



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

August 22, 2024

Licensee
Souriyathy Housing With Services
6231 Sunny Lane
Brooklyn Park, MN 55428

RE: Project Number(s) SL35294015

Dear Licensee:

On July 30, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the December 6, 2023, survey and the follow-up surveys conducted on February 27, 2024, and May 21, 2024, were corrected. This follow-up survey verified that the facility is back in compliance.

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

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'Tim Hanna'.

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

JMD



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

June 13, 2024

Licensee
Souriyathy Housing With Services
6231 Sunny Lane
Brooklyn Park, MN 55428

RE: Project Number(s) SL35294015

Dear Licensee:

On May 21, 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 December 6, 2023. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the December 6, 2023 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on December 6, 2023, found not corrected at the time of the May 21, 2024, follow-up survey and/or subject to penalty assessment are as follows:

0820 - Fire Protection And Physical Environment - 144g.45 Subd. 2 (g)

The details of the violations noted at the time of this follow-up survey completed on May 21, 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.

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.

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.

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

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:

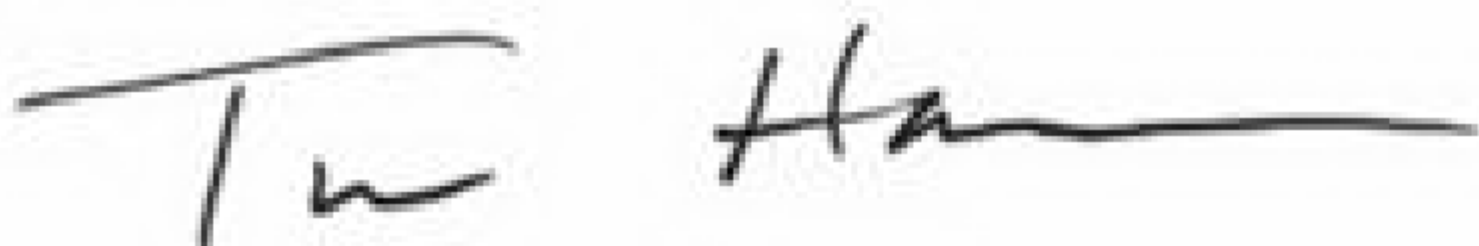
<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

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 Tim Hanna at 507-208-8982.

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,



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

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35294	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 05/21/2024
NAME OF PROVIDER OR SUPPLIER SOURIYATHAY HOUSING WITH SERVIC			STREET ADDRESS, CITY, STATE, ZIP CODE 6231 SUNNY LANE BROOKLYN PARK, MN 55428		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
{0 000}	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER 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: SL35294015-2 On May 21, 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 February 27, 2024. At the time of the survey, there were 04 residents; 04 receiving services under the Assisted Living license. As a result of the follow-up survey, the following orders were reissued.	{0 000}			
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (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: No further action required.	{0 480}			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35294	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 05/21/2024
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{0 820}	Continued From page 1	{0 820}			
{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, record review, and interview, the licensee failed to ensure physical facility elements did not constitute a distinct hazard to life. The licensee failed to provide resident bedrooms with the minimum window opening meeting the minimum state standard for egress. This had the potential to affect some residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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:	{0 820}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35294	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 05/21/2024
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{0 820}	Continued From page 2 On May 21, 2024, at 2:30 p.m., survey staff toured the facility with unlicensed personnel (ULP)-B. It was observed that bedroom #1 had not had a new, egress compliant window installed since the last survey. ULP-B stated they did not realize that bedroom #1 was non-compliant and would get it replaced as quickly as possible. Occupied Sleeping Room: Bedroom #1 occupied: two (2) windows, both windows measured 23 inches clear width, 21 inches clear height, and 483 square inches total open area each side. The windows in bedroom #1 did not meet the minimum requirements for total openable area. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. Survey staff explained to ULP-B that at least one window in each bedroom in a state-licensed facility must meet the minimum state fire code standard for an egress window to be a complying bedroom for resident occupancy. Record review of the plan of correction from the initial survey completed on December 06, 2023, indicated the licensee planned to conduct a fire watch until the non-compliant egress windows were brought into compliance. Record review of the fire watch log indicated that the facility had an active fire watch and was completing it per their fire watch policy. During interview on February 13, 2024, at 1:00	{0 820}			

Minnesota Department of Health

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{0 820}	Continued From page 3 p.m. ULP-B stated they understood the requirements for the windows and would continue the fire watch until a window in bedroom #1 was replaced. No Further information was provided.	{0 820}			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

