



*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically Delivered

December 13, 2023

Licensee  
Sakinah Homes LLC  
120 East Frost Street  
S St Paul, MN 55075

RE: Project Number(s) SL37193015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on November 28, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the 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. The 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 the MDH within 15 calendar days of the correction order receipt date.

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

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

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,



Jodi Johnson, Supervisor  
State Evaluation Team  
Email: [jodi.johnson@state.mn.us](mailto:jodi.johnson@state.mn.us)  
Telephone: 507-344-2730 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

|                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                     |
|------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>37193</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | (X3) DATE SURVEY COMPLETED<br><br><b>11/28/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SAKINAH HOMES @ FROST</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>120 EAST FROST STREET<br/>S ST PAUL, MN 55075</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                         | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 000                                                            | <p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>ASSISTED LIVING PROVIDER LICENSING<br/>CORRECTION ORDER(S)</p> <p>In accordance with Minnesota Statutes, section<br/>144G.08 to 144G.95, these correction orders are<br/>issued pursuant to a survey.</p> <p>Determination of whether violations are corrected<br/>requires compliance with all requirements<br/>provided at the Statute number indicated below.<br/>When Minnesota Statute contains several items,<br/>failure to comply with any of the items will be<br/>considered lack of compliance.</p> <p>INITIAL COMMENTS:<br/>SL37193015-0</p> <p>On November 27, 2023, through November 28,<br/>2023, the Minnesota Department of Health<br/>conducted a full survey at the above provider, and<br/>the following correction orders are issued. At the<br/>time of the survey, there were four active<br/>residents; four receiving services under the<br/>Assisted Living license.</p> | 0 000                                                                  | <p>Minnesota Department of Health is<br/>documenting the State Correction Orders<br/>using federal software. Tag numbers have<br/>been assigned to Minnesota State<br/>Statutes for Assisted Living License<br/>Providers. The assigned tag number<br/>appears in the far left column entitled "ID<br/>Prefix Tag." The state Statute number and<br/>the corresponding text of the state Statute<br/>out of compliance is listed in the<br/>"Summary Statement of Deficiencies"<br/>column. This column also includes the<br/>findings which are in violation of the state<br/>requirement after the statement, "This<br/>Minnesota requirement is not met as<br/>evidenced by." Following the surveyors'<br/>findings is the Time Period for Correction.</p> <p>PLEASE DISREGARD THE HEADING OF<br/>THE FOURTH COLUMN WHICH<br/>STATES,"PROVIDER'S PLAN OF<br/>CORRECTION." THIS APPLIES TO<br/>FEDERAL DEFICIENCIES ONLY. THIS<br/>WILL APPEAR ON EACH PAGE.</p> <p>THERE IS NO REQUIREMENT TO<br/>SUBMIT A PLAN OF CORRECTION FOR<br/>VIOLATIONS OF MINNESOTA STATE<br/>STATUTES.</p> <p>The letter in the left column is used for<br/>tracking purposes and reflects the scope<br/>and level issued pursuant to 144G.31<br/>subd. 1, 2, and 3.</p> |  |                                                     |
| 0 470<br>SS=F                                                    | <p>144G.41 Subdivision 1 Minimum requirements</p> <p>(11) develop and implement a staffing plan for<br/>determining its staffing level that:</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 0 470                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                     |

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

|                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                               |                                                                                                                          |  |                                                        |
|------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>37193</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>11/28/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SAKINAH HOMES @ FROST</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>120 EAST FROST STREET<br/>S ST PAUL, MN 55075</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                         | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ID<br>PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 0 470                                                            | <p>Continued From page 1</p> <p>(i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility;</p> <p>(ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and</p> <p>(iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility;</p> <p>(12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be:</p> <p>(i) awake;</p> <p>(ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time;</p> <p>(iii) capable of communicating with residents;</p> <p>(iv) capable of providing or summoning the appropriate assistance; and</p> <p>(v) capable of following directions;</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on interview and record review, the licensee failed to develop and implement a staffing plan to determine staffing levels to meet the needs of all residents; and failed to ensure the staffing schedule was posted as required. This had the potential to affect all residents, staff, and visitors.</p> <p>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</p> | 0 470                                                                                         |                                                                                                                          |  |                                                        |

Minnesota Department of Health

|                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                               |                                                                                                                          |                                                        |
|------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>37193</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>11/28/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SAKINAH HOMES @ FROST</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>120 EAST FROST STREET<br/>S ST PAUL, MN 55075</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                         | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ID<br>PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 470                                                            | Continued From page 2<br><br>resident's health or safety, but was not likely to<br>cause serious injury, impairment, or death), and<br>was issued at a widespread scope (when<br>problems are pervasive or represent a systemic<br>failure that has affected or has potential to affect<br>a large portion or all of the residents).<br><br>The findings include:<br><br>The licensee held and assisted living license. The<br>facility was licensed for a capacity of four and had<br>a current census of four residents.<br><br>During the entrance conference on November 27,<br>2023, at 9:45 a.m., licensed assisted living<br>director (LALD)-A stated the licensee had not<br>developed a staffing plan or posted a staff<br>schedule.<br><br>No further information was provided.<br><br>TIME PERIOD OF CORRECTION: Seven (7)<br>days | 0 470                                                                                         |                                                                                                                          |                                                        |
| 0 480<br>SS=F                                                    | 144G.41 Subd 1 (13) (i) (B) Minimum<br>requirements<br><br>(13) offer to provide or make available at least the<br>following services to residents:<br>(B) food must be prepared and served according<br>to the Minnesota Food Code, Minnesota Rules,<br>chapter 4626; and<br><br>This MN Requirement is not met as evidenced<br>by:<br>Based on observation, interview, and record<br>review, the licensee failed to ensure food was<br>prepared and served according to the Minnesota<br>Food Code.                                                                                                                                                                                                                                                                                                                                         | 0 480                                                                                         |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                        |                                                                                                                          |  |                                                     |
|------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>37193</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>11/28/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SAKINAH HOMES @ FROST</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>120 EAST FROST STREET<br/>S ST PAUL, MN 55075</b>                            |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                         | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 480                                                            | <p>Continued From page 3</p> <p>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).</p> <p>The findings include:</p> <p>Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated November 27, 2023, for the specific Minnesota Food code deficiencies.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>                                                                                | 0 480                                                                  |                                                                                                                          |  |                                                     |
| 0 570<br>SS=C                                                    | <p><b>144G.42 Subdivision 1 Display of license</b></p> <p>The original current license must be displayed at the main entrance of each assisted living facility. The facility must provide a copy of the license to any person who requests it.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation and interview, the licensee failed to display the original, current license at the main entrance of the assisted living facility. This had the potential to affect all the licensee's four residents, staff, and visitors.</p> <p>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</p> | 0 570                                                                  |                                                                                                                          |  |                                                     |

Minnesota Department of Health

|                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                               |                                                                                                                          |                                                        |
|------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>37193</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>11/28/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SAKINAH HOMES @ FROST</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>120 EAST FROST STREET<br/>S ST PAUL, MN 55075</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                         | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 570                                                            | <p>Continued From page 4</p> <p>widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents).</p> <p>The findings include:</p> <p>On November 27, 2023, at approximately 9:30 a.m. upon entering the facility, the surveyor did not observe the facility's license posted at the main entrance as required.</p> <p>On November 27, 2023, at approximately 10:15 a.m. during the facility tour with licensed assisted living director (LALD)-A, the surveyor observed the facility's license posted on the wall of licensee's office which was in the basement. The license was not visible to the public with the normal flow of traffic.</p> <p>On November 27, 2023, at 2:08 p.m., LALD-A stated the license was not posted at the main entrance.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p> | 0 570                                                                                         |                                                                                                                          |                                                        |
| 0 680<br>SS=F                                                    | <p>144G.42 Subd. 10 Disaster planning and emergency preparedness</p> <p>(a) The facility must meet the following requirements:</p> <p>(1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 0 680                                                                                         |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                               |                                                                                                                          |  |                                                        |
|------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>37193</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>11/28/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SAKINAH HOMES @ FROST</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>120 EAST FROST STREET<br/>S ST PAUL, MN 55075</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                         | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ID<br>PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 0 680                                                            | <p>Continued From page 5</p> <p>emergency;<br/>(2) post an emergency disaster plan prominently;<br/>(3) provide building emergency exit diagrams to all residents;<br/>(4) post emergency exit diagrams on each floor; and<br/>(5) have a written policy and procedure regarding missing residents.<br/>(b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site.<br/>(c) The facility must meet any additional requirements adopted in rule.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation, interview, and record review, the licensee failed to post an emergency disaster plan prominently, have a written emergency preparedness (EP) plan with all the required content. This had the potential to affect all residents, staff, and visitors of the facility.</p> <p>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).</p> <p>The findings include:</p> | 0 680                                                                                         |                                                                                                                          |  |                                                        |

