



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

April 18, 2025

Licensee

Jmkay Healthcare Services Inc.

2318 55th Avenue North

Brooklyn Center, MN 55430

RE: Project Number(s) SL33608015

Dear Licensee:

On March 21, 2025, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on September 18, 2024, and the follow-up survey completed on December 19, 2024. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the September 18, 2024 survey.

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

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on September 18, 2024, found not corrected at the time of the March 21, 2025, follow-up survey and/or subject to penalty assessment are as follows:

1290 - Background Studies Required - 144g.60 Subdivision 1

The details of the violations noted at the time of this follow-up survey completed on March 21, 2025 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

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 outlined on the state form; however, plans of correction are not required to be submitted for approval.

IMPOSITION OF FINES:

Level 1: no fines or enforcement.

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in §144G.20 for widespread violations;

Level 3: a fine of \$3,000 per violation per incident, in addition to any enforcement mechanism authorized in §144G.20.

Level 4: a fine of \$5,000 per incident, in addition to any enforcement mechanism authorized in

§144G.20.

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

To submit a hearing request, please visit:

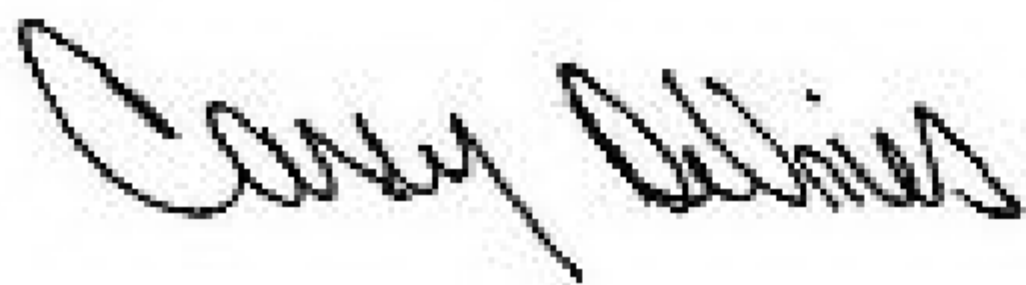
<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration or a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

We urge you to review these orders carefully. If you have questions, please contact Casey DeVries at 651-201-5917.

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

Sincerely,



Casey DeVries, Supervisor
State Evaluation Team
Email: casey.devries@state.mn.us
Telephone: 651-201-5917 Fax: 1-866-890-9290

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 03/21/2025
NAME OF PROVIDER OR SUPPLIER JMKAY HEALTHCARE SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2318 55TH AVENUE NORTH BROOKLYN CENTER, MN 55430		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
{0 000}	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS SL33608015-2 On March 19, 2025, through March 21, 2025, the Minnesota Department of Health conducted a second follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on September 18, 2024, and a follow-up survey completed December 19, 2024. At the time of the survey, there were two residents; both received services under the provider's Assisted Living license. As a result of the follow-up survey, the following orders were reissued.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
{0 480} SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	{0 480}			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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{0 480}	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are	{0 480}			

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{0 480}	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by:	{0 480}	Not reviewed during this survey.		
{0 485} SS=C	144G.41 Subdivision 1.a (a) Minimum requirements; required food services All assisted living facilities must offer to provide or make available 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 menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes. The facility must not require a resident to include and pay for meals in the resident's contract. This MN Requirement is not met as evidenced by:	{0 485}			

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{0 485}	Continued From page 3	{0 485}	Not reviewed during this survey.		
{0 630} SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by:	{0 630}			
{0 810} SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff 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.	{0 810}			

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{0 810}	Continued From page 4 (c) Staff 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 staff 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:	{0 810}			
{0 970} SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by:	{0 970}	Not reviewed during this survey.		
			Not reviewed during this survey.		

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{01060}	Continued From page 5	{01060}			
{01060} SS=C	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not	{01060}			

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{01060}	Continued From page 6 returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by:	{01060}	Not reviewed during this survey.		
{01290} SS=E	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure background studies were affiliated with the assisted living facility license for five of nine employees (unlicensed personnel (ULP)-M, ULP-N, ULP-O, ULP-P, registered nurse (RN)-Q).	{01290}			

Minnesota Department of Health

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{01290}	Continued From page 7 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On March 19, 2025, at 2:58 p.m., via telephone interview, the surveyor initiated the follow up survey and requested licensed assisted living director (LALD)-C send the NETStudy 2.0 roster (web-based system used to submit background study requests to the Department of Human services (DHS)), via email, as soon as possible. At 3:21 p.m., the surveyor sent an email to LALD-C, requesting an employee roster, a current resident roster, a discharge resident roster, and repeated the request for the NETStudy 2.0 roster. At 4:18 p.m., the surveyor called LALD-C to inquire about the status of the requested documents. The unidentified person who answered the phone, stated LALD-C was in a meeting and would call back. No call was received. At 11:11 p.m., the surveyor received an email from LALD-C with the requested information. The Employee List, dated March 19, 2025, indicated the following: - ULP-M was hired to provide direct assisted living services to the licensee's residents on June 6, 2024; - ULP-N was hired to provide direct assisted living services to the licensee's residents on	{01290}			

Minnesota Department of Health

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{01290}	Continued From page 8 February 3, 2025; - ULP-O was hired to provide direct assisted living services to the licensee's residents on July 1, 2019; - ULP-P was hired to provide direct assisted living services to the licensee's residents on November 25, 2024; and - RN-Q was hired to provide supervision and direct assisted living services to the licensee's residents on October 11, 2017. The licensee's NETStudy 2.0 roster, printed March 19, 2025, at 8:46 p.m., indicated ULP-M, ULP-N, ULP-O, ULP-P, and RN-Q were affiliated to the licensee's Health Facility Identification (HFID) number on March 19, 2025, the same date the NETStudy 2.0 roster was requested by the surveyor. In addition, a person search in NETStudy 2.0 roster for ULP-M, ULP-N, ULP-O, ULP-P, and RN-Q indicated the following: - ULP-M was affiliated with another license number operated under the same ownership umbrella as the licensee. ULP-M was affiliated with the licensee's HFID number on March 19, 2025, at 3:34 p.m., after the NETStudy 2.0 roster was requested by the surveyor; - ULP-N was affiliated with another license number operated under the same ownership umbrella as the licensee. ULP-N was affiliated with the licensee's HFID number on March 19, 2025, at 3:19 p.m., after the NETStudy 2.0 roster was requested by the surveyor; - ULP-O was affiliated with another license number operated under the same ownership umbrella as the licensee. ULP-O was affiliated with the licensee's HFID number on March 19, 2025, at 3:33 p.m., after the NETStudy 2.0 roster was requested by the surveyor; - ULP-P was affiliated with another license number operated under the same ownership	{01290}			

