resident planned to reside, any arrangements that had been made for the resident's follow-up care, and any post discharge	0 730		

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0 730	Continued From page 5 medical and nonmedical services the resident would need. On September 23, 2024, at 2:00 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she was not aware of the required content needed in the discharge summary. The licensee's Clinical Records policy dated August 1, 2021, indicated, "in the event the resident is transferred to another assisted living provider or health care practitioner or is admitted to an inpatient facility, [facility name] will, upon request of the resident or responsible party, send a copy or summary of the clinical record to the new provider, facility or to the resident as appropriate including: the residents full name, date of birth and insurance information; the name, telephone number and address of the resident; designated representatives and legal representatives, as applicable; the name and telephone number of the residents physician; copies of the healthcare directives, "DNR" orders and any guardianship orders or powers of attorney; and relevant to the services provided, residents current documented diagnoses, the residents known allergies, the current physician orders, all medication administration records and the most recent resident assessment." Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0120, Subp. 9, effective October 2022, at the time of discharge, the facility must provide the resident, and, with the resident's consent, the resident's representatives, and case manager, with a written discharge summary that includes all content as applicable in sections A.-D. A. A summary of the residents stay that included	0 730		

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0 730	Continued From page 6 diagnoses, courses of illnesses, allergies, treatments, and therapies, and pertinent lab, radiology, and consultation results; B. A final summary of the resident's status from the latest assessment or review under Minnesota Statutes, section 144G.70, if applicable, which included the resident status, including baseline and current mental, behavioral, and functional status; C. A reconciliation of all predischarge medications with the resident's post discharge prescribed and over-the-counter medications; and D. A post discharge care plan that was developed with the resident and, with the resident's consent, the resident's representatives, which would help the resident adjust to a new living environment. The post discharge care plan must indicate where the resident planned to reside, any arrangements that had been made for the resident's follow-up care, and any post discharge medical and nonmedical services the resident would need. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
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: (i) provide smoke alarms in each room used for sleeping purposes;	0 780		

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0 780	Continued From page 7 (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 provide smoke alarms that are interconnected so that the activation of one alarm causes all alarms in the home to operate for proper notification. This has 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 of the residents). The findings include: On September 24, 2024, from approximately, 1:00 p.m. to 2:00 p.m., survey staff toured the	0 780		

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0 780	Continued From page 8 home with manager (M)-B. During the tour, survey staff observed that the smoke alarms in the home were not interconnected as required. Each smoke alarm sounded local when M-B tested the smoke alarms. The above deficient finding was verified by M-B at the time of discovery. During an interview, survey staff explained to M-B that when one smoke alarm is activated, all smoke alarms in the home must operate (interconnect) and sound for proper notification. M-B explained that he is aware and intends to replace the smoke alarms with the hardwired type, so all alarms are interconnected. M-B understood and acknowledged the finding. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 790 SS=C	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and	0 790		

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0 790	Continued From page 9 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the proper installation of the portable fire extinguisher. This had the potential to directly affect residents and staff. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On September 24, 2024, from approximately, 1:00 p.m. to 2:00 p.m., survey staff toured the home with manager (M)-B. During the tour, survey staff observed the portable fire extinguisher (PFE) unit in the kitchen was improperly mounted and not secured. The PFE hung loosely on a bracket. In addition, the PFE was incorrectly mounted at a height of 68 inches above the floor. The maximum height allowed by the state standard for extinguishers (weighing less than 40 pounds) at 60 inches (5 feet) above the floor. During an interview, survey staff explained the deficient findings to M-B. M-B acknowledged the findings at the time of discovery. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	0 790		

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0 790	Continued From page 10 days	0 790		
0 800 SS=C	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 of the facility in a continuous state of good repair and operation. This has the potential to directly affect the health, safety, and well-being of the residents and staff. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On September 24, 2024, from approximately, 1:00 p.m. to 2:00 p.m., survey staff toured the home with manager (M)-B. During the home tour, survey staff observed the following:	0 800		