March 7, 2024

Licensee

Souriyathy Housing With Service

6231 Sunny Lane

Brooklyn Park, MN 55428

RE: Project Number(s) SL35294015

Dear Licensee:

On February 27, 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 December 6, 2023. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the December 6, 2023 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on December 6, 2023, found not corrected at the time of the February 27, 2024, follow-up survey and/or subject to penalty assessment are as follows:

0480-Minimum Requirements-144g.41 Subd 1 (13) (i) (b) - \$500.00

The details of the violations noted at the time of this follow-up survey completed on February 27, 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.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$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 within the time period 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.

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

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 Kelly Thorson at 320-223-7336.

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 that reads "Kelly Thorson". The signature is written in a cursive, flowing style.

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

PMB

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35294	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 02/27/2024
NAME OF PROVIDER OR SUPPLIER SOURIYATHAY HOUSING WITH SERVIC			STREET ADDRESS, CITY, STATE, ZIP CODE 6231 SUNNY LANE BROOKLYN PARK, MN 55428		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
{0 000}	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER 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: SL35294015-1 On February 27, 2024, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on December 6, 2023. At the time of the survey, there were five residents; all receiving services under the Assisted Living license. As a result of the revisit, the following orders were reissued.	{0 000}	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. 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 surveyors' 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 subd. 1, 2, and 3.		
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	{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 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 February 27, 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}			
{0 820} SS=C	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	{0 820}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35294	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 02/27/2024
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{0 820}	Continued From page 2 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 properly sized egress windows for resident rooms that did not create a distinct hazard for residents. This had the potential to directly affect a portion of the residents and staff. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On February 26, 2024, at 2:01 p.m., survey staff did a desk follow-up per email with owner (O)-A. During the desk follow-up, survey staff inquired about the egress windows in resident rooms (1,2,3 and 4) not meeting the minimum size egress requirements from the survey that was conducted on December 04, 2023. O-A stated, that "we have had several estimates and all companies are booking for 2-3 months out. but we are continuing log our investigating reports on checking the premise for every half hour." A record review of the fire watch logs indicated	{0 820}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35294	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 02/27/2024
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{0 820}	Continued From page 3 that the licensee has continued fire watch protocols every 30 minutes of each day since executing this as the plan of correction from the immediate order from the previous survey. O-A emailed these logs which confirmed that the staff was executing all required fire watch protocols during each shift.	{0 820}			

Type: Follow-Up
Date: 02/27/24
Time: 13:31:04
Report: 1031241050

Food and Beverage Establishment Inspection Report

Page 1

Location:

Souriyathy Housing With Servic
6231 Sunny Lane
Brooklyn Park, MN55428
Hennepin County, 27

Establishment Info:

ID #: 0037481
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6123681236
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 previously issued on 12/04/23 have NOT been corrected.

2-100 Supervision**2-102.12AMN**

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.
REPEAT FROM DEC 2023 INSPECTION

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

Issued on: 12/04/23

Comply By: 12/04/23

4-500 Equipment Maintenance and Operation**4-501.11AB**

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.
REPEAT FROM DEC 2023 INSPECTION

KITCHEN SINK HAS CHIPS/PITS. REPAIR OR REPLACE SINK.

Issued on: 12/04/23

Comply By: 12/25/23

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Quaternary Ammonia: = 200 at Degrees Fahrenheit

Location: Clorox wipes

Violation Issued: No

Type: Follow-Up
Date: 02/27/24
Time: 13:31:04
Report: 1031241050
Souriyathy Housing With Servic

Food and Beverage Establishment
Inspection Report

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

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 1031241050 of 02/27/24.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: ____/____/____

Inspection report reviewed with person in charge and emailed.

Signed:_____
Phinhsaykeo Souriyathy
Person in Charge

Signed:_____

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



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

January 26, 2024

Licensee

Souriyathay Housing with Services

6231 Sunny Lane

Brooklyn Park, MN 55428

RE: Project Number(s) SL35294015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on December 6, 2023, 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 . . ."

IMPOSITION OF FINES

In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be imposed immediately with no opportunity to correct the violation first as follows:

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.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5), MDH may impose fine amounts of either \$1,000 or \$5,000 to licensees who are found to be responsible for maltreatment.