Minnesota Department of Health

|                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                               |                                                                                                                          |  |                                                        |
|------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>37193</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>11/28/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SAKINAH HOMES @ FROST</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>120 EAST FROST STREET<br/>S ST PAUL, MN 55075</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                         | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ID<br>PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 0 680                                                            | <p>Continued From page 6</p> <p><b>EMERGENCY PLAN POSTED</b><br/>On November 27, 2023, at 10:00 a.m. during the facility tour with licensed assisted living director (LALD)-A, the surveyor did not observe any signage or information regarding the licensee's emergency disaster or preparedness plan posted. At this time, LALD-A stated the plan was not posted prominently.</p> <p><b>EMERGENCY PREPAREDNESS PLAN (EPP) CONTENT</b><br/>The licensee's Emergency Preparedness plan, undated, was reviewed and lacked the following:</p> <ul style="list-style-type: none"> <li>- establish and maintain a comprehensive EPP, reviewed/updated annually;</li> <li>- how they would coordinate with other health care facilities and community during an emergency or disaster (natural, man-made, facility, etc.), reviewed/updated annually;</li> <li>- documented date of reviews and updates;</li> <li>- community risk assessment with documentation;</li> <li>- consider duration of interruptions;</li> <li>- arrangements/contracts to re-establish utility services;</li> <li>- develop strategies for addressing community-based risks (evacuation plans, staffing/shortage, back-up plans);</li> <li>- an assessment of at-risk population's needs including maintaining independence, communication, transportation, supervision, and medical care;</li> <li>- must identify which staff would assume specific roles in another's absence through succession planning and delegation of authority;</li> <li>- a qualified person who is authorized, in writing, to act in the absence of the administrator;</li> <li>- a process for cooperation and collaboration with local, tribal, regional, State and Federal EP to maintain integrated response;</li> </ul> | 0 680                                                                                         |                                                                                                                          |  |                                                        |

Minnesota Department of Health

|                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                               |                                                                                                                          |                                                        |
|------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>37193</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>11/28/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SAKINAH HOMES @ FROST</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>120 EAST FROST STREET<br/>S ST PAUL, MN 55075</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                         | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 680                                                            | <p>Continued From page 7</p> <ul style="list-style-type: none"> <li>- develop and implement EP policies/procedures and review/update annually;</li> <li>- develop/implement EP policies and procedures to address evacuation and shelter in place for staff and residents which must include: <ul style="list-style-type: none"> <li>- alternate sources of energy to maintain temperature, safety and sanitary storage of provisions;</li> <li>- alternate sources of energy to fire detection, extinguishing, alarms systems;</li> <li>- a tracking system used to document locations of residents, staff, and relocation of staff;</li> </ul> </li> <li>- develop policies and procedures to address safe evacuation from the facility including: <ul style="list-style-type: none"> <li>- needs of evacuees;</li> <li>- staff responsibilities;</li> <li>- transportation;</li> <li>- alternate communication means;</li> </ul> </li> <li>- develop policy and procedures for shelter in place for residents, staff and volunteers who remain at the facility;</li> <li>- develop policy and procedures to address: <ul style="list-style-type: none"> <li>- systems of medical documentation that preserve resident information;</li> <li>- protects confidentiality;</li> <li>- secures/maintains availability of records;</li> </ul> </li> <li>- develop policy and procedures must address use of volunteers including process and role for integration;</li> <li>- develop policy and procedures which address development and arrangements with other facilities or providers to receive residents in the event continuity of services cannot be provided;</li> <li>- develop a written communication plan and review/update annually; <ul style="list-style-type: none"> <li>- communication plan must include all the following names/contact information: <ul style="list-style-type: none"> <li>- entities providing services under agreement;</li> </ul> </li> </ul> </li> </ul> | 0 680                                                                                         |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                               |                                                                                                                          |                                                        |
|------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>37193</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>11/28/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SAKINAH HOMES @ FROST</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>120 EAST FROST STREET<br/>S ST PAUL, MN 55075</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                         | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ID<br>PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 680                                                            | <p>Continued From page 8</p> <ul style="list-style-type: none"> <li>- residents' physicians;</li> <li>- volunteers;</li> <li>- communication plan must include contact information for: <ul style="list-style-type: none"> <li>- other sources of assistance;</li> </ul> </li> <li>- communication plan must include: <ul style="list-style-type: none"> <li>- means to provide information about facility occupancy;</li> <li>- and ability to provide assistance;</li> <li>- authority having jurisdiction;</li> <li>- incident Command Center;</li> <li>- or designee;</li> </ul> </li> <li>- communication plan must include a method for sharing information from emergency plan;</li> <li>- must develop and maintain EP training and testing program, review/update annually;</li> <li>- must conduct exercises to test the EP plan at least twice per year including unannounced staff drills using the EP;</li> <li>- must implement emergency and standby power systems based on their EP; and</li> <li>- if part of a healthcare system consisting of separately certified healthcare facilities and elects to have a unified and integrated EP, they may choose to participate.</li> </ul> <p>On November 28, 2023, at 9:10 a.m. LALD-A stated the licensee's current EP plan did not include the above content specific to the licensee.</p> <p>The licensee's Emergency Preparedness policy dated August 1, 2021, indicated the licensee would have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services.</p> <p>No additional information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one</p> | 0 680                                                                                         |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                        |                                                                                                                          |  |                                                     |
|------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>37193</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>11/28/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SAKINAH HOMES @ FROST</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>120 EAST FROST STREET<br/>S ST PAUL, MN 55075</b>                            |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                         | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 680                                                            | Continued From page 9<br><br>(21) days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 0 680                                                                  |                                                                                                                          |  |                                                     |
| 0 790<br>SS=F                                                    | <b>144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment</b><br><br>(2) install and maintain portable fire extinguishers in accordance with the State Fire Code;<br><br>(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<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to install and maintain the portable fire extinguishers as required by statute. This deficient condition had the potential to affect all residents, staff, and visitors.<br><br>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).<br><br>The findings include:<br><br>On November 27, 2023, at 11:00 a.m., survey | 0 790                                                                  |                                                                                                                          |  |                                                     |

Minnesota Department of Health

|                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                        |                                                                                                                          |  |                                                     |
|------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>37193</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>11/28/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SAKINAH HOMES @ FROST</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>120 EAST FROST STREET<br/>S ST PAUL, MN 55075</b>                            |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                         | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 790                                                            | <p>Continued From page 10</p> <p>staff toured the home with housing manager (HM)-C. During the tour, survey staff observed the following:</p> <p>1. Tags or labels were not attached to the fire extinguishers showing annual maintenance had been performed by certified service personnel.</p> <p>2. The tag attached to the fire extinguisher in the basement showed one monthly inspection recorded on 04/19/2023. The tag attached to the fire extinguisher in the kitchen showed one monthly inspection recorded on 05/18/2023. Fire extinguisher inspections must be conducted every month to ensure each extinguisher is in its designated place, that it has not been tampered with, and there is no obvious physical damage or condition that would interfere with its use or operation.</p> <p>3. The kitchen fire extinguisher was stored in a cabinet under the sink and the location was not identified. A sign must be provided indicating the fire extinguisher's location if it is not visible. The fire extinguisher sign was found inside the cabinet and reinstalled during the facility tour.</p> <p>During an interview on November 28, 2023, at 2:00 p.m., licensed assisted living director (LALD)-A verified the fire extinguishers had not been properly maintained and installed. LALD-A stated the licensee would start performing fire extinguisher inspections every month and ensure that annual maintenance was completed.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-One (21) days</p> | 0 790                                                                  |                                                                                                                          |  |                                                     |