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0 800	Continued From page 11 -The return air grilles in the upper-level resident room 1, the lower-level resident 4, and the lower-level common area were dirty and covered with thick dust. M-B confirmed the findings and initiated the cleaning of the grilles. -The exterior exhaust vent for the dryer was covered with thick lint. -The lower-level bathroom was missing a baseboard next to the shower compartment where moisture damage may occur. The above deficient findings were verbally and visually verified by M-B at the time of discovery. During an interview, survey staff explained the above deficient conditions to M-B and care coordinator (CC)-D, and they understood and acknowledged the findings. No further information was provided. 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	0 810		

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	36725	A. BUILDING: _____ B. WING _____	09/25/2024

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TOPCARE HEALTH SERVICES LLC	9665 THOMAS AVENUE NORTH BROOKLYN PARK, MN 55444

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0 810	Continued From page 12 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 provide all required contents on the fire safety and evacuation plan, the minimum number of fire evacuation drills, and the required minimum training of staff on the fire safety and evacuation plan. This has the potential to directly affect the safety of visitors, staff, and all residents. This practice resulted in a level 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	0 810		

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0 810	Continued From page 13 of the residents). The findings include: On September 24, 2024, from approximately, 1:00 p.m. to 2:00 p.m., survey staff toured the home with manager (M)-B. During the tour, survey staff observed the resident rooms did not have numbering labels to match the room numbers posted on fire evacuation diagrams (plans). M-B verified the finding at the time of discovery. On September 24, 2024, at approximately 2:00 p.m., document and record review and interview with care coordinator (CC)-D, on the home's fire safety and evacuation plan, titled Fire Emergency, dated August 1, 2021, and related training policies, procedures, and records indicated the following: -Document review indicated the resident bedroom numbers shown on the fire evacuation diagrams did not reflect the room numbers verbally provided to survey staff during the home tour. Evacuation plans must include the accurate location and resident sleeping room numbers. -Document review indicated the licensee's fire safety and evacuation plan did not include and identify in the plan the specific fire protection procedures for residents who are capable of self-evacuation on the proper actions to be taken in case of a fire or similar emergency. During the interview, CC-D verified that the fire safety and evacuation plan did not include these provisions. -Record review of available documentation indicated that the licensee did not provide employee training specific to fire safety and evacuation plan twice per year after the initial hire training. During an interview, CC-D verified that	0 810		

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0 810	Continued From page 14 they lacked employee training on fire safety and evacuation twice a year. CC-D stated that they thought the annual employee training on emergency preparedness was sufficient. -Record review indicated the licensee failed to provide the minimum required employee fire evacuation drills twice per year, per shift with at least one evacuation drill every other month. Survey staff received drill records documenting that drills were completed but included both day and night shift employees throughout calendar years 2022, 2023, and 2024, and lacked the minimum drill frequency per year. The above deficient findings were verified by CC-D during the interview. On September 24, 2024, at 2:30 p.m., survey staff explained the deficient findings to M-B and CC-D, and they acknowledged the findings during the exit interview. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 820 SS=D	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	0 820		

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0 820	Continued From page 15 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 the minimum state standard-sized egress window for unoccupied lower-level resident sleeping room 3. This had the potential to affect staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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: On September 24, 2024, from approximately, 1:00 p.m. to 2:00 p.m., survey staff toured the home with manager (M)-B. Survey staff observed the clear window openings of the sliding windows in unoccupied sleeping room 3 on the lower-level floor did not meet the minimum state-standard size egress window requirement. M-B opened the maximum openable window with opening dimensions, height at 31.5 inches, and width at 17 inches, totaling an area opening size of 535.5 inches. The window openings did not meet the required minimum clear opening area of 648	0 820		

