Electronically Delivered

January 5, 2023

Licensee
Cardenas Friendship House
13808 County Road 5
Burnsville, MN 55337

RE: Project Number(s) SL20980015

Dear Licensee:

The Minnesota Department of Health completed an evaluation on December 29, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's

resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

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

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

Please address your cover letter for general reconsideration requests to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

Free from Maltreatment reconsideration requests should be addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

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

Sincerely,

Paul Spencer, Supervisor
Health Regulation Division
State Rapid Response Team
85 East Seventh Place, Suite 220
P.O. Box 64970
St. Paul, MN 55164-0970
Email: paul.spencer@state.mn.us
Phone: 651-587-4460 | Fax: 651-215-6894

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20980	A. BUILDING: _____ B. WING _____	12/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDENAS FRIENDSHIP HOUSE	13808 COUNTY ROAD 5 BURNSVILLE, MN 55337

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDERS In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL20980015 On December 27 through December 29, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were three residents receiving services under the provider's Provisional Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to comply with Minnesota Food Code. This had the potential to affect all three residents residing at the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Please refer to the additional documentation included in the Food and Beverage Establishment	0 480		

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0 480	Continued From page 2 Inspection Reports dated December 27, 2022. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	0 480		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post the required content in common areas to include: (1) required information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557, (2) required information related to the grievance procedure and contact information for the Office of Ombudsman for Long-Term Care and Mental Health and Developmental Disabilities, and (3) contact information for the Office of Health Facility Complaints. This had the potential to affect all three residents, staff, and visitors.	0 640		

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0 640	Continued From page 3 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee lacked a posting for the contact information or reporting number for the Minnesota Adult Abuse Reporting Center (MAARC) and the Office of Ombudsman for Long-Term Care (OOLTC) and Mental Health and Developmental Disabilities and the Office of Health Facility Complaints (OHFC). During a facility tour on December 27, 2022, at approximately 12:30 p.m., the surveyor observed the three common areas, living room, dining room and kitchen, shared by residents, staff and visitors, lacked the required posting related to reporting suspected maltreatment to MAARC and grievances to OOLTC. During an interview on December 27, 2022, at approximately 2:00 p.m., unlicensed person (ULP)-D stated she did not know where the posting information for MAARC or the OOLTC was located in the facility. ULP-D stated if she had concerns, she would let owner/licensed assisted living director (LALD)-A know. During an interview on December 27, 2022, at approximately 2:10 p.m., the LALD-A confirmed the required content noted above was not posted	0 640		

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0 640	Continued From page 4 as required but the information was located inside a three-ring binder resting on a side table in the living area out of view from the other common areas of the facility. The licensee policy titled 2.10 Complaint/Grievance Posting effective July 25, 2022, indicated the licensee will: 1) Post in a conspicuous place, information and the name, telephone number, and email contact information for the individual(s) who are responsible for handling resident complaint/grievances. 2) The posting will include the contact information for the Office of Ombudsman for Long Term Care and the Ombudsman for Mental Health and Development Disabilities. 3) The posting will also have the contact information for the Office of Health Facility Complaints. 4) The posting will include information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC). TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 640		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis	0 660		

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0 660	Continued From page 5 Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a comprehensive tuberculosis (TB) infection control prevention program according to the most current guidelines issued by the Centers for Disease Control (CDC), including a baseline TB testing for the presence of the infection with a two-step tuberculin skin test (TST) or single TB blood test for two employees, registered nurse (RN)-C, and for employee unlicensed person (ULP)-D, with records reviewed. This had the potential to affect all three residents receiving assisted living services, as well as staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). Findings include: RN-C's employee record indicated a hire date of June 2, 2022. RN-C's employee record lacked	0 660		