Minnesota Department of Health

|                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                        |                                                                                                                          |  |                                                     |
|------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>37193</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY COMPLETED<br><br><b>11/28/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SAKINAH HOMES @ FROST</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>120 EAST FROST STREET<br/>S ST PAUL, MN 55075</b>                            |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                         | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 800                                                            | Continued From page 11                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 0 800                                                                  |                                                                                                                          |  |                                                     |
| 0 800<br>SS=D                                                    | <p><b>144G.45 Subd. 2 (a) (4) Fire protection and physical environment</b></p> <p>(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.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation and interview, the licensee failed to provide 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 one resident, and all staff.</p> <p>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 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).</p> <p>The findings include:</p> <p>On November 27, 2023, at 11:00 a.m., survey staff toured the home with housing manager (HM)-C. During the tour, survey staff observed the path to the egress window was obstructed by furniture and personal items in bedroom 3, occupied by R1. The improper placement of furniture and personal items could delay exiting in the event of an emergency.</p> | 0 800                                                                  |                                                                                                                          |  |                                                     |

Minnesota Department of Health

|                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                               |                                                                                                                 |                                                     |
|------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>37193</b>                        | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                          | (X3) DATE SURVEY COMPLETED<br><br><b>11/28/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SAKINAH HOMES @ FROST</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>120 EAST FROST STREET<br/>S ST PAUL, MN 55075</b> |                                                                                                                 |                                                     |
| (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                                  |
| 0 800                                                            | Continued From page 12<br><br>During an interview on November 28, 2023, at 2:00 p.m., licensed assisted living director (LALD)-A verified the path to the egress window was obstructed. LALD-A stated they would work with the resident in bedroom 3 to rearrange the furniture and personal items to ensure that the egress window was accessible.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 0 800                                                                                         |                                                                                                                 |                                                     |
| 0 810<br>SS=F                                                    | <b>144G.45 Subd. 2 (b)-(f) Fire protection and physical environment</b><br><br>(b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:<br>(1) location and number of resident sleeping rooms;<br>(2) employee actions to be taken in the event of a fire or similar emergency;<br>(3) fire protection procedures necessary for residents; and<br>(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.<br>(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.<br>(d) Fire safety and evacuation plans shall be readily available at all times within the facility.<br>(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 | 0 810                                                                                         |                                                                                                                 |                                                     |

Minnesota Department of Health

|                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                        |                                                                                                                          |  |                                                     |
|------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>37193</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY COMPLETED<br><br><b>11/28/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SAKINAH HOMES @ FROST</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>120 EAST FROST STREET<br/>S ST PAUL, MN 55075</b>                            |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                         | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 810                                                            | <p>Continued From page 13</p> <p>training shall be made available to residents at least once per year.</p> <p>(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.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation, record review, and interview, the licensee failed to develop fire safety and evacuation plans with the required content, and provide the required training and drills. This had the potential to directly affect all residents, staff, and visitors.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p><b>EMERGENCY EXIT</b><br/>On November 27, 2023, at 11:00 a.m., survey staff toured the home with housing manager (HM)-C. During the tour, survey staff observed the patio door from the dining room led to a deck enclosed by railings with no exit.</p> <p>The emergency floor plans label three exits to the outside of the home. One of the labeled exits directed occupants to exit the building through the</p> | 0 810                                                                  |                                                                                                                          |  |                                                     |

Minnesota Department of Health

|                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                               |                                                                                                                          |  |                                                        |
|------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>37193</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>11/28/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SAKINAH HOMES @ FROST</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>120 EAST FROST STREET<br/>S ST PAUL, MN 55075</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                         | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ID<br>PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 0 810                                                            | <p>Continued From page 14</p> <p>dining room patio door. All paths of egress must provide unobstructed exiting.</p> <p>During an interview on November 28, 2023, at 2:00 p.m., licensed assisted living director (LALD)--A stated that the licensee would revise the emergency floor plans and remove the label for this exit.</p> <p>On November 27, 2023, LALD-A and HM-C provided documents on the fire safety and evacuation plans (FSEP), fire safety and evacuation training, and employee evacuation drills for the facility.</p> <p><b>FIRE SAFETY AND EVACUATION PLANS</b><br/>The FSEP dated August 1, 2021, was a template and had not been developed for use at this facility.</p> <p>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.</p> <p>The FSEP did not identify specific fire protection procedures for residents evident by limited instructions directing residents to stoop or crawl to avoid smoke. No additional fire protection procedures necessary for residents were included.</p> <p>The FSEP directed employees to evacuate residents from the building but failed to include information on where residents should relocate to in the event of a fire.</p> <p>During an interview on November 28, 2023, at 2:00 p.m., LALD-A stated the licensee would work</p> | 0 810                                                                                         |                                                                                                                          |  |                                                        |

Minnesota Department of Health

|                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                               |                                                                                                                          |                                                        |
|------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>37193</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>11/28/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SAKINAH HOMES @ FROST</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>120 EAST FROST STREET<br/>S ST PAUL, MN 55075</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                         | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ID<br>PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 810                                                            | <p>Continued From page 15</p> <p>on revising the fire safety and evacuation plans. LALD-A explained residents would relocate to the sidewalk in the event of an evacuation and confirmed this was not included in the plans.</p> <p><b>TRAINING</b><br/>Record review indicated the licensee failed to provide training to employees on the FSEP upon hire and/or at least twice per year as evident by the lack of training documentation. One training record was provided dated 12/29/22.</p> <p>During an interview on November 28, 2023, at 2:00 p.m., LALD-A explained employees were trained on fire safety and evacuation upon hire and annually. LALD-A further explained the licensee was in the process of planning for the next employee training on fire safety and evacuation and did not realize this training was required twice a year.</p> <p><b>DRILLS</b><br/>Record review indicated the licensee failed to conduct employee evacuation drills twice per year, per shift with at least one evacuation drill every other month as evident by a review of the completed fire drill logs. Fire drill records dated 09/06/2021, 03/01/2022, 09/06/2022, 02/01/2023, and 09/11/2023 were provided for review.</p> <p>During an interview on November 28, 2023, at 2:00 p.m., LALD-A stated the licensee would increase the fire drill frequency as they were not aware that 6 employee evacuation drills were required annually.</p> <p><b>TIME PERIOD FOR CORRECTION:</b> Twenty-one (21) days</p> | 0 810                                                                                         |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                        |                                                                                                                          |  |                                                     |
|------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>37193</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>11/28/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SAKINAH HOMES @ FROST</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>120 EAST FROST STREET<br/>S ST PAUL, MN 55075</b>                            |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                         | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 950                                                            | Continued From page 16                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 0 950                                                                  |                                                                                                                          |  |                                                     |
| 0 950<br>SS=C                                                    | <p><b>144G.50 Subd. 3 Designation of representative</b></p> <p>(a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract:</p> <p><b>"RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES.</b></p> <p>You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable."</p> <p>(b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on interview and record review, the licensee failed to offer the resident the opportunity to identify a designated representative in writing with the required statutory language. This had the potential to affect all residents.</p> | 0 950                                                                  |                                                                                                                          |  |                                                     |