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0 820	Continued From page 16 square inches and the minimum of 20 inches in width. Existing egress window openings must meet a minimum clear opening area of 648 square inches and have minimum dimensions of 20 inches in height and 20 inches in width. The windowsill height from the floor to the clear opening shall be not more than 48 inches. The above finding was verbally verified with M-B accompanying the tour. On September 24, 2024, at approximately 2:30 p.m., during an interview, survey staff again explained the above deficient finding to M-B and care coordinator (CC)-D and they acknowledged the finding. M-B stated that they would be replacing the windows. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 820		
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 17 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 resident assessments were completed using the uniform assessment tool 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) 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 23, 2024, at 11:40 a.m. during entrance conference, the licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated resident assessments would be conducted every 90 days, with a change in resident condition and hospital returns. R1's diagnoses included hypertension (high blood	01620		

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01620	Continued From page 18 pressure), chronic kidney disease and diabetes. R1's Service Plan dated October 10, 2023, indicated R1 received assistance with medication administration, housekeeping, laundry, shopping, and transportation. R1's 90 Day Nurse Reassessment Forms dated July 23, 2024, and April 23, 2024, lacked the following required content of the uniform assessment tool: -the resident's personal lifestyle preferences, including: sleep schedule, dietary and social needs, leisure activities, and any other customary routine that is important to the resident's quality of life; -advance health care directives and end-of-life preferences, including whether a person has or wants to seek a "do not resuscitate" or "do not attempt resuscitation" order, or "physician/provider orders for life-sustaining treatment"; -activities of daily living, including: -toileting pattern, bowel, and bladder control -dressing, grooming, bathing, and personal hygiene -eating, dental status, oral care and assistive devices and dentures, if applicable; -instrumental activities of daily living, including: -housework and laundry; and -transportation. - physical health status including: -a review of relevant health history and current health conditions including medical and nursing diagnoses; -allergies and sensitivities related to medication, seasonality, environment, and food and if any of the allergies or sensitivities are life threatening; -a review of medical, dental, and emergency	01620		

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01620	Continued From page 19 room visits in the past 12 months, including visits to a primary health care provider, hospitalizations, surgeries, and care from a post-acute care facility; -a review of any reports from a physical therapist, occupational therapist, speech therapist, or cognitive evaluations within the last 12 months; -cognition including: current memory, orientation, confusion, and decision making. -pain, including: -location, frequency, intensity, and duration; and -effectiveness and nonmedication alternatives -skin conditions; -nutritional and hydration status and preferences; -list of treatments, including type, frequency, and level of assistance needed; -nursing needs, including potential to receive nursing-delegated services; -risk indicators, including: -emergency evacuation ability; -complex medication regimen; -risk for dehydration, including history of urinary tract infections and current fluid intake pattern; -risk for emotional or psychological distress due to personal losses; -unsuccessful prior placements; -elopement risk including history or previous elopements; -smoking, including the ability to smoke without causing burns or injury to the resident or others or damage to property; -alcohol and drug use, including the resident's alcohol use or drug use not prescribed by a physician; and -who has decision-making authority for the resident, including: the presence of any advance health care directive or other legal document that	01620		

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01620	Continued From page 20 establishes a substitute decision maker; and the scope of decision-making authority of a substitute decision maker. On September 25, 2024, at 10:11 a.m., via phone interview LALD/CNS-A stated she was aware of the missing elements in the Nurse Reassessment Form due to a recent survey at another location. LALD/CNS-A stated she was working with a consultant on updating the assessment. LALD/CNS-A stated the reassessment form was used for all current residents. The licensee's Assessment and Reassessment policy dated August 1, 2021, indicated, "ongoing resident reassessments must be conducted by an RN and cannot exceed 90 days from the last date of assessment. Ongoing resident monitoring must be conducted as needed based on changes in the needs of the resident and may be completed by other licensed nurses acting within their scope of licenses." Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0140, Subp. 2, effective October 2022, a nursing assessment or reassessment under Minnesota Statutes, section 144G.70, subdivision 2, paragraphs (b) and (c), must be conducted on a prospective resident or resident receiving any of the assisted living services identified in Minnesota Statutes, section 144G.08, subdivision 9, clauses (6) to (12). B. The nursing assessment or reassessment under item A must: (1) address part 4659.0150, subpart 2, items A to N; (2) be conducted in person unless an exception under Minnesota Statues, section 144G.70, subdivision 2, paragraph (b), applies; (3) be conducted using a uniform assessment	01620		