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0 660	Continued From page 6 evidence of a baseline test with either TST 2-step or a blood assay for tuberculosis upon hire for the licensee. ULP-D's employee record indicated a hire date of January 1, 2022. ULP-D ' s employee record lacked evidence of a baseline test with either TST 2-step or a blood assay for tuberculosis upon hire for the licensee. During an interview on December 27, 2022, at 11:50 a.m., RN-C stated she did not have a two-step or a blood assay test for tuberculosis upon hire but had one done previously. RN-C also stated she did not have any involvement in Tb testing for staff and the owner oversaw this activity. During an interview on December 27, 2022, at 12:10 p.m., owner/licensed assisted living director (LALD)-A stated all staff receive a Mantoux or QuantiFERON blood test for tuberculosis on hire and the registered nurse manages this activity. A policy titled Regulations for Tuberculosis Control in Minnesota Health Care Setting. Baseline Tuberculosis Screening dated July 2013, read November 1, 2021, read "Staff whose essential job functions require work within the same air space of home care clients will be screened and tested for tuberculosis prior to the staff being exposed to clients. Baseline (on hire) screening will be completed. New hires will have an IGRA blood test or two step Mantoux conducted with results documented on the baseline screening tool. TIME PERIOD TO CORRECT: Twenty-one (21) days.	0 660		

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0 770	Continued From page 7	0 770		
0 770 SS=D	144G.45 Subdivision 1 Minimum site Requirements The following are required for all assisted living facilities: (1) public utilities must be available, and working or inspected and approved water and septic systems must be in place; (2) the location must be publicly accessible to fire department services and emergency medical services; (3) the location's topography must provide sufficient natural drainage and is not subject to flooding; (4) all-weather roads and walks must be provided within the lot lines to the primary entrance and the service entrance, including employees' and visitors' parking at the site; and (5) the location must include space for outdoor activities for residents. This MN Requirement is not met as evidenced by: Based on observation, the licensee failed to maintain the facility physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors for the lower level. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and issued at n isolated scope. The findings include:	0 770		

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0 770	Continued From page 8 On December 28,2022, from approximately 0930am to 1030am, survey staff toured the facility with LALD-A. During the facility tour, survey staff observed the exit pathway out of the lower level to the driveway is blocked with snow and ice. LALD-A verbally confirmed survey staff observations during the facility tour. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 770		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing	0 780		

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0 780	Continued From page 9 smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure smoke alarms are interconnected so that actuation of one alarm causes all alarms in the dwelling to actuate as required. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and issued at a widespread scope. The findings include: On December 28,2022, between 0930 and 1030, survey staff toured the facility with LALD-A. During the facility tour, survey staff observed that all smoke detector's are not interconnected through-out the home. LALD-A verbally confirmed survey staff observations during the facility tour. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 780		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment	0 810		

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0 810	Continued From page 10 (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide the required fire safety training and evacuation plans for residents and staff. This has the potential to directly affect all	0 810		

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0 810	Continued From page 11 residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope. The findings include: On December 28,2022, from approximately 0930 to 1000, survey staff toured the facility with LALD-A. During the facility tour, survey staff observed the fire drills did not state time of the fire drills, only am and pm. During interview on December 28,2022 at 1020am, LALD-A stated the staff will start adding time of day to each fire drills from this point. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and	01500		

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01500	Continued From page 12 staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or	01500		

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	20980	A. BUILDING: _____ B. WING _____	12/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDENAS FRIENDSHIP HOUSE	13808 COUNTY ROAD 5 BURNSVILLE, MN 55337

(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
01500	Continued From page 13 (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received at least eight hours of annual training for each 12 months of employment for one of one unlicensed personnel (ULP-D) records reviewed. This had the potential to affect all three residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an 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). Findings include: ULP-D's employee record indicated a hire date of January 1, 2022. ULP-D's training transcript includes online training ending on August 4, 2021, and no other classes were recorded after that date. ULP-D's record lacked evidence of receiving at least a minimum 8 hours of training per the last 12 months of employment. ULP-D's file lacked evidence ULP-D completed annual training for 2022 to include the following content:	01500		

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01500	Continued From page 14 -training on reporting of maltreatment of vulnerable adults under section 626.557; -review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; -review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; -effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; -review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. On December 27, 2022, at 12:10 p.m., during the entrance conference, the licensed assisted living director (LALD)-A, acknowledged current assisted living laws and regulations. On December 28, 2022, at 12:45 p.m., LALD-A stated they use Educare online training and verified ULP-D did not complete the required annual trainings. LALD-A stated the required trainings would be added to ULP-D ' s transcript list to be completed.	01500		