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{01290}	Continued From page 9 umbrella as the licensee. ULP-P was affiliated with the licensee's HFID number on March 19, 2025, at 3:17 p.m., after the NETStudy 2.0 roster was requested by the surveyor; and - RN-Q was affiliated with another license number operated under the same ownership umbrella as the licensee. RN-Q was affiliated with the licensee's HFID number on March 19, 2025, at 3:33 p.m., after the NETStudy 2.0 roster was requested by the surveyor. On March 20, 2025, at 1:21 p.m., LALD-C stated he went "back and forth" with DHS background study staff, and stated it took a long time. When asked if ULP-M, ULP-N, ULP-O, ULP-P, and RN-Q were affiliated after the surveyor requested the NETStudy 2.0 roster, LALD-C stated, "I have to ask the manager," and stated he would call back. At 2:46 p.m., the surveyor sent an email to LALD-C, asking for a return phone call by 4:30 p.m. No phone call was received. At 4:39 p.m., the surveyor attempted to call LALD-C but received no answer. The surveyor received a text message from LALD-C at that time, asking if they could call later. The surveyor left a voice message, asking LALD-C to call back as soon as possible. No phone call was received. On March 21, 2025, at 7:58 a.m., via phone interview, LALD-C stated all employees completed a background study upon hire and they understood that employees needed to be affiliated with the HFID number of the facility where they worked. LALD-C stated there was a delay with DHS and stated the staffing manager submitted the above employees to affiliate them with the licensee's HFID, so they were not sure why it showed staff were not affiliated until March 19, 2025, after the surveyor requested the NETStudy 2.0 roster. LALD-C stated they would	{01290}			

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{01290}	Continued From page 10 send the surveyor emails as "proof" for the surveyor to review. At 9:41 a.m., the surveyor received an email from LALD-C with correspondences between them and DHS dated December 23, 2024, through March 5, 2025. At 10:10 a.m., via phone interview, LALD-C stated, "I can't really say," when asked if the above employees were affiliated to the licensee's HFID number after the surveyor requested the NETStudy 2.0 roster, and stated, "They are now affiliated." When asked if he could provide the original background study clearance letters for ULP-M, ULP-N, ULP-O, ULP-P, and RN-Q, LALD-C stated he had them and would send them; however, the surveyor received no further emails or phone calls from LALD-C. The licensee's Background Check policy updated on May 10, 2024, indicated all individuals hired or providing services in the facilities would undergo a criminal background check prior to employment or engagement; and the licensee would be in compliance with Minnesota Statue 144G for assisted living. No further information was provided.	{01290}			
{01610} SS=F	144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on	{01610}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 03/21/2025
NAME OF PROVIDER OR SUPPLIER JMKAY HEALTHCARE SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2318 55TH AVENUE NORTH BROOKLYN CENTER, MN 55430		
(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	
{01610}	Continued From page 11 which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. This MN Requirement is not met as evidenced by:	{01610}	Not reviewed during this survey.		
{01620} SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a	{01620}			

Minnesota Department of Health

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{01620}	Continued From page 12 facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by:	{01620}	Not reviewed during this survey.		
{01760} SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by:	{01760}			
{01910} SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal.	{01910}			

Minnesota Department of Health

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{01910}	Continued From page 13 (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by:	{01910}	Not reviewed during this survey.		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

February 11, 2025

Licensee

Jmkay Health Care Services INC
2318 55th Avenue North
Brooklyn Center, MN 55430

RE: Project Number(s) SL33608015

Dear Licensee:

On December 19, 2024, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on September 18, 2024. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the September 18, 2024 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on September 18, 2024, found not corrected at the time of the December 19, 2024, follow-up survey and/or subject to penalty assessment are as follows:

0485-Minimum Requirements; Required Food Services-144g.41 Subdivision 1.A (a)
0630-Compliance With Requirements For Reporting Ma-144g.42 Subd. 6 (b)
0970-Waivers Of Liability Prohibited-144g.50 Subd. 5
1620-Initial Reviews, Assessments, And Monitoring-144g.70 Subd. 2 (c-E) - \$500.00

The details of the violations noted at the time of this follow-up survey completed on December 19, 2024 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Also, at the time of this follow-up survey completed on December 19, 2024, we identified the following violation(s):

0110-Assisted Living Director License Required-144g.10 Subdivision 1a
1290-Background Studies Required-144g.60 Subdivision 1 - \$3,000.00
1610-Initial Reviews, Assessments, And Monitoring-144g.70 Subd. 2 (a-B)
1760-Documentation Of Administration Of Medication-144g.71 Subd. 8

The details of the violation(s) noted at the time of this follow-up survey are delineated on the attached State Form. Only the ID Prefix Tag in the left hand column without brackets will identify these state correction orders. It is not necessary to develop a plan of correction.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are**

assessed is \$3,500.00. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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 outlined on the state form; however, plans of correction are not required to be submitted for approval.

IMPOSITION OF FINES:

Level 1: no fines or enforcement.

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in §144G.20 for widespread violations;

Level 3: a fine of \$3,000 per violation per incident, in addition to any enforcement mechanism authorized in §144G.20.

Level 4: a fine of \$5,000 per incident, in addition to any enforcement mechanism authorized in §144G.20.

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

To submit a hearing request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

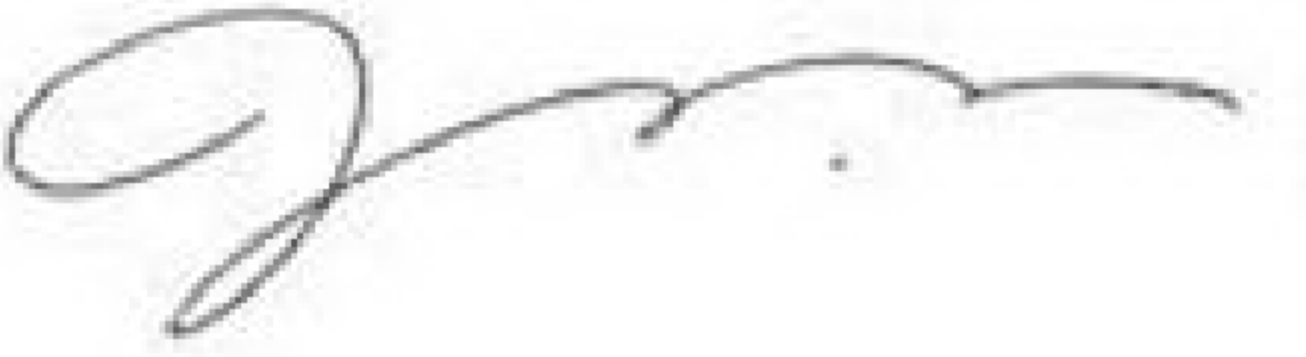
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration or a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

We urge you to review these orders carefully. If you have questions, please contact Jess Schoenecker

at 651-201-3789.

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

Sincerely,

A handwritten signature in black ink, appearing to read 'Jess', with a horizontal line extending to the right.