Minnesota Department of Health

|                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                               |                                                                                                                          |  |                                                        |
|------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>37193</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>11/28/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SAKINAH HOMES @ FROST</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>120 EAST FROST STREET<br/>S ST PAUL, MN 55075</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                         | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ID<br>PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 0 950                                                            | <p>Continued From page 17</p> <p>This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).</p> <p>The findings include:</p> <p>R1 admitted to licensee and began receiving assisted living services on March 16, 2021.</p> <p>R1's Assisted Living Contract was signed on December 31, 2022.</p> <p>R1's record lacked documentation of an opportunity to designate a representative and the verbatim "right to designate a representative for certain purposes" notice.</p> <p>On November 28, 2023, at 9:06 a.m., licensed assisted living director (LALD)-A stated she was unaware of the requirement of including an opportunity to designate a representative utilizing the verbatim language of "right to designate a representative for certain purposes" notice. LALD-A further stated the same contract was utilized for all residents at the facility.</p> <p>The licensee's undated, Assisted Living Contract policy indicated the following:<br/>Residents have the right to designate a representative before they sign a contract. The facility must offer the resident the opportunity to identify a representative in writing on the contract and must provide the following notice on a document separate from the contract:</p> | 0 950                                                                                         |                                                                                                                          |  |                                                        |

Minnesota Department of Health

|                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                               |                                                                                                                          |                                                        |
|------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>37193</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>11/28/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SAKINAH HOMES @ FROST</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>120 EAST FROST STREET<br/>S ST PAUL, MN 55075</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                         | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ID<br>PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 950                                                            | Continued From page 18<br><br>a. RIGHT TO DESIGNATE A<br>REPRESENTATIVE FOR CERTAIN PURPOSES.<br>"You have the right to name anyone as your<br>"Designated Representative." A Designated<br>Representative can assist you, receive certain<br>information and notices about you including some<br>information related to your health care, and<br>advocate on your behalf. A Designated<br>Representative does not take the place of your<br>guardian, conservator, power of attorney<br>("attorney-in-fact") or health care power of<br>attorney ("health care agent"), if applicable.<br>b. The contract must contain a page or space<br>for the name and contact information of the<br>Designated Representative and a box the<br>resident must initial if they decline to name a<br>representative. The resident has the right to add,<br>remove, or change the name and contact<br>information of the Designated Representative at<br>any time.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one<br>(21) days | 0 950                                                                                         |                                                                                                                          |                                                        |
| 0 970<br>SS=C                                                    | 144G.50 Subd. 5 Waivers of liability prohibited<br><br>The contract must not include a waiver of facility<br>liability for the health and safety or personal<br>property of a resident. The contract must not<br>include any provision that the facility knows or<br>should know to be deceptive, unlawful, or<br>unenforceable under state or federal law, nor<br>include any provision that requires or implies a<br>lesser standard of care or responsibility than is<br>required by law.<br><br>This MN Requirement is not met as evidenced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 0 970                                                                                         |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                        |                                                                                                                          |  |                                                     |
|------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>37193</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY COMPLETED<br><br><b>11/28/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SAKINAH HOMES @ FROST</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>120 EAST FROST STREET<br/>S ST PAUL, MN 55075</b>                            |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                         | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 970                                                            | <p>Continued From page 19</p> <p>by:<br/>Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety, or personal property of a resident. This had the potential to affect all residents.</p> <p>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).</p> <p>The findings include:</p> <p>The licensee's assisted living contract included a clause that indicated the resident would waive the licensee's liability for health, safety, or personal property of a resident.</p> <p>-Page 13 of the contract indicated:<br/>"Indemnification: the licensee shall not be liable for any damage or injury to the resident, or any other person, or to any property, occurring on the premises, or any part thereof, or in common areas thereof, and the resident agrees to hold the licensee harmless from any claims or damages unless caused solely by negligence of the licensee."</p> <p>-Page 13 of the contract indicated: "Liability: "The resident agrees to be liable and responsible for all obligations herein referenced, monetary and otherwise, of the resident and where the contract has been executed by a party designated below. Or where a separate responsible party agreement has been executed by a third party, said third party and the resident shall be jointly and</p> | 0 970                                                                  |                                                                                                                          |  |                                                     |

Minnesota Department of Health

|                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                               |                                                                                                                          |  |                                                        |
|------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>37193</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>11/28/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SAKINAH HOMES @ FROST</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>120 EAST FROST STREET<br/>S ST PAUL, MN 55075</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                         | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 0 970                                                            | Continued From page 20<br><br>severally liable and responsible for all obligations,<br>monetary and otherwise, of the resident herein<br>referenced."<br><br>On November 28, 2023, at 9:06 a.m. licensed<br>assisted living director (LALD)-A stated the<br>licensee's contract included the above content,<br>and further stated the same contract was utilized<br>for all residents at the facility.<br><br>The licensee's undated, Assisted Living Contract<br>policy indicated the following:<br>The contract must not include a waiver of facility<br>liability for the health and safety or personal<br>property of a resident. The contract must not<br>include any provision that the facility knows or<br>should know to be deceptive, unlawful or<br>unenforceable under state or federal law.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one<br>(21) days | 0 970                                                                                         |                                                                                                                          |  |                                                        |
| 01290<br>SS=F                                                    | 144G.60 Subdivision 1 Background studies<br>required<br><br>(a) Employees, contractors, and regularly<br>scheduled volunteers of the facility are subject to<br>the background study required by section<br>144.057 and may be disqualified under chapter<br>245C. Nothing in this subdivision shall be<br>construed to prohibit the facility from requiring<br>self-disclosure of criminal conviction information.<br>(b) Data collected under this subdivision shall be<br>classified as private data on individuals under<br>section 13.02, subdivision 12.<br>(c) Termination of an employee in good faith<br>reliance on information or records obtained under                                                                                                                                                                                                                                             | 01290                                                                                         |                                                                                                                          |  |                                                        |

Minnesota Department of Health

|                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                        |                                                                                                                          |  |                                                     |
|------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>37193</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>11/28/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SAKINAH HOMES @ FROST</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>120 EAST FROST STREET<br/>S ST PAUL, MN 55075</b>                            |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                         | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01290                                                            | <p>Continued From page 21</p> <p>this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on interview and record review, the licensee failed to ensure a background study was affiliated with the assisted living facility (ALF) license for one of two employees (unlicensed personnel (ULP)-E). This had the potential to affect all residents living in the facility.</p> <p>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).</p> <p>The findings include:</p> <p>ULP-E was hired on July 5, 2023, to provide direct care and services to the facility's residents.</p> <p>ULP-E's employee record contained a Background Study Clearance dated July 5, 2023, from a sister facility. However, ULP-E was not affiliated with the facility's license.</p> <p>On November 27, 2023, at 3:32 p.m., licensed assisted living director (LALD)-A stated ULP-E's background study was not affiliated to the facility's licensee.</p> <p>The licensee's Background Studies policy, undated, indicated the licensee required a</p> | 01290                                                                  |                                                                                                                          |  |                                                     |

Minnesota Department of Health

|                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                        |                                                                                                                          |  |                                                     |
|------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>37193</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY COMPLETED<br><br><b>11/28/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SAKINAH HOMES @ FROST</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>120 EAST FROST STREET<br/>S ST PAUL, MN 55075</b>                            |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                         | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01290                                                            | Continued From page 22<br><br>background study to be completed for all employees.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Two (2) days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 01290                                                                  |                                                                                                                          |  |                                                     |
| 01470<br>SS=D                                                    | 144G.63 Subd. 2 Content of required orientation<br><br>(a) The orientation must contain the following topics:<br>(1) an overview of this chapter;<br>(2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person;<br>(3) handling of emergencies and use of emergency services;<br>(4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC);<br>(5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;<br>(6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person;<br>(7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints;<br>(8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or | 01470                                                                  |                                                                                                                          |  |                                                     |

Minnesota Department of Health

|                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                        |                                                                                                                          |  |                                                     |
|------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>37193</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY COMPLETED<br><br><b>11/28/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SAKINAH HOMES @ FROST</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>120 EAST FROST STREET<br/>S ST PAUL, MN 55075</b>                            |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                         | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01470                                                            | <p>Continued From page 23</p> <p>other relevant advocacy services; and<br/>(9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure.<br/>(b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics:<br/>(1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication;<br/>(2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or<br/>(3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on interview and record review, the licensee failed to ensure one of two employees (unlicensed personnel (ULP)-E) received orientation to assisted living facility licensing requirements and regulations before providing services.</p> <p>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</p> | 01470                                                                  |                                                                                                                          |  |                                                     |