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01500	Continued From page 15 Licensee provided policy titled 5.06 Annual Required Staff Training, effective date August 1, 2021, indicated All staff that perform direct care services at Cardenas Friendship Homes will complete at least eight (8) hours of annual training for each 12 months of employment. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	01500		
01530 SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for	01530		

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01530	Continued From page 16 each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure completion and documentation of required dementia training for two of two employees (RN-C and ULP-D) records reviewed. This had the potential to affect all three residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include: RN-C's employee record indicated a hired date of June 2, 2022. RN-C's training transcript includes an online training class titled, Dementia - Person centered care completed on June 6, 2022, for 0.75 contact hour. No other dementia classes were noted. ULP-D's employee record indicated hired on January 1, 2022. ULP-D's employee record lacked evidence of receiving at least eight hours total for dementia training within of a total 120 working hours as required. ULP-D's training transcript includes an online training class titled, Dementia Overview	01530		

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CARDENAS FRIENDSHIP HOUSE	13808 COUNTY ROAD 5 BURNSVILLE, MN 55337

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01530	Continued From page 17 completed on August 4, 2021, for 1 contact hour. No other dementia classes were noted. ULP-D's employee record lacked evidence of receiving at least eight hours total for dementia training within of a total 160 working hours as required. On December 27, 2022, at 12:10 p.m., licensed assisted living director (LALD)-A, affirmed knowledge of the current assisted living laws and regulations. On December 28, 2022, at 12:45 p.m., LALD-A stated each employee had an individual personnel file that included orientation and training documentation and verified the required trainings were not completed. The licensee's Dementia Training policy effective date August 1, 2021, indicated supervisors would complete a minimum of eight hours of initial dementia training within 120 hours of employment and direct care staff would complete a minimum of eight hours of initial dementia training on within 160 working hours of the employment start date. The training would include the topics of an explanation of Alzheimer's disease and other dementia's, assistance with activities of daily living, problem solving with challenging behaviors, communication skills and person-centered planning and service delivery. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	01530		
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication	01730		

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01730	Continued From page 18 management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management.	01730		

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01730	Continued From page 19 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop an individualized medication management plan with the required content for two of two residents (R2, R3) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2 started receiving services on November 16, 2022, under the current assisted living facility license. R2's diagnoses included Parkinson's. R2's uniform assessment tool dated October 25, 2022, indicated R2 depended on staff for medication administration but most of the medication section was left blank. A review of R2 ' s record indicated that an individualized medication plan was not in R2 ' s record. R3 started receiving assisted living services on October 20, 2022, under the current assisted living facility license. R3's diagnoses included chronic obstructive pulmonary disease (COPD). R3's service plan dated October 25, 2022, indicated R3 received services which included	01730		

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01730	Continued From page 20 medication administration. A review of R3 's record indicated that an individualized medication plan was not in R3's record. On December 27, 2022, at 11:35 a.m., registered nurse (RN)-C verified that staff administered medications to R2 and R3 and both should have had a medication assessment completed. The licensee's 7.01 Medication Management - Assessment policy dated August 1, 2021, indicated: 1) The assessment must be conducted face-to-face with the resident by an RN. 2) The assessment must include an identification and review of all medications the resident is known to be taking. 3) The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. 4) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. ** "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. TIME PERIOD FOR CORRECTION: Seven (7) days.	01730		

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01880	Continued From page 21	01880		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure all medications were securely locked in substantially constructed compartments and permit only authorized personnel had access. This had the potential to affect all three (3) residents in the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On December 27, 2022, at 11:35 a.m., the closet containing all resident medications was observed. Registered nurse (RN)-C took keys from a plastic storage drawer in the dining area which was accessible to all staff, residents, and visitors. RN-C proceeded to unlock the medication closet. Inside the closet, a narcotic medication lock box with a three-digit combination lock was inspected and found to be unlocked. The box contained multiple narcotic medications prescribed to	01880		