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01620	Continued From page 21 tool that complies with part 4659.0150; and (4) be in writing, dated, and signed by the registered nurse who conducted the assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and	01730		

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01730	Continued From page 22 (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and maintain a current individualized medication management record to include all required content for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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 23, 2024, at 10:40 a.m., during the entrance conference, the licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee provided medication management services.	01730		

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01730	Continued From page 23 R1's diagnoses included hypertension (high blood pressure), chronic kidney disease and diabetes. R1's Service Plan dated October 10, 2023, indicated R1 received services to include assistance with medication administration, housekeeping, laundry, shopping, and transportation. On September 24, 2024, at 11:25 a.m., the surveyor observed unlicensed personnel (ULP)-C administering R1's scheduled and sliding scale noon insulin. R1's 90 Day Nurse Reassessment Forms dated July 23, 2024, and April 23, 2024, included a section for Medication Management Plan/Care Plan indicating the plan was reviewed and appropriate for R1's needs. R1's undated Medication Management Plan/Care Plan, lacked the following content: -a description of medication storage of medications based on the residents needs and preferences, risk for diversion, and consistent with the manufacturer directions -identification of medication management tasks that may be delegated to unlicensed personnel -procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services -any resident specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions On September 25, 2024, at 10:11 a.m., via phone	01730		

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01730	Continued From page 24 interview, the LALD/CNS-A stated the medication management plan was missing some components and was working with a consultant to review and update the assessments. The licensee's Assessment of Medications policy dated August 1, 2021, indicated based on the results of the assessment, the RN would document an individualized medication management plan, including the following: -a description of medication management services provided -description of medication storage based on resident need, preferences, risk of diversion and manufacturer's direction -document procedures -procedures for verification that medications are administered as prescribed -procedures for monitoring medication use to prevent complications or adverse reactions -identification of person(s) responsible for monitoring medication supplies and ensuring refills are ordered in a timely manner -identification of medication management tasks delegated to unlicensed staff -procedures for notifying the registered nurse or licensed health professional regarding problems arising with medication management services No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01760 SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the	01760		

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01760	Continued From page 25 resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to accurately document medication was administered as prescribed for two of two residents (R1, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and 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 R1's diagnoses included hypertension (high blood pressure), chronic kidney disease and diabetes. R1's Service Plan dated October 10, 2023, indicated R1 received services including assistance with medication administration, housekeeping, laundry, shopping, transportation,	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36725	A. BUILDING: _____ B. WING _____	09/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOPCARE HEALTH SERVICES LLC	9665 THOMAS AVENUE NORTH BROOKLYN PARK, MN 55444