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

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 12/19/2024
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{0 000}	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been 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: SL33608015-1 On December 16, 2024, through December 19, 2024, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on September 18, 2024. At the time of the survey, there was one resident receiving services under the Assisted Living license. As a result of the follow-up survey, the following orders were issued or reissued. An immediate correction order was issued for tag identification number 1290 on December 17, 2024. During the course of the survey, the licensee took action to mitigate the immedite risk. Noncompliance remained and the scope and level remain unchanged.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 110	Continued From page 1	0 110			
0 110 SS=C	144G.10 Subdivision 1a Assisted living director license required Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensed assisted living director (LALD) was listed as the Director of Record for the licensee through the Board of Executives for Long-Term Service and Supports (BELTSS) website. This had the potential to affect all the licensee's residents, staff, and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: On December 16, 2024, at 7:19 a.m., the BELTSS website indicated the health facility identification number (HFID) 33608 had LALD-C listed as the director of record, but this had ended on October 31, 2022. The website did not list another LALD as the director of record for the licensee's HFID. On December 16, 2024, at 10:29 a.m., LALD-C stated they were told they did not have a director	0 110			

Minnesota Department of Health

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0 110	Continued From page 2 of record listed with BELTSS for the licensee's HFID at the last survey in September, however, they did not have any active residents at that time. On December 16, 2024, at 10:35 a.m., the BELTSS website indicated LALD-C was issued a license on September 21, 2021, with an expiration date of October 31, 2025. On December 19, 2024, at 4:01 p.m., LALD-C stated they were still waiting to hear back from BELTSS, and they had planned to get the director of record information updated with BELTSS. On December 19, 2024, at 4:40 p.m., LALD-C stated they were on the BELTSS website at that time and were going to update the BELTSS website that day to indicate the director of record for the license. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110			
{0 480} SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius	{0 480}			

Minnesota Department of Health

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{0 480}	Continued From page 3 and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be	{0 480}			

Minnesota Department of Health

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{0 480}	Continued From page 4 provided with a self-closing door. This MN Requirement is not met as evidenced by:	{0 480}	Not reviewed during survey.		
{0 485} SS=C	144G.41 Subdivision 1.a (a) Minimum requirements; required food services All assisted living facilities must offer to provide or make available 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 menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes. The facility must not require a resident to include and pay for meals in the resident's contract. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee's assisted living contract required the resident to pay for meals for one of one resident (R2). This had the potential to affect all residents. 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	{0 485}			

Minnesota Department of Health

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{0 485}	Continued From page 5 or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: On December 16, 2024, at 10:21 a.m., licensed assisted living director (LALD)-C provided to surveyor, the licensee's plan of correction from previous survey dated September 18, 2024. The licensee's plan of correction indicated the licensee revised the contract and updated the contract to the current standards for all residents. Also, the plan of correction indicated the administrative manager would follow up on the policy and procedure to ensure the contract was reviewed and signed by the residents. R2 was admitted to licensee on November 8, 2024, with diagnosis of schizophrenia bipolar (extreme mood swings) type. R2's [licensee] Assisted Living Contract signed November 8, 2024, indicated three (3) meals per day was included in the basic monthly fee. On December 16, 2024, at 12:35 p.m., LALD-C stated [R2] does get three meals per day and sometimes more than three meals per day. LALD-C stated they would change it on the contract going forward and would have R2 sign a new contract. No further information provided.	{0 485}			
{0 630} SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an	{0 630}			

Minnesota Department of Health

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{0 630}	Continued From page 6 individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement an individual abuse prevention plan (IAPP) with required content for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On December 16, 2024, at 10:21 a.m., licensed assisted living director (LALD)-C provided to surveyor, the licensee's plan of correction from previous survey dated September 18, 2024. The licensee's plan of correction under 0630 indicated the licensee had initiated compliance and requirement for reporting when a resident was hospitalized for more then four days. The licensee's plan of correction did not address the	{0 630}			

Minnesota Department of Health

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{0 630}	Continued From page 7 individual adult prevention plan and the required content per Minnesota Statue. R2 was admitted to licensee on November 8, 2024, with diagnosis of schizophrenia bipolar (extreme mood swings) type. R2's IAPP dated November 7, 2024, failed to address if R2 was at risk of abusing other vulnerable adults and specific measures the licensee would take to minimize the risk. On December 16, 2024, at 2:56 p.m., registered nurse (RN)-G stated they were limited due to using paper and not the licensee's electronic documenting system which was better and stated this was an oversight. The licensee's Individual Abuse Prevention policy updated August 1, 2024, indicated the licensee's IAPP risk assessment would include assessment of the resident's susceptibility to abuse by others, including other vulnerable adults. The policy did not indicate all the required content of an IAPP that included assessment of the resident's risk for abusing other vulnerable adults. No further information provided.	{0 630}			
{0 810} SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency;	{0 810}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 12/19/2024
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{0 810}	Continued From page 8 (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) Staff 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 staff 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:	{0 810}			
{0 970} SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a	{0 970}	Not reviewed during the survey.		

Minnesota Department of Health

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{0 970}	Continued From page 9 lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for the health, safety, or personal property of a resident for one of one resident (R2). This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: On December 16, 2024, at 10:21 a.m., licensed assisted living director (LALD)-C provided to surveyor, the licensee's plan of correction from previous survey dated September 18, 2024. The licensee's plan of correction under 0970 indicated the licensee had revised and updated the assisted living contract regarding the language warning that licensee's liability for health, safety, and personal property of residents. The plan of correction did not specify what the language indicated regarding the licensee's liability. R2 was admitted to licensee on November 8, 2024, with diagnosis of schizophrenia bipolar (extreme mood swings) type.	{0 970}			

Minnesota Department of Health

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{0 970}	Continued From page 10 R2's [licensee] Assisted Living Contract signed November 8, 2024, read under the Miscellaneous Provisions section for 1. Insurance Liability and Release, "the resident agrees that [licensee] will not be liable to the resident for any personal injury or property damage." Additionally, the section Indemnification read, "[licensee] shall not be liable for any damage or injury to the resident ... or to any property." On December 16, 2024, at 12:35 p.m. licensed assisted living director (LALD)-C stated they had reviewed the licensee's citation from their last survey; however, it was confusing as they thought the contract seemed good. No further information provided.	{0 970}			
{01060} SS=C	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is	{01060}			

Minnesota Department of Health

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{01060}	Continued From page 11 expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by:	{01060}			
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be	01290	Not reviewed during the survey.		

Minnesota Department of Health

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01290	Continued From page 12 classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study was conducted prior to staff providing services for four of nine employees (unlicensed personnel (ULP)-I, ULP-J, ULP-K, ULP-L)). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's undated [house name] staff list was provided to the surveyor on December 16, 2024, at 3:03 p.m. Licensed assisted living director (LALD)-C stated the roster was updated to include all current staff that would come to the facility with their hire dates. The licensee's [house name] staff list included ULP-I, ULP-J, ULP-K, ULP-L. ULP-I ULP-I was hired on August 27, 2021, as a home	01290	During the course of the survey, the licensee took action to mitigate the immediate risk. Noncompliance remained and the scope and level remain unchanged.		