Minnesota Department of Health

|                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                               |                                                                                                                          |                                                        |
|------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>37193</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>11/28/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SAKINAH HOMES @ FROST</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>120 EAST FROST STREET<br/>S ST PAUL, MN 55075</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                         | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 01470                                                            | <p>Continued From page 24</p> <p>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).</p> <p>The findings include:</p> <p>ULP-E was hired on July 5, 2023, to provide direct care and services to the facility's residents.</p> <p>ULP-E's employee record did not include the following required orientation content:</p> <ul style="list-style-type: none"> <li>-an overview of the 144G statutes</li> <li>-compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); and</li> <li>-the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person.</li> </ul> <p>On November 28, 2023, at 9:08 a.m. licensed assisted living director (LALD)-A stated ULP-E had not completed all components of the required orientation training for assisted living facilities.</p> <p>The licensee's Staff Orientation and Education policy dated August 1, 2021, indicated:</p> <p>3 Orientation topics would include, but not limited to, the following:</p> <ul style="list-style-type: none"> <li>a. overview of Minnesota Assisted Living Statute 144G and Minnesota Rules Chapter 4659</li> <li>e. compliance with Minnesota's Vulnerable Adult (sections 626.556 and 5572), including requirements based on organizational policy, identification of incidents of maltreatment (abuse, financial exploitation and neglect) and that any that constitutes maltreatment is prohibited.</li> <li>g. the principles of person-centered planning and service delivery and how they apply to direct</li> </ul> | 01470                                                                                         |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                               |                                                                                                                          |  |                                                        |
|------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>37193</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>11/28/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SAKINAH HOMES @ FROST</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>120 EAST FROST STREET<br/>S ST PAUL, MN 55075</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                         | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ID<br>PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 01470                                                            | Continued From page 25<br><br>support services provided by staff.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION:<br>Twenty-One (21) days.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 01470                                                                                         |                                                                                                                          |  |                                                        |
| 01530<br>SS=D                                                    | <b>144G.64 TRAINING IN DEMENTIA CARE<br/>REQUIRED</b><br><br>(a) All assisted living facilities must meet the<br>following training requirements:<br>(1) supervisors of direct-care staff must have at<br>least eight hours of initial training on topics<br>specified under paragraph (b) within 120 working<br>hours of the employment start date, and must<br>have at least two hours of training on topics<br>related to dementia care for each 12 months of<br>employment thereafter;<br>(2) direct-care employees must have completed<br>at least eight hours of initial training on topics<br>specified under paragraph (b) within 160 working<br>hours of the employment start date. Until this<br>initial training is complete, an employee must not<br>provide direct care unless there is another<br>employee on site who has completed the initial<br>eight hours of training on topics related to<br>dementia care and who can act as a resource<br>and assist if issues arise. A trainer of the<br>requirements under paragraph (b) or a supervisor<br>meeting the requirements in clause (1) must be<br>available for consultation with the new employee<br>until the training requirement is complete.<br>Direct-care employees must have at least two<br>hours of training on topics related to dementia for<br>each 12 months of employment thereafter;<br><br>This MN Requirement is not met as evidenced<br>by: | 01530                                                                                         |                                                                                                                          |  |                                                        |

Minnesota Department of Health

|                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                               |                                                                                                                          |  |                                                        |
|------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>37193</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>11/28/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SAKINAH HOMES @ FROST</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>120 EAST FROST STREET<br/>S ST PAUL, MN 55075</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                         | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 01530                                                            | <p>Continued From page 26</p> <p>Based on interview and record review, the licensee failed to ensure one of two employees (unlicensed personnel (ULP)-E received the required amount of dementia care training in the required time frame.</p> <p>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).</p> <p>The findings include:</p> <p>The licensee provided services under an Assisted Living license.</p> <p>ULP-E was hired on July 5, 2023, to provide direct care and services to the facility's residents.</p> <p>ULP-E's employee record contained evidence the employee received seven and a half hours of dementia care training, not the required eight hours of training within 160 working hours of the employment start date.</p> <p>On November 28, 2023, at 9:08 a.m., licensed assisted living director (LALD)-A verified ULP-E's record lacked the required amount of training in dementia care and stated ULP-E had worked more than 160 hours.</p> <p>The licensee's Staff Orientation and Education policy dated August 1, 2021, indicated all staff would receive the required training on dementia.</p> | 01530                                                                                         |                                                                                                                          |  |                                                        |

Minnesota Department of Health

|                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                               |                                                                                                                          |                                                        |
|------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>37193</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>11/28/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SAKINAH HOMES @ FROST</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>120 EAST FROST STREET<br/>S ST PAUL, MN 55075</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                         | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ID<br>PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 01530                                                            | Continued From page 27<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One<br>(21) days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 01530                                                                                         |                                                                                                                          |                                                        |
| 01620<br>SS=D                                                    | 144G.70 Subd. 2 (c-e) Initial reviews,<br>assessments, and monitoring<br><br>(c) Resident reassessment and monitoring must<br>be conducted no more than 14 calendar days<br>after initiation of services. Ongoing resident<br>reassessment and monitoring must be conducted<br>as needed based on changes in the needs of the<br>resident and cannot exceed 90 calendar days<br>from the last date of the assessment.<br>(d) For residents only receiving assisted living<br>services specified in section 144G.08, subdivision<br>9, clauses (1) to (5), the facility shall complete an<br>individualized initial review of the resident's needs<br>and preferences. The initial review must be<br>completed within 30 calendar days of the start of<br>services. Resident monitoring and review must<br>be conducted as needed based on changes in<br>the needs of the resident and cannot exceed 90<br>calendar days from the date of the last review.<br>(e) A facility must inform the prospective resident<br>of the availability of and contact information for<br>long-term care consultation services under<br>section 256B.0911, prior to the date on which a<br>prospective resident executes a contract with a<br>facility or the date on which a prospective<br>resident moves in, whichever is earlier.<br><br>This MN Requirement is not met as evidenced<br>by:<br>Based on interview and record review, the<br>licensee failed to ensure the registered nurse<br>(RN) conducted ongoing nursing assessments<br>not to exceed 90 days from the previous | 01620                                                                                         |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                               |                                                                                                                          |  |                                                        |
|------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>37193</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>11/28/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SAKINAH HOMES @ FROST</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>120 EAST FROST STREET<br/>S ST PAUL, MN 55075</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                         | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ID<br>PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 01620                                                            | <p>Continued From page 28</p> <p>assessment for one of one resident (R1).</p> <p>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).</p> <p>The findings include:</p> <p>R1 admitted to licensee on March 16, 2021, with diagnoses that included obsessive compulsive disorder (a personality disorder characterized by excessive orderliness, perfectionism, attention to details, and a need for control relating to others).</p> <p>R1's service plan signed on November 15, 2023, indicated R1 received services to include assistance with bathing, grooming, behavior management, meals, laundry, and medication management.</p> <p>R1's ongoing nursing assessments were requested. Assessments dated March 7, 2023, June 7, 2023, and November 24, 2023, were provided.</p> <p>The June 7, 2023, assessment was done 92 days after the date of the previous assessment and the November 24, 2023, assessment was done 170 days after the date of the previous assessment, both assessments exceeding 90 calendar days.</p> <p>On November 27, 2023, at 1:49 p.m. RN-B stated the November 24, 2023, assessment was done on September 5, 2023, but had not been marked</p> | 01620                                                                                         |                                                                                                                          |  |                                                        |