(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
01760	Continued From page 26 and behavioral management. On September 24, 2024, at 11:25 a.m., the surveyor observed unlicensed personnel (ULP)-C assist R1 with insulin administration. R1's September 2024 eMAR indicated R1 received Fiasp (for diabetes) Flextouch insulin pen100 unit/milliliter (u/ml), as follows: 9 units three times daily at 8:00 a.m., 12:00 p.m., and 6:00 p.m., as well as per the following sliding scale: -150-200= 1u, -201-250= 2u, -251-300= 3u, -301-350= 4u, -351-400= 5u, -401-450= 6u, -451-500= 7u. The eMAR further indicated R1 received Fiasp Flextouch 100 unit/ml, two units at night, as well as the following sliding scale: -251-300=1u, -301-350=2u, -351-400=3u, -401-450=4u, -451-500=5u. R1's insulin box included undated typed instructions that indicated, "Novolog insulin pen 100 unit/ml" with the same sliding scale indicated for Fiasp in the eMAR, but indicated the following: -"At breakfast, give 5 units of NovoLog plus sliding scale when eating. -At lunch or meals between, give 6 units of NovoLog plus sliding scale when eating. -At dinner give 9 units of Novolog plus sliding scale when eating. If blood sugar is less than 100, give 5 units." The typed instructions further indicated Bedtime	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36725	A. BUILDING: _____ B. WING _____	09/25/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01760	Continued From page 27 sliding scale: -250-300=1u, -301-350=2u, -351-400=3u, -401-450=4u, -451 and above =5u. The typed instructions lacked the correct medication name, included a different daytime baseline insulin dosage than indicated in the eMAR, and lacked any baseline insulin dosage at bedtime. On September 24, 2024, at approximately 11:30 a.m., licensed assisted living director/clinical nursing supervisor (LALD/CNS)-A stated she must not have updated the eMAR and would need to check R1's prescriber orders. -ULP-C stated she always used the typed instructions in the medication box when giving insulin. ULP-C further stated training composed of online training, and training by the registered nurse (RN). R1's prescriber orders dated September 6, 2024, indicated: -Fiasp Flextouch 100 unit (u)/ml insulin, 5u before breakfast, 6u before lunch and 9u before dinner, and the following sliding scale: -less than 150=0u, -150-200=1u, -201-250=2u, -251-300=3u, -301-350=4u, -351-400=5u, and -greater than 400=6u. The prescriber orders indicated a different beseline dosage than was documented in the eMAR. The daytime sliding scale insulin order differed from both the eMAR and the typed instructions. The prescriber orders lacked a	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01760	Continued From page 28 baseline or sliding scale insulin dose at bedtime. R3 R3's diagnoses included bipolar disorder (episodes of mood swings), insomnia and generalized anxiety. R3's service plan dated October 30, 2023, indicated R3 received services including assistance with medication administration, laundry, housekeeping, shopping, transportation and behavioral management. On September 24, 2024, at 8:04 a.m., the surveyor observed ULP-C prepare to assist R3 with medication administration. R3's eMAR for September 2024 indicated to give: divaloproex (mood) 250 milligrams (mg), 1 tablet at 8:00 a.m. The pharmacy label on the pharmacy prefilled bubble pack indicated for 8:00 a.m., divalproex 500 mg, 2 tablets. On September 24, 2024, at approximately 8:10 p.m., LALD/CNS-A stated the order was probably changed and the eMAR was not updated. LALD/CNS stated she would need to check R3's provider orders. R3's September 1 through 24, 2024, eMAR indicated R3 received the following medications: -divalproex 250 mg at 8:00 a.m., 12:00 p.m. -divalproex 500 mg three times a day at 8:00 a.m., 12:00 p.m., and 8:00 p.m. R3's prescriber orders dated September 12, 2024, indicated: -divalproex 500 mg, take 2 tablets by mouth in	01760		

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	36725	A. BUILDING: _____ B. WING _____	09/25/2024

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01760	Continued From page 29 the morning, two tablets in the afternoon and one tablet at bedtime. On September 24, 2024, at 12:15 p.m., LALD/CNS-A stated the correct medication was given, but the eMAR was incorrect. LALD/CNS-A stated the staff should have notified her if there were discrepancies between the eMAR and pharmacy bubble packs. The licensee's undated Medication Management program policy indicated the following services are included in the Medication Management Program: performing medication set up, administering medications, storing and securing medications, documenting medication activities, verifying and monitoring the effectiveness of systems to ensure safe handling and administration, coordinating refills, handling and implementing changes to prescriptions, communication with the pharmacy about the residents medications, and coordinating and communication with the prescriber. The licensee's Medication Administration policy dated August 1, 2021, indicated, "residents of [name] homes are entitled to the safe administration of medication by qualified personnel according to a written Medication Management Plan". No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically	01820		