Minnesota Department of Health

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01290	Continued From page 13 health aide (HHA). ULP-I's employee record lacked evidence of a completed background study clearance as required prior to providing services for the licensee's residents. ULP-J ULP-J was hired on September 4, 2023, as an administrator. ULP-J's employee record lacked evidence of a completed background study clearance as required prior to providing services for the licensee's residents. ULP-K ULP-K was hired on May 12, 2021, as a home health aide (HHA). ULP-K's employee record lacked evidence of a completed background study clearance as required prior to providing services for the licensee's residents. ULP-L ULP-L was hired on January 29, 2021, as a certified nursing assistant (CNA)/home health aide (HHA). ULP-L's employee record lacked evidence of a completed background study clearance as required prior to providing services for the licensee's residents. On December 17, 2024, at 1:10 p.m., LALD-C stated [ULP-J] was currently working for licensee and would be the person to complete all paperwork with residents. LALD-C stated [ULP-I, ULP-K and ULP-L] have worked and would	01290			

Minnesota Department of Health

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01290	Continued From page 14 continue to work at this facility to provide direct care to residents. On December 17, 2024, at 2:22 p.m., LALD-C stated they think they understood regarding the missing backgrounds but then stated they were a little confused as the licensee currently managed three different accounts for their staff and then requested a few minutes from the surveyor. On December 17, 2024, at 3:25 p.m., LALD-C stated the background check was the very first thing the licensee does for every new employee; and the licensee was not aware the backgrounds needed to be affiliated to each facility and the background would no longer be good after a facility closed or was changed to a different license. LALD-C stated they understood the background process going forward. The licensee's Background Check policy updated on May 10, 2024, indicated all individuals hired or providing services in the facilities would undergo a criminal background check prior to employment or engagement; and the licensee would be in compliance with Minnesota Statue 144G for assisted living. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	01290			
01610 SS=F	144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a	01610			

Minnesota Department of Health

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01610	Continued From page 15 nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed an initial assessment prior to the date on which a prospective resident executed a contract with a facility or on the day the resident moved in for one of one resident (R2). Also, the licensee failed to ensure a registered nurse (RN) completed comprehensive assessments to include all required content identified per Minnesota Administrative Rule 4659.0150 Uniform Assessment Tool for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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).	01610			

Minnesota Department of Health

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01610	Continued From page 16 The findings include: R2 was admitted to licensee on November 8, 2024, with diagnosis of schizophrenia bipolar (extreme mood swings) type. R2's Assisted Living Contract was signed on November 8, 2024. R2's Home Care Service Plan dated November 8, 2024, indicated R2 received assistance with personal cares and medication administration services. On December 17, 2024, at 7:05 a.m., the surveyor observed unlicensed personnel (ULP)-H assist with medication administration for R2. R2's Admission Nurse Note dated November 9, 2024, was indicated by registered nurse (RN)-G to be R2's initial assessment. The initial assessment was completed one day after R2 signed a contract with the licensee and one day after R2 had moved into the facility. Also, R2's initial assessment indicated no acute changes in her physical condition however this was the first assessment completed by the licensee's nurse. In addition, R2's initial assessment lacked the following information as required per Minnesota Administrative Rule 4659.0150 Uniform Assessment Tool: - lifestyle choices to included sleep, culture preferences, advance directive, do not resuscitate (DNR); - activity of daily living (ADL's) to include toileting pattern, bladder/bowel control, dressing, grooming, hygiene, assistive devices, eating, dental status, and oral care needs; - independent activities of daily living (IALD's) to include housework, laundry, transportation,	01610			

Minnesota Department of Health

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01610	Continued From page 17 self-management of medications; - physical status to include allergies, weight, hospitalizations and emergency room visits in the past 12 months; - cognition assessment to include decision making status and ability; - communication and sensory capabilities in include hearing, vision, speech, assistive communication and sensory devices, hearing aids, and the ability to understand and be understood; - skin conditions; - hydration status; - risk factors to include falls, emergency evacuation ability, complex medication regimen, risk for dehydration, history of urinary tract infection (UTI), current fluid intake pattern, risk for emotional or psychological distress due to personal losses, unsuccessful prior placements, elopement risk, history of previous elopements, smoking (include ability without causing harm to self/others/property), and drug/alcohol use; and - decision making authority to include presence of legal document and scope of decision-making authority. R2's notes dated November 8, 2024, at 1:17 p.m. (electronically signed on December 16, 2024, at 1:25 p.m., after the initiation of survey), indicated resident had moved into the facility and staff took R2's vital signs, assisted R2 with putting away their clothes, R2 had lunch and then went out, R2 came back home around 5:00 p.m., ate dinner, and took their bedtime medications. R2's notes did not indicate they were seen by a nurse for assessment. R2's notes dated November 8, 2024, at 1:05 p.m. (electronically signed on December 16, 2024, at 1:10 p.m., after the initiation of survey) indicated	01610			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 12/19/2024
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01610	Continued From page 18 R2 went to bed at 9 p.m., woke up at 7:00 a.m., had coffee and a cigarette and then went out. R2's notes did not indicate they were seen by a nurse for assessment. R2's notes dated November 9, 2024, at 7:50 p.m. (electronically signed on November 9, 2024, at 8:01 p.m.) indicated R2 had returned home at 11:30 a.m.; and the nurse and director were notified when R2 arrived. On December 16, 2024, at 11:16 a.m., licensed assisted living director (LALD)-C stated the admission nurse note was the licensee's assessment for R2 and stated the licensee had completed the assessments on paper to save time. On December 16, 2024, at 2:41 p.m., registered nurse (RN)-G stated the licensee had a program they normally used for assessments but were not using it for this location since they had not had any residents at this facility for a while. RN-G stated the licensee planned to re-implement the program as it had the required content for the uniform assessment tool and was better to use then the forms. On December 16, 2024, at 2:52 p.m., RN-G stated most of the time, the nurse is at the facility when a person was admitted otherwise the resident would not get their medications. RN-G stated they thought it may be an error on the date documented on the assessment. The licensee's Assessment and Reassessment policy dated August 1, 2021, indicated the initial RN assessment should be completed prior to the date on which the prospective resident executed a contract or on the date on which the	01610			

Minnesota Department of Health

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01610	Continued From page 19 prospective resident moved in. Also, the policy read, "The RN will provide the admission visit, conduct and document** a comprehensive assessment*** and prepare a care plan based on the comprehensive evaluation." The policy did not identify required content per the Minnesota Rule 4659.0150 Uniform Assessment Tool for each comprehensive assessment completed by the RN. Minnesota Administrative Rule 4659.0140, subpart 2, B., (3) dated August 11, 2021, indicated the nursing assessment or reassessment must be conducted using a uniform assessment tool that complied with part 4659.0150. Minnesota Administrative Rule 4659.0150, subpart 2 dated August 11, 2021, indicated the required elements of the uniform assessment tool to comprehensively evaluate a resident's physical, mental, and cognitive needs. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01610			
{01620} SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living	{01620}			

Minnesota Department of Health

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{01620}	Continued From page 20 services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a registered nurse (RN) completed comprehensive assessments to include all required content identified per Minnesota Administrative Rule 4659.0150 Uniform Assessment Tool for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: R2	{01620}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 12/19/2024
NAME OF PROVIDER OR SUPPLIER JMKAY HEALTHCARE SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2318 55TH AVENUE NORTH BROOKLYN CENTER, MN 55430		
(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	
{01620}	Continued From page 21 R2 was admitted to licensee on November 8, 2024, with diagnosis of schizophrenia bipolar (extreme mood swings) type. R2's Home Care Service Plan dated November 8, 2024, indicated R2 received assistance with personal cares and medication administration services. On December 17, 2024, at 7:05 a.m., the surveyor observed unlicensed personnel (ULP)-H assist with medication administration for R2. R2's 14-Day Follow Up Nurse Note dated November 22, 2024, lacked the following information as required: - lifestyle choices to included sleep, culture preferences, advance directive, do not resuscitate (DNR); - activity of daily living (ADL's) to include toileting pattern, bladder/bowel control, dressing, grooming, hygiene, assistive devices, eating, dental status, and oral care needs; - independent activities of daily living (IALD's) to include housework, laundry, transportation, self-management of medications; - physical status to include health history, allergies, weight, hospitalizations and emergency room visits in the past 12 months; - cognition assessment to include decision making status and ability; - communication and sensory capabilities in include hearing, vision, speech, assistive communication and sensory devices, hearing aids, and the ability to understand and be understood; - skin conditions; - hydration status; - risk factors to include falls, emergency evacuation ability, complex medication regimen,	{01620}			