Minnesota Department of Health

|                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                               |                                                                                                                          |  |                                                        |
|------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>37193</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>11/28/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SAKINAH HOMES @ FROST</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>120 EAST FROST STREET<br/>S ST PAUL, MN 55075</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                         | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ID<br>PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 01620                                                            | Continued From page 29<br><br>completed until November 24, 2023. RN-B and<br>licensed assisted living director (LALD)-A both<br>verified the November 24, 2023, assessment<br>indicated the assessment was "completed in<br>person by RN-B on 11/24/23" and was<br>electronically signed and completed by RN-B on<br>November 24, 2023, at 4:05 p.m., which<br>exceeded 90 calendar days from the previous<br>assessment.<br><br>The licensee's Assessment and Reassessment<br>policy dated August 1, 2021, indicated ongoing<br>resident reassessments would be conducted by<br>an RN and could not exceed 90 days from the<br>last assessment.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one<br>(21) days                                  | 01620                                                                                         |                                                                                                                          |  |                                                        |
| 01760<br>SS=D                                                    | <b>144G.71 Subd. 8 Documentation of<br/>administration of medication</b><br><br>Each medication administered by the assisted<br>living facility staff must be documented in the<br>resident's record. The documentation must<br>include the signature and title of the person who<br>administered the medication. The documentation<br>must include the medication name, dosage, date<br>and time administered, and method and route of<br>administration. The staff must document the<br>reason why medication administration was not<br>completed as prescribed and document any<br>follow-up procedures that were provided to meet<br>the resident's needs when medication was not<br>administered as prescribed and in compliance<br>with the resident's medication management plan. | 01760                                                                                         |                                                                                                                          |  |                                                        |

Minnesota Department of Health

|                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                        |                                                                                                                          |  |                                                     |
|------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>37193</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>11/28/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SAKINAH HOMES @ FROST</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>120 EAST FROST STREET<br/>S ST PAUL, MN 55075</b>                            |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                         | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01760                                                            | <p>Continued From page 30</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation, interview, and record review, the licensee failed to ensure medications were clarified and transcribed correctly per physician order for one of one resident (R1).</p> <p>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).</p> <p>The findings include:</p> <p>R1's diagnoses included obsessive compulsive disorder (a personality disorder characterized by excessive orderliness, perfectionism, attention to details, and a need for control relating to others).</p> <p>R1's service plan signed on November 15, 2023, indicated R1 received assistance with medication management.</p> <p>On November 27, 2023, at 2:09 p.m., the surveyor observed unlicensed personnel (ULP)-D administer R1's oral medications.</p> <p>ROUTES OF ADMINISTRATION<br/>R1's medication administration record (MAR) dated November 2023, lacked the route of administration for the following medications:<br/>-Methadone; take 1 bottle [20 milligrams (mg)] every morning<br/>-Prednisone 20 mg; take two tablets daily in the morning with breakfast</p> | 01760                                                                  |                                                                                                                          |  |                                                     |

Minnesota Department of Health

|                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                               |                                                                                                                          |                                                     |
|------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>37193</b>                        | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY COMPLETED<br><br><b>11/28/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SAKINAH HOMES @ FROST</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>120 EAST FROST STREET<br/>S ST PAUL, MN 55075</b> |                                                                                                                          |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                         | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ID<br>PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                            |
| 01760                                                            | <p>Continued From page 31</p> <p>-Imodium; take 2 tablets initially and 1 tablet every time you have a loose bowel movement to a maximum of 8 tablets per day</p> <p>-Milk of magnesia; take 15 milliliters (ml) at a time with water, and repeat up to four times per day as needed</p> <p>-acetaminophen 650 mg; take every four hours as needed</p> <p>-Maalox 30 cubic centimeters (cc) every four hours as needed</p> <p><b>TRANSCRIPTION ERROR</b></p> <p>R1's MAR dated November 2023, indicated Milk of Magnesia; take 15 ml at a time with water and repeat up to four times per day as needed.</p> <p>- Prescriber orders dated March 23, 2021, indicated milk of magnesia; take 30 milliliter (ml) every day as needed.</p> <p>On November 27, 2023, at 3:00 p.m., licensed assisted living director (LALD)-A stated the above medications were missing the route and the verified the milk of magnesia order was transcribed incorrectly.</p> <p>The licensee's Prescriber's Orders policy dated August 1, 2021, indicated all medications being administered would include the following in the order:</p> <ul style="list-style-type: none"> <li>-purpose</li> <li>-dosage</li> <li>-route</li> <li>-frequency</li> <li>-instructions related to the medication and specific to the residents, as appropriate</li> <li>-side effects</li> <li>-resident allergies to medications</li> </ul> <p>No further information provided.</p> | 01760                                                                                         |                                                                                                                          |                                                     |

Minnesota Department of Health

|                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                               |                                                                                                                          |                                                        |
|------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>37193</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>11/28/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SAKINAH HOMES @ FROST</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>120 EAST FROST STREET<br/>S ST PAUL, MN 55075</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                         | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ID<br>PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 01760                                                            | Continued From page 32<br><br>TIME PERIOD FOR CORRECTION: Seven (7)<br>days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 01760                                                                                         |                                                                                                                          |                                                        |
| 01790<br>SS=F                                                    | <p>144G.71 Subd. 10 Medication management for residents who will</p> <p>(2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days;</p> <p>(3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and</p> <p>(4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled.</p> <p>(b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if:</p> <p>(1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and</p> <p>(2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address:</p> <p>(i) the type of container or containers to be used for the medications appropriate to the provider's medication system;</p> <p>(ii) how the container or containers must be labeled;</p> | 01790                                                                                         |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                               |                                                                                                                          |  |                                                        |
|------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>37193</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>11/28/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SAKINAH HOMES @ FROST</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>120 EAST FROST STREET<br/>S ST PAUL, MN 55075</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                         | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ID<br>PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 01790                                                            | <p>Continued From page 33</p> <p>(iii) written information about the medications to be provided;</p> <p>(iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information;</p> <p>(v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative;</p> <p>(vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and</p> <p>(vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on interview and record review, the licensee failed to ensure the registered nurse (RN) developed training and competencies for unlicensed personnel (ULP) providing medications to residents for unplanned time away from home when the licensed nurse was not available for two of two employees (ULP-D, ULP-E).</p> <p>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</p> | 01790                                                                                         |                                                                                                                          |  |                                                        |

Minnesota Department of Health

|                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                        |                                                                                                                          |  |                                                     |
|------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>37193</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>11/28/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SAKINAH HOMES @ FROST</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>120 EAST FROST STREET<br/>S ST PAUL, MN 55075</b>                            |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                         | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01790                                                            | <p>Continued From page 34</p> <p>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).</p> <p>The findings include:</p> <p>ULP-D<br/>ULP-D was hired on August 27, 2019.</p> <p>ULP-D's employee record lacked documentation of training and competencies for providing medications for unplanned time away when the RN was not available.</p> <p>ULP-E<br/>ULP-E was hired on July 5, 2023.</p> <p>ULP-E's employee record lacked documentation of training and competencies for providing medications for unplanned time away when the RN was not available.</p> <p>On November 28, 2023, at 9:08 a.m., licensed assisted living director (LALD)-A stated all ULP were trained, and competency tested on providing medications to residents for unplanned time away but did not have documentation of the training or competencies.</p> <p>The licensee's Medication Management Plan for Residents Away from Home policy dated August 1, 2021, indicated for unplanned times away from home or for temporary periods when an adequate medication supply could not be obtained from the pharmacy or set up by the nurse in a timely manner, the nurse could delegate to an ULP to provide the medications only after the nurse had trained the ULP and determined the ULP</p> | 01790                                                                  |                                                                                                                          |  |                                                     |

Minnesota Department of Health

|                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                               |                                                                                                                          |  |                                                        |
|------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>37193</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>11/28/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SAKINAH HOMES @ FROST</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>120 EAST FROST STREET<br/>S ST PAUL, MN 55075</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                         | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 01790                                                            | Continued From page 35<br><br>competent to follow procedures for giving<br>medications to residents.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7)<br>days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 01790                                                                                         |                                                                                                                          |  |                                                        |
| 01830<br>SS=D                                                    | 144G.71 Subd. 14 Renewal of prescriptions<br><br>Prescriptions must be renewed at least every 12<br>months or more frequently as indicated by the<br>assessment in subdivision 2. Prescriptions for<br>controlled substances must comply with chapter<br>152.<br><br>This MN Requirement is not met as evidenced<br>by:<br>Based on observation, interview, and record<br>review, the facility failed to renew prescriptions at<br>least every 12 months for one of one resident<br>(R1).<br><br>This practice resulted in a level two violation (a<br>violation that did not harm a resident's health or<br>safety but had the potential to have harmed a<br>resident's health or safety, but was not likely to<br>cause serious injury, impairment, or death) and<br>was issued at an isolated scope (when one or a<br>limited number of residents are affected or one or<br>a limited number of staff are involved, or the<br>situation has occurred only occasionally).<br><br>The findings include:<br><br>R1's record lacked an annual renewal of<br>prescriber orders for medications.<br><br>R1 diagnoses included obsessive compulsive | 01830                                                                                         |                                                                                                                          |  |                                                        |