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	36725	A. BUILDING: _____ B. WING _____	09/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01820	Continued From page 30 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 current written or electronically recorded prescriptions was obtained for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1's diagnoses included hypertension (high blood pressure), chronic kidney disease and diabetes. R1's Service Plan dated October 10, 2023, indicated R1 received services to include assistance with medication administration, housekeeping, laundry, shopping, transportation, and behavioral management. On September 24, 2024, at 11:25 a.m., the surveyor observed unlicensed personnel (ULP)-C assist R1 with insulin administration. R1's September 2024 eMAR indicated Fiasp (for diabetes) Flextouch insulin pen100 units/milliliter (u/ml), administered as follows:	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36725	A. BUILDING: _____ B. WING _____	09/25/2024

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01820	Continued From page 31 9u three times daily at 8:00 a.m., 12:00 p.m., and 6:00 p.m., as well as per the following sliding scale: -150-200= 1u, -201-250= 2u, -251-300= 3u, -301-350= 4u, -351-400= 5u, -401-450= 6u, -451-500= 7u. The eMAR further indicated Fiasp Flextouch 100 unit/ml, two units at night, as well as the following sliding scale: -251-300=1u, -301-350=2u, -351-400=3u, -401-450=4u, -451-500=5u. R1's insulin medication box included undated typed instructions that indicated, "Novolog insulin pen 100 unit/ml" with the same daytime sliding scale indicated for Fiasp in the eMAR. The instructions indicated the following baseline insulin dosages: -"At breakfast, give 5 units of NovoLog plus sliding scale when eating. -At lunch or meals between, give 6 units of NovoLog plus sliding scale when eating. -At dinner give 9 units of Novolog plus sliding scale when eating. If blood sugar is less than 100, give 5 units." The typed instructions further indicated Bedtime sliding scale: -250-300=1u, -301-350=2u, -351-400=3u, -401-450=4u, -451 and above =5u. The typed instructions lacked the correct	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01820	Continued From page 32 medication name, included a different daytime baseline insulin dosage than indicated in the eMAR, and lacked any baseline insulin dosage at bedtime. On September 24, 2024, at approximately 11:30 a.m., LALD/CNS-A stated she must not have updated the eMAR and would need to check R1's prescriber orders. -ULP-C stated she always used the typed instructions in the medication box when giving insulin. ULP-C further stated training composed of online training, and training by the registered nurse (RN). R1's prescriber orders dated September 6, 2024, indicated: -Fiasp Flextouch 100 u/ml insulin, 5u before breakfast, 6u before lunch and 9u before dinner, and the following sliding scale: -less than 150=0u, -150-200=1u, -201-250=2u, -251-300=3u, -301-350=4u, -351-400=5u, and -greater than 400=6u. The prescriber orders indicated a different beseline dosage than was documented in the eMAR. The daytime sliding scale insulin order differed from both the eMAR and the typed instructions. R1's record lacked orders for baseline or sliding scale insulin at bedtime. The licensee's Medication Orders policy dated August 1, 2021, indicated, "[facility name] will maintain a current written or electronically recorded prescription for all prescribed	01820		

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01820	Continued From page 33 medications managed for the resident." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were securely stored and only authorized personnel had access. This had the potential to affect all residents residing in the facility, 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 September 23, 2024, at 12:35 p.m., during the entrance tour, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A opened an unsecured corner cupboard in the	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01880	Continued From page 34 dining room and removed a plastic covered tub. LALD/CNS-A stated R1's current insulins were kept in the tub. LALD/CNS-A removed one unlabeled Fiasp Flex insulin pen and one Tresiba Flex insulin pen. Additionally, inside the tub were lancets, insulin pen needles and alcohol wipes. LALD/CNS-A stated the cupboard was unsecured, and the staff were the only ones that had access. During this time, R3 was observed in the kitchen, cooking. LALD/CNS-A asked the unlicensed personnel to take the container and place it in the secured medication closet downstairs. LALD/CNS-A stated the licensee would get a lock on the cupboard. The licensee's Storage/Control of Medications policy dated August 1, 2021, indicated, "when [facility name] is providing storage of medications outside of the resident's private living space, all prescription drugs are securely locked in substantially constructed compartments according to the manufacturer's directions. Only authorized personnel have access to the stored medications." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug.	01890		