Minnesota Department of Health

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{01620}	Continued From page 22 risk for dehydration, history of urinary tract infection (UTI), current fluid intake pattern, risk for emotional or psychological distress due to personal losses, unsuccessful prior placements, elopement risk, history of previous elopements, smoking (include ability without causing harm to self/others/property), and drug/alcohol use; and - decision making authority to include presence of legal document and scope of decision-making authority. On December 16, 2024, at 11:16 a.m., licensed assisted living director (LALD)-C stated the 14-day Follow Up Nurse Note was the licensee's nurse assessment for R2 and stated the licensee had completed the assessments on paper to save time. On December 16, 2024, at 2:41 p.m., registered nurse (RN)-G stated the licensee had a program they normally used for assessments but were not using it for this location since they had not had any residents at this facility for a while. RN-G stated the licensee planned to re-implement the program as it had the required content for the uniform assessment tool and was better to use then the forms. The licensee's Assessment and Reassessment policy dated August 1, 2021, indicated the RN would provide a reassessment visit to update the evaluation of the resident and services no more then 14 days after the initiation of services. Also, the policy read, "The RN will provide the admission visit, conduct and document** a comprehensive assessment*** and prepare a care plan based on the comprehensive evaluation." The policy lacked to identify required content per the Minnesota Rule 4659.0150 Uniform Assessment Tool for each	{01620}			

Minnesota Department of Health

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{01620}	Continued From page 23 comprehensive assessment completed by the RN. Minnesota Administrative Rule 4659.0140, subpart 2, B., (3) dated August 11, 2021, indicated the nursing assessment or reassessment must be conducted using a uniform assessment tool that complied with part 4659.0150. Minnesota Administrative Rule 4659.0150, subpart 2 dated August 11, 2021, indicated the required elements of the uniform assessment tool to comprehensively evaluate a resident's physical, mental, and cognitive needs. No further information provided.	{01620}			
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the	01760			

Minnesota Department of Health

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01760	Continued From page 24 licensee failed to ensure medication was administered as ordered for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 was admitted to licensee on November 8, 2024, with diagnosis of schizophrenia bipolar (extreme mood swings) type. R2's Home Care Service Plan dated November 8, 2024, indicated R2 received assistance with personal cares and medication administration services. On December 17, 2024, at 7:05 a.m., the surveyor observed unlicensed personnel (ULP)-H assist with medication administration for R2. R2's physician orders dated November 8, 2024, included the following medications: - MiraLAX 17 grams (g) in 8 ounces of water, juice, or tea and drink daily; and - senna laxative 8.6 milligrams (mg) take one tablet by mouth daily. R2's medication administration record (MAR) dated November 2024 and December 2024, did not have MiraLAX and senna laxative listed as being administered.	01760			

Minnesota Department of Health

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01760	Continued From page 25 On December 19, 2024, at 11:04 a.m., registered nurse (RN)-G stated [R2] was not their patient but were covering for the other nurse who had performed the assessments on [R2] since that nurse was not available to the surveyor for further questions. RN-G stated in general, the nurse would be expected to perform a medication reconciliation that would include comparing the provider orders and updating the MAR to reflect the orders. RN-G stated the nurse would need to call the provider if there were clarifications needed on the orders. RN-G stated they did not know if the medications were reconciled at the time [R2] was admitted to the licensee or if the provider was contacted by the nurse for medication clarification. RN-G stated they had just saw the orders for [R2] but did not see the ordered medications the surveyor had asked about. The surveyor showed RN-G where the medications were listed on the admission orders. RN-G stated the patient was transferred from another assisted living facility; the licensee had never seen those orders that were sent to the surveyor for R2 as most patients come from the hospital and have discharge orders. RN-G stated [another licensee] had given the licensee the orders and they believed the orders may have been discontinued at the other facility. RN-G stated they were using the same pharmacy that the other licensee had used, so they got their orders from the pharmacy. The licensee's Medication Administration policy updated August 1, 2024, indicated the nurse would be responsible for assessing medications to assure all medications were current and ordered by the prescriber and to identify any expired or outdated medications.	01760			

Minnesota Department of Health

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01760	Continued From page 26 The licensee's medication management program policy updated August 1, 2024, indicated the medication management program included documentation of medication activities, communication with the pharmacy about the residents' medications, and coordination and communication with the prescriber. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			
{01910} SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by:	{01910}			

Minnesota Department of Health

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{01910}	Continued From page 27	{01910}	Not reviewed during the survey.		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

October 17, 2024

Licensee

Jmkay Healthcare Services Inc
2318 55th Avenue North
Brooklyn Center, MN 55430

RE: Project Number(s) SL33608015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on September 18, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

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

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

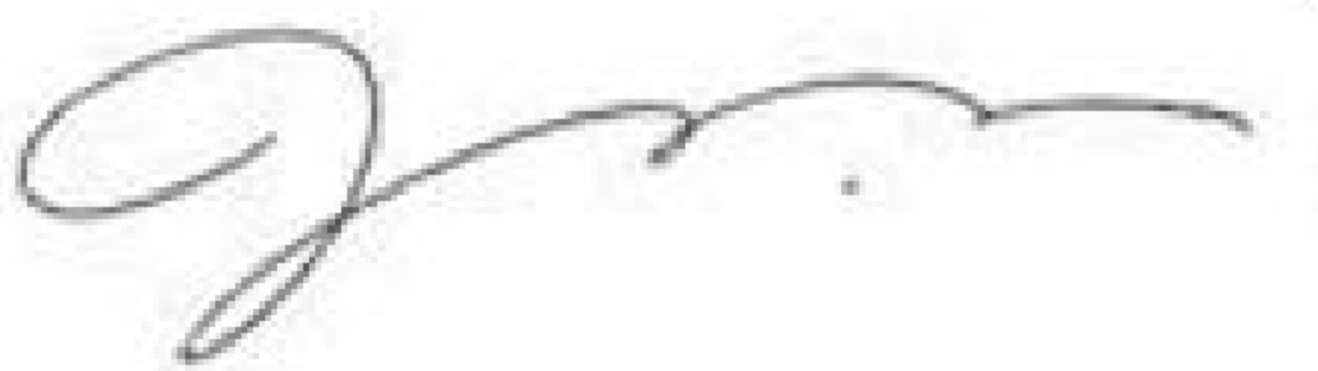
<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **<https://forms.office.com/g/Bm5uQEPhVa>**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,



Jess Schoenecker, Supervisor

State Evaluation Team

Email: Jess.Schoenecker@state.mn.us

Telephone: 651-201-3789 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2024
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0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL33608015-0 On September 16, 2024, through September 18, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were zero (0) residents receiving services under the Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated September 16, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			
0 485 SS=C	144G.41 Subdivision 1. (13)(i)(A)and(C) Minimum Requirements (13) offer to provide or make available at least the following services to residents:	0 485			