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01880	Continued From page 22 residents of the facility. On December 27, 2022, at 12:05 p.m., after completion of the entrance conference, RN-C verified that the keys should be kept on the staff person passing the medication for the day and the narcotic lock box inside the closet should be locked. On December 28, 2022, at 12:30 p.m., unlicensed person (ULP)-D was asked to open the medication closet. ULP-D opened the closet, and the narcotic lock box was inspected. The lock box was unlocked and easily opened. ULP-D stated that she was sure she locked it after the last use but must have not moved the combination locks far enough. The licensee's 7.11 Medication Storage policy dated August 1, 2021, indicated medications would be kept securely locked and stored per manufacturer's directions and only authorized staff would have access to stored medications. In addition, schedule II Drugs (narcotics) will be stored under a double lock system and stored separately from other medications. TIME PERIOD FOR CORRECTION: Seven (7) days.	01880		

Minnesota Department of Health
Environmental Health, FPLS
P.O Box 64975
Saint Paul
651-201-4500

Type: Full
Date: *12/27/22*
Time: 08:28:39
Report: 1018221199

Food and Beverage Establishment Inspection Report

Location:
Cardenas Friendship House
13808 County Road 5
Burnsville, MN55337
Dakota County, 19

Establishment Info:
ID #: 0038217
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6126701380
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 IS NOT CURRENTLY RECORDING INSTANCES OF ILLNESS WITH FOOD WORKERS. COMPLY WITH RULE. ILLNESS LOG SENT WITH REPORT.

Comply By: 12/28/22

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

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

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

RAW EGGS OBSERVED TO BE STORED OVER READY TO EAT FOODS IN THE REFRIGERATOR. COMPLY WITH RULE.

Comply By: 12/28/22

4-700 Sanitizing Equipment and Utensils

4-702.11 ** Priority 1 **

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

DISHES ARE NOT BEING SANITIZED AFTER CLEANING. ESTABLISHMENT DOES NOT HAVE A DISHWASHER OR AN APPROVED 3 COMPARTMENT SINK. DISCUSSED WITH THE MANAGER THE REQUIREMENT FOR ONE OR THE OTHER AND THE SANITIZING REQUIREMENT. COMPLY WITH RULE.

Comply By: 12/28/22

3-500C Microbial Control: date marking

3-501.17B ** Priority 2 **

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

NO DATE MARKS OBSERVED IN THE REFRIGERATOR. DISCUSSED 7 DAY DATE MARKING PROCEDURE WITH MANAGER. COMPLY WITH RULE.

Comply By: 12/28/22

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.115AB ** Priority 2 **

MN Rule 4626.1585AB Remove all live animals from the establishment except as specified in rule.

LIVE DOG OBSERVED TO HAVE FREE RANGE OF THE KITCHEN AREA. DISCUSSED WITH THE MANAGER TO BLOCK OFF THE KITCHEN AREA SO THAT THE DOG MAY NOT HAVE ENTRY. (ESTABLISHMENT IS A RESIDENTIAL HOME)

Comply By: 12/28/22

Food and Equipment Temperatures

Process/Item: Cold Holding/ CHEESE
Temperature: 40 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: No

Process/Item: Cold Holding/ DELI MEAT
Temperature: 40 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: No

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

INSPECTION CONDUCTED WITH CHRISTINE BLUHM (HRD) PRESENT.

THIS ESTABLISHMENT IS A RESIDENTIAL HOME WITH A RESIDENTIAL KITCHEN. PHYSICAL FACILITIES WERE OBSERVED TO BE IN GOOD CONDITION.

DISCUSSED SAME DAY SERVICE FOR COOKED FOODS AND ILLNESS POLICY.

A SANITIZING PROCEDURE FOR DISHES WAS ESTABLISHED WHILE THE MANAGER MAKES ARRANGEMENTS TO HAVE A DISHWASHER INSTALLED.

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1018221199 of 12/27/22.

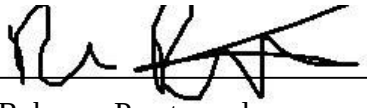
Certified Food Protection Manager: JESSE JOSEPH WOLF

Certification Number: FM105865 Expires: 04/09/24

Inspection report reviewed with person in charge and emailed.

Signed: _____

JESSE WOLF
MANAGER

Signed: 

Rebecca Prestwood
Sanitarian 3
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rebecca.prestwood@state.mn.us