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01890	Continued From page 35 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure medications dispensed by the pharmacy included a prescription label and were labeled with open and expiration dates for time sensitive medications for one of one resident (R1). This had the potential to affect all residents residing in 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) 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 September 23, 2024, at 12:35 p.m., during the entrance tour, the licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A opened an unsecured corner cupboard in the dining room and removed a plastic covered tub. LALD/CNS-A stated R1's current insulins were kept in the tub. LALD/CNS-A removed one Fiasp FlexTouch insulin pen with a green dot, dated September 19, and one Tresiba FlexTouch insulin pen with a yellow dot, dated September 9. Both pens lacked a pharmacy label to identify to whom the medication belonged. LALD/CNS-A stated the dates on the insulin pens were open dates, and the resident used the insulin before the expiration dates. LALD/CNS-A stated the Fiasp FlexTouch insulin pen was good for 45 days from opening and the Tresiba FlexTouch insulin pen was good for 28 days. LALD/CNS-A stated the labels for the	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01890	Continued From page 36 insulins were on the box the insulin pens came in. LALD/CNS-A was not aware the individual insulin pens needed pharmacy labels and open and expiration dates. The manufacturer's instructions for Fiasp insulin pen dated July 2023, indicated to throw away 28 days after opened, even if it still had insulin in it and the expiration date had not passed. The manufacturer's instructions for Tresiba insulin pen dated July 2022, indicated to throw away 56 days after opened, even if it still had insulin in it and the expiration date had not passed. The licensee's Storage/Control medications policy dated August 1, 2023, indicated, "the medication is labeled completely and legibly. The medication label should contain the following: prescription number and name of medication; strength and quantity; expiration date for time-dated drugs; directions for use; residents name; date issued; name and address of licensed pharmacy issuing the medication. The licensed nurse is responsible for dating time-sensitive medications when opened." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

Minnesota Department of Health

3333 Division St #212
St. Cloud
320 223-7300

Type: Full
Date: *09/23/24*
Time: 12:30:00
Report: 1051241121

Food and Beverage Establishment Inspection Report

Location:

Topcare Health Services Llc
9665 Thomas Avenue North
Brooklyn Park, MN55444
Hennepin County, 27

Establishment Info:

ID #: 0039343
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7632087116
ID #:

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

The following orders were issued during this inspection.

4-300 Equipment Numbers and Capacities

4-302.12B ***** 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.

AT TIME OF INSPECTION, THERE IS NO THIN-TIPPED THERMOMETER.
Comply By: 09/25/24

Food and Equipment Temperatures

Process/Item: Upright Cooler
Temperature: 39 Degrees Fahrenheit - Location: MILK
Violation Issued: No

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

MET WITH NURSE EVALUATOR, ANN BOUTWELL.

DISCUSSED THE FOLLOWING WITH THE STAFF, OBINNA:

EMPLOYEE ILLNESS LOG
VOMIT CLEAN-UP PROCEDURES

THE KITCHEN HAS A NSF 184 DISHWASHER, LAMINATE FLOORS AND COUNTERTOPS WITH HOLLOW BASES, SMOOTH TEXTURE CEILING, AND MDF WOODEN CABINETS.

Type: Full
Date: *09/23/24*
Time: 12:30:00
Report: 1051241121
Topcare Health Services Llc

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1051241121 of 09/23/24.

Certified Food Protection Manager: Onyeka T. Osakwe

Certification Number: FM40774 Expires: 07/27/27

Inspection report reviewed with person in charge and emailed.

Signed: _____
Obinna

Signed: _____
Kai Yang
Public Health Sanitarian 1
St. Cloud
320 640-3532
Kai.Yang@state.mn.us