Minnesota Department of Health

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0 485	Continued From page 2 (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: (A) menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; and (C) the facility cannot require a resident to include and pay for meals in their contract; (ii) weekly housekeeping; (iii) weekly laundry service; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee's assisted living contract required the resident to pay for meals. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On September 16, 2024, at 10:45 a.m., licensed assisted living director (LALD)-C provided R1's assisted living contract and indicated the contract was representative of the contract licensee would	0 485			

Minnesota Department of Health

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0 485	Continued From page 3 use for all residents who signed a contract. R1 was admitted on November 17, 2023. R1's [licensee] Assisted Living Contract signed November 15, 2023, indicated the following services were included in the basic monthly fee: - Three (3) meals per day On September 17, 2024, at 11:00 a.m., LALD-C stated the licensee had purchased a contract template from a provider organization. LALD-C stated licensee was not aware meals could not be included in the basic monthly fee. LALD-C stated licensee would need to create an addendum to licensee's assisted living contract to offer the identified service as optional. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485			
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse.	0 630			

Minnesota Department of Health

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0 630	Continued From page 4 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement an individual abuse prevention plan (IAPP) with required content for all identified independent living 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 isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted on November 17, 2023. R1's IAPP dated November 17, 2023, was completed by clinical nurse supervisor (CNS)-D and failed to address if R1 was at risk of abusing other vulnerable adults and specific measures the licensee would take to minimize the risk. On September 17, 2024, at 11:00 a.m., CNS-D stated when they completed R1's IAPP, they must have skipped the question addressing R1's risk to abuse others. CNS-D state the licensee was aware of the requirements for an IAPP, but since CNS-D failed to complete the full IAPP, the question was not addressed and specific measures to reduce the risk were not developed. The licensee's Vulnerable Adult policy dated August 1, 2021, indicated the licensee would develop an IAPP with all required content and	0 630			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2024
NAME OF PROVIDER OR SUPPLIER JMKAY HEALTHCARE SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2318 55TH AVENUE NORTH BROOKLYN CENTER, MN 55430		
(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
0 630	Continued From page 5 specific measures to reduce the risk of abuse or to abuse others. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630			
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records	0 650			

Minnesota Department of Health

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0 650	Continued From page 6 included all required content (annual performance review and authenticated competency training) for one of one employee (ULP-A). 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). The findings include: ULP-A was hired July 14, 2020. ULP-A's record included an undated stapled competency packet with the first page titled Skill Competency Infection Control Techniques. The end of each competency included a signature at the bottom next to Evaluator's Title and included clinical nurse supervisor's (CNS)-D signature. No other identifying information was included with the packet to indicate who was trained, if they passed training, their authentication of the completion of the training, and when the training was completed. Additionally, ULP-A's record lacked evidence of the following: - annual performance reviews - supervision of delegated tasks - medication management for residents with unexpected time away from home. On September 17, 2024, at 11:00 a.m., CNS-D stated licensee had completed competency trainings with ULP-A when they were originally hired. CNS-D stated licensee had failed to	0 650			

Minnesota Department of Health

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0 650	Continued From page 7 document the competencies and supervision of delegated tasks when they were completed and then failed to document the trainings accurately. CNS-D stated they placed the packet in ULP-A's record to remind licensee to complete the documentation, but licensee failed to audit the record and complete the documentation. CNS-D stated licensee also failed to document annual performance reviews, supervision of delegated tasks and medication management training for residents with unexpected time away from home for ULP-A. CNS-D stated they met with every employee annually to review performance and goals but was unsure why ULP-A's performance reviews were not documented. The licensee's Personnel Records policy dated August 1, 2021, indicated evidence of competencies, trainings, and performance reviews would be maintained in each employee's record. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650			
0 660 SS=D	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 Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that	0 660			

Minnesota Department of Health

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0 660	Continued From page 8 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 document completion of a baseline tuberculosis (TB) screening at the time of hire or prior to providing services to residents for one of one unlicensed personnel ((ULP)-A). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-A was hired July 14, 2020. ULP-A's record lacked a TB screening prior to provision of services. On September 17, 2024, at 11:00 a.m., clinical nurse supervisor (CNS)-D stated the licensee was aware all employees were required to have a TB screening prior to the provision of services. CNS-D stated ULP-A was sent to get a TB Gold (a blood test to determine if a TB infection is present) but licensee had failed to complete the	0 660			

Minnesota Department of Health

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0 660	Continued From page 9 screening and maintain a copy in the employee's file. The licensee's Tuberculosis Screening/Prevention policy dated August 1, 2021, indicated the licensee would complete and maintain a TB screening in each employee's respected record. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660			
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 smoke alarms complies with the State Fire Code,	0 780			

Minnesota Department of Health

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0 780	Continued From page 10 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 comply with the current Minnesota Fire Code provisions. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include: On a facility tour on September 17, 2024, from 11:30 a.m. to 12:30 p.m., with director of operations (DO)-E, the surveyor made the following observations of non-compliance with current Minnesota Fire Code provisions: It was observed that the required hardwired smoke alarm in the main floor hallway had a manufacture date of 2012. Smoke alarms inside resident sleeping rooms 1,2,3, and outside resident sleeping room 4 in the basement had a manufacturing date of 2004. Smoke alarms are required to be replaced within 10 years of manufacture date according to current Minnesota Fire Code. During the facility tour DO-E, verified the above listed observations while accompanying on the	0 780			

Minnesota Department of Health

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0 780	Continued From page 11 tour. TIME PERIOD FOR CORRECTION: Two (2) day.	0 780			
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.	0 810			

Minnesota Department of Health

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0 810	Continued From page 12 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop the fire safety and evacuation plan with required content, make the plan readily available, and provide required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) 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: During observation on September 17, 2024, at 12:30 p.m., the surveyor observed the fire safety and evacuation plan was not located in a central location for all staff and occupants' accessibility. The plan was located at the main office offsite. On September 17, 2024, at 12:30 p.m., administrator (A)-F, provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee provided FSEP dated August 1, 2021, failed to include the following: The available FSEP did not identify specific fire	0 810			

Minnesota Department of Health

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0 810	Continued From page 13 protection actions for residents as evident by providing documentation non-specific to the facility. Documentation provided indicated residents pulling fire alarm pull stations, and not using elevators that don't exist in the house. During an interview on September 17, 2024, at 12:45 p.m. A-F stated ...she was going to e-mail resident actions by end of day. On September 17, 2024, at 4:55 p.m., A-F provided an e-mail with resident procedure documentation not accurate to the facility. TRAINING Record review of the available documentation indicated the licensee failed to provided evacuation training to residents at least once per year as evident by no residents living at the facility since November 2023. During an interview on September 17, 2024, at 12:45 p.m. A-F stated there have been no residents living at the facility since November 2023. DRILLS Record review of the available documentation indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month as evident by providing documentation indicating drills were completed every other month in year 2023, but didn't indicate anything for 2024, or which shifts did the drill. During an interview on September 17, 2024, at 12:45 p.m. A-F states she was going to e-mail drills documentation by end of day. On	0 810			