Minnesota Department of Health

|                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                               |                                                                                                                          |  |                                                        |
|------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>37193</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>11/28/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SAKINAH HOMES @ FROST</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>120 EAST FROST STREET<br/>S ST PAUL, MN 55075</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                         | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ID<br>PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 01830                                                            | <p>Continued From page 36</p> <p>disorder (a personality disorder characterized by excessive orderliness, perfectionism, attention to details, and a need for control relating to others).</p> <p>R1's service plan signed on November 15, 2023, indicated R1 received assistance with medication management.</p> <p>On November 27, 2023, at 2:09 p.m., the surveyor observed unlicensed personnel (ULP)-D administer R1's oral medications.</p> <p>The following physician orders lacked evidence of being renewed annually:</p> <ul style="list-style-type: none"> <li>-famotidine 20 milligrams (mg); take one tablet by mouth twice daily as needed, per physician order dated October 24, 2022.</li> <li>-Imodium 2 mg; take 4 mg after 1st loose stool, 2 mg after each loose stool. Max 16 mg per day, per physician order dated March 23, 2021.</li> <li>-Milk of Magnesia; take 30 milliliter (ml) everyday as needed, per physician order dated March 23, 2021.</li> <li>-Robitussin DM; take two teaspoons by mouth every four hours, per physician order dated on March 23, 2021.</li> <li>-acetaminophen 650 mg every four hours as needed, per physician order dated on March 23, 2021.</li> <li>-fluticasone 50 micrograms (mcg); instill two sprays into both nostrils daily as needed, per physician order dated on October 24, 2022.</li> <li>-loratadine 10 mg; take one tablet by mouth daily as needed, per physician order dated October 24, 2022.</li> <li>-Maalox; take 30 ml every four hours as needed, per physician order March 23, 2021.</li> <li>-triamcinolone acetonide 0.1% cream; apply to affected area twice daily as needed, per physician order dated October 24, 2022.</li> </ul> | 01830                                                                                         |                                                                                                                          |  |                                                        |

Minnesota Department of Health

|                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                               |                                                                                                                          |  |                                                        |
|------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>37193</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>11/28/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SAKINAH HOMES @ FROST</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>120 EAST FROST STREET<br/>S ST PAUL, MN 55075</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                         | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ID<br>PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 01830                                                            | Continued From page 37<br><br>On November 27, 2023, at 1:06 p.m. housing manager (HM)-C stated R1's prescriber orders listed above had not been renewed at least annually as required.<br><br>The licensee's Prescriber's Orders policy dated August 1, 2021, indicated all medication and treatment orders would be renewed at least every year or when changes occurred.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days                                                                                                                                                                                                                                                                                                                                                                                                                     | 01830                                                                                         |                                                                                                                          |  |                                                        |
| 03090<br>SS=C                                                    | 144.6502, Subd. 8 Notice to Visitors<br><br>(a) A facility must post a sign at each facility entrance accessible to visitors that states:<br>"Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities."<br>(b) The facility is responsible for installing and maintaining the signage required in this subdivision.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure the required notice was posted at the main entry way of the establishment to display statutory language to disclose electronic monitoring activity, potentially affecting all current residents, staff, and any visitors of the facility.<br><br>This practice resulted in a level one violation (a violation that has not potential to cause more than | 03090                                                                                         |                                                                                                                          |  |                                                        |

Minnesota Department of Health

|                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                        |                                                                                                                          |  |                                                     |
|------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>37193</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>11/28/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SAKINAH HOMES @ FROST</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>120 EAST FROST STREET<br/>S ST PAUL, MN 55075</b>                            |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                         | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 03090                                                            | <p>Continued From page 38</p> <p>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).</p> <p>The finding include:</p> <p>On November 27, 2023, at approximately 9:30 a.m. upon arriving at the establishment, an observation outside the front entrance, or just inside the front entrance, lacked the required posting for electronic monitoring devices.</p> <p>On November 27, 2023, at approximately 10:15 a.m. the surveyor toured the residence with licensed assisted living director (LALD)-A. LALD-A stated licensee utilized cameras in the common areas of the residence and further stated no posting was available related to the statutory language for electronic monitoring.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION:<br/>Twenty-One (21) days</p> | 03090                                                                  |                                                                                                                          |  |                                                     |

Type: Full  
Date: 11/27/23  
Time: 12:00:00  
Report: 1031231312

## Food and Beverage Establishment Inspection Report

Page 1

**Location:**

Sakinah Homes @ Frost  
120 East Frost Street  
South St Paul, MN55075  
Dakota County, 19

**Establishment Info:**

ID #: 0038450  
Risk:  
Announced Inspection: No

**License Categories:**

Expires on: / /

**Operator:**

Phone #: 6514609188  
ID #:

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

The following orders were issued during this inspection.

### 2-200 Employee Health

#### 2-201.11C

**\*\* Priority 1 \*\***

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

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

*Comply By: 11/27/23*

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

#### 3-302.11A(1)

**\*\* Priority 1 \*\***

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

OBSERVED RAW EGGS AND RAW RED MEAT STORED NEXT TO DELI MEAT. HAD RAW ITEMS MOVED TO BOTTOM DRAWER. REFRIGERATOR STORAGE DIAGRAM ATTACHED TO EMAIL.

*Comply By: 11/27/23*

### 3-500B Microbial Control: hot and cold holding

#### 3-501.16A2

**\*\* Priority 1 \*\***

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

BUTTER IN REFRIGERATOR MEASURED 45F. STAFF INSTRUCTED TO TURN DOWN REFRIGERATOR. MONITOR TEMPERATURES. REPAIR REFRIGERATOR IF FOOD TEMPS DO NOT DROP TO 41F OR BELOW.

*Comply By: 11/27/23*

Type: Full  
Date: 11/27/23  
Time: 12:00:00  
Report: 1031231312  
Sakinah Homes @ Frost

---

# Food and Beverage Establishment Inspection Report

Page 2

## 3-800 Highly Susceptible Populations

### **3-801.11C** \*\* *Priority 1* \*\*

MN Rule 4626.0447C Discontinue serving raw or partially cooked animal foods or sprouts to a highly susceptible population.

NON-PASTEURIZED EGGS BEING SERVED TO SUSCEPTIBLE POPULATION NOT FULLY COOKED.  
\*\*\*DISCONTINUE PRACTICE.\*\*\* ONLY SERVE PASTEURIZED EGGS UNDERCOOKED TO  
SUSCEPTIBLE POPULATION.

*Comply By: 11/27/23*

## 4-700 Sanitizing Equipment and Utensils

### **4-703.11B** \*\* *Priority 1* \*\*

MN Rule 4626.0905B Sanitize food contact surfaces of equipment and utensils after cleaning by using mechanical hot water operations that achieve a utensil surface temperature of 160 degrees F (71 degrees C) and are set up and maintained in accordance with the specifications of NSF International and the manufacturer's data plate.

UTENSIL TEMPERATURE OF DISH MACHINE MEASURED 150F. \*\*\*DISCONTINUE USE OF DISH  
MACHINE FOR SANITIZING PURPOSES UNTIL REPAIRED.\*\*\* STAFF NEEDS TO SANITIZE IN  
2-COMP SINK AS DISCUSSED OR SWITCH TO DISPOSABLE PRODUCTS UNTIL REPAIRED.