Minnesota Department of Health

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0 810	Continued From page 14 September 17, 2024, at 4:55 p.m., A-F provided an e-mail with drill documentation. The documentation provided by e-mail shows all drills in 2023, were performed every other month but no shift indicated and no drills for 2024. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810			
0 820 SS=D	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide facilities that were not a distinct hazard to life. This had the potential to directly affect a limited number of residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of	0 820			

Minnesota Department of Health

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0 820	Continued From page 15 residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). Findings include: On a facility tour on September 17, 2024, from 11:30 a.m. to 12:30 p.m., with director of operations (DO)-E, it was observed that compliant emergency escape and rescue openings were not provided in resident sleeping rooms 3. UNOCCUPIED ROOM Resident sleeping room 3, emergency escape and rescue clear window opening measurements were 28 inches wide, 19 ½ inches in height and 546 square inches in openable area. The window was measured with DO-E, and survey staff present. The window did not meet the minimum requirements for clear opening height and square inch openable area. It was explained to DO-E, that at least one compliant emergency escape and rescue opening is required within each resident sleeping room. Existing emergency escape and rescue openings are required to meet a minimum clear opening area of 648 square inches and have a minimum dimension of 20 inches in height and a minimum dimension of 20 inches in width. These deficient conditions were visually verified by DO-E, accompanying on the tour. TIME PERIOD FOR CORRECTION: Two (2) days.	0 820			

Minnesota Department of Health

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0 950	Continued From page 16	0 950			
0 950 SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract included the designation of representative statutory language. This had the	0 950			

Minnesota Department of Health

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0 950	Continued From page 17 potential to affect all residents who lived in the licensee's facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On September 16, 2024, at 10:45 a.m., licensed assisted living director (LALD)-C provided R1's assisted living contract and indicated the contract was representative of the contract licensee would use for all residents who signed a contract. R1 was admitted on November 17, 2023. R1's [licensee] Assisted Living Contract signed November 15, 2023, lacked the verbatim notice language and lacked the ability for a resident to identify or decline to identify a designed representative. On September 17, 2024, at 11:00 a.m., LALD-C stated licensee had purchased a contract template from a provider organization. LALD-C stated licensee was not aware of the verbatim notice and option for a resident to identify a designated representative was required in the assisted living contract. LALD-C stated licensee would add the appropriate notice and option for a resident to identify or decline a designated representative. No further information provided.	0 950			

Minnesota Department of Health

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0 950	Continued From page 18	0 950			
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for the health, safety, or personal property of a resident. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On September 16, 2024, at 10:45 a.m., licensed assisted living director (LALD)-C provided R1's assisted living contract and indicated the contract	0 970			

Minnesota Department of Health

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0 970	Continued From page 19 was representative of the contract licensee would use for all residents who signed a contract. R1 was admitted on November 17, 2023. R1's [licensee] Assisted Living Contract signed November 15, 2023, read under the Miscellaneous Provisions section for 1. Insurance Liability and Release, "the resident agrees that [licensee] will not be liable to the resident for any personal injury or property damage." Additionally, the section Indemnification read, "[licensee] shall not be liable for any damage or injury to the resident, or any other person, or to any property." On September 17, 2024, at 11:00 a.m., LALD-C stated licensee had purchased a contract template from a provider organization. LALD-C stated licensee was not aware a liability waiver could not be included in the assisted living contract. LALD-C stated licensee would edit licensee's assisted living contract template to remove all liability waivers. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970			
01060 SS=C	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains,	01060			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2024
NAME OF PROVIDER OR SUPPLIER JMKAY HEALTHCARE SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2318 55TH AVENUE NORTH BROOKLYN CENTER, MN 55430		
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01060	Continued From page 20 at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation to	01060			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2024
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01060	Continued From page 21 the resident, legal representative, and designated representative and failed to provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC) when the resident did not return from the emergency relocation after four (4) days for one of one resident (R1). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 was admitted on November 17, 2023. R1's Resident Notes - One Resident dated December 4, 2023, at 8:01 a.m., read, "Resident on Loa [leave of absence]." On September 17 at 9:45 a.m., licensed assisted living director (LALD)-C stated on December 3, 2023, R1 was sent to the hospital as their mental health was declining and R1 required a trip to the emergency room (ER) for stabilization. LALD-C stated R1 was not able to stabilize and was admitted to the hospital on December 4, 2023. R1 decided they wanted to seek a different living arrangement and R1 was discharged on December 26, 2023, once living arrangements were secured for R1's discharge. On September 17, 2024, at 11:00 a.m., LALD-C stated licensee was not aware of the contents of an emergency relocation notice and licensee was not aware the notice was required to be provided	01060			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33608	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2024
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01060	Continued From page 22 to the OOLTC if the resident was relocated for longer than 4 days. LALD-C was directed to statute for emergency relocation notice and LALD-C stated licensee would need to develop a document which contained all required content for the notice. The licensee's Discharge and Transfer of Residents policy dated August 1, 2021, accurately identified all required content of an emergency relocation notice, who the notice would be provided to in the event of an emergency relocation, and the notice would be provided to the OOLTC if the resident did not return within 4 days. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060			
01350 SS=F	144G.60 Subd. 5 Temporary staff When a facility contracts with a temporary staffing agency, those individuals must meet the same requirements required by this section for personnel employed by the facility and shall be treated as if they are staff of the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure agency (also known as temporary or contracted) staff met the same training requirements and had all required content for an employee record as licensee personnel for one of one agency unlicensed personnel ((ULP)-B).	01350			

Minnesota Department of Health

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01350	Continued From page 23 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: ULP-B was an agency staff employee. ULP-B's record included a copy of ULP-B's driver license and copy of ULP-B's background study as only documents. ULP-B's record lacked all evidence of any orientation, training, health screenings, and competencies. On September 16, 2024, at 1:20 p.m., licensed assisted living director (LALD)-C stated ULP-B was an agency staff and licensee was not aware a complete employee record was required to be maintained for agency staff and were to be treated as if they were staff of the facility. LALD-C stated none of the five (5) agency staff would have a completed employee record. The licensee's Personnel Records policy dated August 1, 2021, indicated each paid employee who provided service would have a completed employee record with all required content. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01350			

Minnesota Department of Health

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01620	Continued From page 24	01620			
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN) completed a comprehensive 14-day reassessment for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	01620			

Minnesota Department of Health

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01620	Continued From page 25 was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted on November 17, 2023. R1's Assessment History by Client dated September 16, 2024, indicated R1 had a pre-admission assessment completed on November 14, 2023, and an admission assessment completed on November 17, 2023. R1's 14-day assessment was due on or before December 1, 2023. R1's Resident Notes - One Resident dated December 4, 2023, at 8:01 a.m., read, "Resident on Loa [leave of absence]." On September 17, 2024, at 9:45 a.m., licensed assisted living director (LALD)-C stated on December 3, 2023, R1 was sent to the hospital as their mental health was declining and R1 required a trip to the emergency room (ER) for stabilization. LALD-C stated R1 was not able to stabilize and was admitted to the hospital on December 4, 2023. R1 decided they wanted to seek a different living arrangement and R1 was discharged on December 26, 2023, once living arrangements were secured for R1's discharge. On September 17, 2024, at 11:00 a.m., clinical nurse supervisor (CNS)-D stated licensee was aware a 14-day reassessment was required to be completed. CNS-D stated they were responsible for completing the 14-day reassessment but failed to complete it and when CNS-D realized it was overdue, R1 had been relocated to the	01620			