*Comply By: 11/28/23*

## 4-700 Sanitizing Equipment and Utensils

### **4-703.11C** \*\* *Priority 1* \*\*

MN Rule 4626.0905C Sanitize food contact surfaces of equipment and utensils after cleaning by using an approved chemical sanitizer in manual or mechanical operations for at least 7 or 10 seconds for chlorine depending on temperature, concentration, and pH; and 30 seconds for all other chemical sanitizers or a contact time used in relation with a combination of temperature, concentration, and pH.

LYSOL SPRAY USED FOR COUNTERS MEASURED > 400PPM. \*\*\*DISCONTINUE USING  
PRODUCT.\*\*\* STAFF INSTRUCTED TO MAKE SANITIZER SPARY AND USE SANITIZER TEST  
STRIPS TO CHECK CONCENTRATION.

*Comply By: 11/27/23*

## 4-300 Equipment Numbers and Capacities

### **4-302.12B** \*\* *Priority 2* \*\*

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

ESTABLISHMENT DOES NOT HAVE A THIN PROBE THERMOMETER.

*Comply By: 11/29/23*

## 4-300 Equipment Numbers and Capacities

### **4-302.13B** \*\* *Priority 2* \*\*

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

ESTABLISHMENT MISSING IRREVERSIBLE MEASURING DEVICE. PROVIDE IRREVERSIBLE  
MEASURING DEVICE AND MEASURE UTENSIL TEMPERATURE (160F REQUIRED) AT REGULAR  
INTERVALS.

*Comply By: 11/30/23*

Type: Full  
Date: 11/27/23  
Time: 12:00:00  
Report: 1031231312  
Sakinah Homes @ Frost

---

# Food and Beverage Establishment Inspection Report

Page 3

## 4-300 Equipment Numbers and Capacities

### 4-302.14 **\*\* Priority 2 \*\***

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

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

*Comply By: 11/29/23*

## 2-100 Supervision

### 2-102.12AMN

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

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

ESTABLISHMENT DOES HAVE SAFESERV OR SIMILAR POSTED.

*Comply By: 11/27/23*

## 4-200 Equipment Design and Construction

### 4-204.112A

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

1. REFRIGERATOR IN KITCHEN HAS BROKEN THERMOMETER. REPLACE THERMOMETER.

2. GARAGE REFRIGERATOR MISSING THERMOMETER. PLACE THERMOMETER IN REFRIGERATOR.

*Comply By: 12/11/23*

## 4-500 Equipment Maintenance and Operation

### 4-501.11AB

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

STOVE TOP LIGHT IS BURNT OUT. REPLACE LIGHT.

*Comply By: 12/11/23*

## 4-600 Cleaning Equipment and Utensils

### 4-601.11B

MN Rule 4626.0840B Maintain the food contact surfaces of cooking equipment and pans free of encrusted grease deposits and other soil accumulations.

OVEN INTERIOR FOUND WITH ENCRUSTED FOOD DEBRIS THROUGHOUT CAVITY AND ON GLASS. CLEAN OVEN.

*Comply By: 12/11/23*

## 6-500 Physical Facility Maintenance/Operation and Pest Control

### 6-501.12A

MN Rule 4626.1520A Clean and maintain all physical facilities clean.

LAZY SUSAN HAS FOOD DEBRIS SPILLS. CLEAN LAZY SUSAN.

*Comply By: 12/11/23*

Type: Full  
Date: 11/27/23  
Time: 12:00:00  
Report: 1031231312  
Sakinah Homes @ Frost

# Food and Beverage Establishment Inspection Report

## Surface and Equipment Sanitizers

Dimethyl Ethyl Benzyl Ammo: > 400 at Degrees Fahrenheit  
Location: Lysol Spray  
Violation Issued: Yes

Hot Water: = at 150 Degrees Fahrenheit  
Location: Dish Machine  
Violation Issued: Yes

## Food and Equipment Temperatures

Process/Item: Cold Hold/Butter  
Temperature: 45 Degrees Fahrenheit - Location: Refrigerator  
Violation Issued: Yes

Process/Item: Cold Hold/Cutie Orange  
Temperature: 31 Degrees Fahrenheit - Location: Garage Refrigerator  
Violation Issued: No

| Total Orders | In This Report | Priority 1 | Priority 2 | Priority 3 |
|--------------|----------------|------------|------------|------------|
|              |                | 6          | 3          | 5          |

Inspection conducted by Chris F.

All violations discussed with Keria during the inspection.

### NOTES:

- Establishment has a residential kitchen (4626.0506(G)(2)) Same-day service only. No saving and reheating of foods or preparation of foods the day prior to eating. Any remaining food from meals to be removed/discarded at end of day.
- Residents wanting to keep food after a meal must prepare/reheat foods by themselves.
- Staff must sanitizer spray to use with disposable paper towels. Check concentration of sanitizer when preparing with test strips. Replace sanitizer solution as needed.
- Make sure to datemark any prepared cold items that are kept in refrigerator.
- Gloves should be used for single-purpose only; switch gloves whenever leaving kitchen to do other work.
- - Establishment needs to check dish washer utensil temperature weekly (160F required). If utensil temp not reaching 160F, use washer to wash/rinse and sink basin with sanitizer solution to sanitize dishes then air dry.
- 2-Comp sink has left basin designated for handwashing and the right basin for product washing/prep sink.
- When preparing food, make sure to use a thin-probe thermometer to check temperatures.

Type: Full  
Date: 11/27/23  
Time: 12:00:00  
Report: 1031231312  
Sakinah Homes @ Frost

# Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Environmental Health inspection report number 1031231312 of 11/27/23.

Certified Food Protection Manager: \_\_\_\_\_

Certification Number: \_\_\_\_\_ Expires: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Inspection report reviewed with person in charge and emailed.**

Signed: \_\_\_\_\_

Keria Abbadulla  
Person in Charge

Signed: \_\_\_\_\_

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

Report #: 1031231312

DEPARTMENT OF HEALTH

Environmental Health

Food, Pools, and Lodging

625 Robert St. N

St. Paul

No. of RF/PHI Categories Out

6

No. of Repeat RF/PHI Categories Out

0

Legal Authority MN Rules Chapter 4626

Date

11/27/23

Time In

12:00:00

Time Out

Sakinah Homes @ Frost

Address

120 East Frost Street

City/State

South St Paul, MN

Zip Code

55075

Telephone

6514609188

License/Permit #

0038450

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 Hygienic 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 proceeedures identified as the most prevalent contributing factors of foodborne illness or injury. Public Health Interventions (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

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

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

COS

R

Safe Food and Water

30

IN

OUT

N/A

Pasteurized eggs used where required

31

Water & ice obtained from an approved source

32

IN

OUT

N/A

Variance obtained for specialized processing methods

Food Temperature Control

33

Proper cooling methods used; adequate equipment for temperature control

34

IN

OUT

N/A

N/O

Plant food properly cooked for hot holding

35

IN

OUT

N/A

N/O

Approved thawing methods used

36

X

Thermometers provided & accurate

Food Identification

37

Food properly labled; original container

Prevention of Food Contamination

38

Insects, rodents, & animals not present

39

Contamination prevented during food prep, storage & display

40

Personal cleanliness

41

Wiping cloths: properly used & stored

42

Washing fruits & vegetables

COS

R

Proper Use of Utensils

43

In-use utensils: properly stored

44

Utensils, equipment & linens: properly stored, dried, & handled

45

Single-use/single service articles: properly stored & used

46

Gloves used properly

Utensil Equipment and Vending

47

X

Food & non-food contact surfaces cleanable, properly designed, constructed, & used

48

X

Warewashing facilities: installed, maintained, & used; test strips

49

X

Non-food contact surfaces clean

Physical Facilities

50

Hot & cold water available; adequate pressure

51

Plumbing installed; proper backflow devices

52

Sewage & waste water properly disposed

53

Toilet facilities: properly constructed, supplied, & cleaned

54

Garbage & refuse properly disposed; facilities maintained

55

X

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)

Inspector (Signature)

Date:

11/28/23