Minnesota Department of Health

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01620	Continued From page 26 hospital. The licensee's Assessment and Reassessment policy dated August 1, 2021, indicated a RN would complete a reassessment no more than 14-days after the initiation of services. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01620			
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the	01910			

Minnesota Department of Health

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01910	Continued From page 27 licensee failed to maintain documentation in the resident's record regarding the disposition of medication to include quantity and names of staff and other individuals involved in the disposition of medications for one of one discharged resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was discharged on December 26, 2023. R1's Service Plan signed November 15, 2023, indicated R1 required medication management services. R1's Individualized Medications Management Plan dated November 17, 2023, indicated all medications would be secured in a medication cart or medication cabinet and medication self-administration was not applicable. R1's record lacked a disposition of medications to include the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. On September 17, 2024, at 11:00 a.m., clinical nurse supervisor (CNS)-D stated licensee was	01910			

Minnesota Department of Health

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01910	Continued From page 28 aware of the disposition of medication requirement and provided accurate example from another resident. CNS-D stated licensee must have failed to print the disposition from the licensee's electronic health record and failed to fill out the medications and where they were disposed. The licensee's Disposition and Disposal of Medications policy dated August 1, 2021, indicated a disposition of medications will all required content would be completed for each discharged resident. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910			

Type: Full
Date: 09/16/24
Time: 11:00:00
Report: 1031241258

Food and Beverage Establishment Inspection Report

Page 1

Location:

Jmkay Healthcare Services Inc
2318 55th Avenue North
Brooklyn Center, MN55430
Hennepin County, 27

Establishment Info:

ID #: 0038933
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7632450668
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: 09/17/24

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.

UNABLE TO OBTAIN DISH MACHINE TEMP. PURCHASE IRREVERSIBLE THERMOMETER AND TEST DISH MACHINE TEMP (160F MINIMUM). REPAIR OR REPLACE. DISH MACHINE IF NOT 160F OR ABOVE.

Comply By: 09/17/24

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: 09/20/24

Type: Full
Date: 09/16/24
Time: 11:00:00
Report: 1031241258
Jmkay Healthcare Services Inc

Food and Beverage Establishment Inspection Report

Page 2

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 AND MEASURE UTENSIL TEMPERATURE (160F REQUIRED) AT REGULAR INTERVALS.

Comply By: 09/20/24

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 SANITIZER TESTING KIT ON SITE. PURCHASE KIT AND TEST SANI CONCENTRATION (50-200PPM BLEACH, 150-400PPM QUAT)

Comply By: 09/20/24

2-100 Supervision

2-102.12AMN

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

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

Comply By: 09/17/24

4-200 Equipment Design and Construction

4-201.11BMN

MN Rule 4626.0506B Provide an exhaust ventilation hood that meets the requirements in the Minnesota Mechanical Code, Minnesota Rules, chapter 1346.

STOVE IS MISSING VENT HOOD. INSTALL VENT HOOD.

Comply By: 10/08/24

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.

1. REFRIGERATOR NOT 41F OR BELOW.

2. REFRIGERATOR BOTTOM DRAWER BROKEN

REPAIR REFRIGERATOR ITEMS OR REPLACE REFRIGERATOR PRIOR TO RESIDENT MOVE-IN..

Comply By: 10/08/24

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. CLEAN AND MAINTAIN CLEAN.

Comply By: 10/08/24

Type: Full
Date: 09/16/24
Time: 11:00:00
Report: 1031241258
Jmkay Healthcare Services Inc

Food and Beverage Establishment
Inspection Report

6-300 Physical Facility Numbers and Capacities

6-301.14A

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

HANDWASH REMINDER SIGN MISSING FROM SINK HANDWASH STATION. COPY OF REMINDER SIGN SENT WITH REPORT. PRINT AND POST SIGN OR PURCHASE SIMILAR.

Comply By: 10/08/24

6-300 Physical Facility Numbers and Capacities

6-303.11C

MN Rule 4626.1470C Provide at least 50 foot candles (540 LUX) of light intensity for areas where food employees are working with utensils and equipment where safety is a factor.

MAIN KITCHEN CEILING LIGHT NOT WORKING. REPAIR OR REPLACE LIGHT.

Comply By: 10/08/24

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.11

MN Rule 4626.1515 Maintain the physical facilities in good repair.

- 1. WALL COVERINGS PEELING OFF. REMOVE AND REPLACE WALL COVERINGS.
- 2. MULTIPLE SHELVES HAVE DAMAGED SURFACES. COVER ALL DAMAGED SURFACES WITH CONTACT PAPER.
- 3. REPAIR HOLE AND ROTTED BOARDS UNDER SINK. COVER SURFACE WITH CONTACT PAPER AFTER REPAIR.

Comply By: 10/08/24

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.111ABD

MN Rule 4626.1565ABD Provide control of insects, rodents, and other pests by routinely inspecting incoming food and supply shipments; routinely inspecting the premises for evidence of pests; and eliminating harborage conditions.

FILL AND PATCH MOUSE HOLE IN CUPBOARD (BOTTOM RIGHT FROM SINK).

Comply By: 10/08/24

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.12A

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

KITCHEN HAS NOT BEEN CLEANED SINCE LAST RESIDENTS. CLEAN AND SANITIZE ALL SURFACES AND CUPBOARD/DRAWER INTERIORS.

Comply By: 10/08/24

Surface and Equipment Sanitizers

Ambient Air Temp: = at 58 Degrees Fahrenheit
Location: Refrigerator
Violation Issued: Yes

Type: Full
Date: 09/16/24
Time: 11:00:00
Report: 1031241258
Jmkay Healthcare Services Inc

Food and Beverage Establishment
Inspection Report

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

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

Nurse Evaluator on site: Brandon Mueller

All violations discussed with PIC during the inspection.

***ESTABLISHMENT DOES NOT HAVE CURRENT RESIDENTS. FOLLOW-UP INSPECTION
RECOMMENDED PRIOR TO HAVING RESIDENTS.

NOTES:

- Establishment has a residential kitchen (4626.0506(G)(2)) Same-day service only. No saving and reheating of foods or preparation of foods the day prior to eating. Any remaining food from meals to be removed/discarded at end of day.
- Staff must prepare sanitizer bucket or squirt bottle daily. Check concentration with test strips (50-200ppm Chlorine) when preparing solution.
- Establishment does not have pasteurized eggs and does not prepare eggs for consumption under 145F. Purchase pasteurized eggs if intending to serve eggs undercooked.
- Make sure to datemark any prepared cold items that are kept in refrigerator.
- Employee food needs to be labeled and separated from residents food.
- Single-use gloves should be used whenever handling ready-to-eat items.
- Cutting boards should be utilized as food contact surfaces and not counters or plates.
- 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, as discussed during inspection.
- 2-Comp sink has right basin designated for handwashing and the left basin for product washing/prep sink.
- When preparing food, make sure to use a thin-probe thermometer to check temperatures.

Type: Full
Date: 09/16/24
Time: 11:00:00
Report: 1031241258
Jmkay Healthcare Services Inc

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 1031241258 of 09/16/24.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: ____/____/____

Inspection report reviewed with person in charge and emailed.

Signed:_____
Obafeni Oladeji
Person in Charge

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