MDH may impose a fine of \$1,000 for each substantiated maltreatment violation that consists of

abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. MDH also may impose a fine of \$5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this survey:

St - 0 - 0110 - 144g.10 Subdivision 1a - Assisted Living Director License Required - \$500.00

St - 0 - 0250 - 144g.20 Subdivision 1 - Conditions - \$3,000.00

St - 0 - 0820 - 144g.45 Subd. 2 (g) - Fire Protection And Physical Environment - \$3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$6,500.00**. 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 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>

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.

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,

A handwritten signature in cursive script that reads "Kelly Thorson".

Kelly Thorson, Supervisor

State Evaluation Team

Email: kelly.thorson@state.mn.us

Telephone: 320-223-7336 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35294	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/06/2023
NAME OF PROVIDER OR SUPPLIER SOURIYATHY HOUSING WITH SERVIC			STREET ADDRESS, CITY, STATE, ZIP CODE 6231 SUNNY LANE BROOKLYN PARK, MN 55428		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL35294015 On December 4, 2023, through December 6, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were five residents; all receiving services under the Assisted Living license. An immediate correction order was identified on December 5, 2023, issued for SL35294015-0, tag identification 0820. On December 7, 2023, the immediacy of correction order 0820 was removed, however non-compliance remained at a scope and level of I.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. 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 surveyors' 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 subd. 1, 2, and 3.		
0 110 SS=F	144G.10 Subdivision 1a Assisted living director license required	0 110			

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 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 observation, interview, and record review, the facility failed to employ a licensed assisted living director (LALD) licensed by the Board of Executives for Long Term Services and Supports. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On December 4, 2023, at 11:00 a.m., the surveyor observed a posted director in residence license for clinical nurse supervisor (CNS)-C. This license was for a sister facility with a different health facility identification number (HFID). On December 4, 2023, at 1:15 p.m., owner (O)-A stated CNS-C's director in residency license was sent to that facility address so she thought it was for that address/HFID. O-A further stated CNS-C would need to apply for a shared license. On December 5, 2023, at 1:20 p.m., CNS-C	0 110			

Minnesota Department of Health

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0 110	Continued From page 2 stated he is working with a mentor regarding his residency permit and will have her assist with applying for shared residency. The licensee's undated Laws, Rules and Definitions document indicated every licensee must employ a Licensed Assisted Living Director (LALD) who holds overall accountability. No further information provided. TIME PERIOD FOR CORRECTION: TWO (2) DAYS	0 110			
0 250 SS=G	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records,	0 250			

Minnesota Department of Health

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0 250	Continued From page 3 files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the management officials who were in charge of the day-to-day operations; and responsible for the resident's assisted living services, understood all of the assisted living facility regulations. This had	0 250			

Minnesota Department of Health

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0 250	Continued From page 4 the potential to affect all residents. 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The licensee's "Application for Assisted Living License", section titled "Official Verification of Owner or Authorized Agent", (page four and five of the application), identified, "I certify I have read and understand the following:" [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45 (opens in a new window), my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17 (opens in a new window). - I have read and fully understand Minn. Stat. sect. 144G.80 (opens in a new window), 144G.81 (opens in a new window). and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22 (opens in a new window), my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G (opens in a new window). - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659 (proposed and not final) (opens in a new window). - Reporting of Maltreatment of Vulnerable Adults (opens in a new window).	0 250			

Minnesota Department of Health

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0 250	Continued From page 5 - Electronic Monitoring in Certain Facilities (opens in a new window)." - "I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G (opens in a new window), and Minnesota Rules, chapter 4659 (proposed and not final) (opens in a new window), governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence f a management agreement or subcontract." - "I have examined this application and all attachments, and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct and complete. I will notify MDH, in writing, of any changes to this information as required." - I attest to have all required policies and procedures of Minn. Stat. chapter 144G (opens in new window). and Minn. Rules chapter 4659 (proposed and not final) (opens in new window), in place upon licensure and to keep them current as applicable." Page five was electronically signed by the owner on January 17, 2023. The licensee had an assisted living license, effective February 1, 2023. 29 correction orders were issued, which indicated the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.01 to 144G.95.	0 250			

Minnesota Department of Health

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0 250	Continued From page 6	0 250			
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (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 December 4, 2023, 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	0 485			

Minnesota Department of Health

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0 485	Continued From page 7 (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (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 observation, interview and record review, the licensee failed to ensure a menu was prepared a week in advance and provided to the residents. This had the potential to affect all five residents who received services. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include:	0 485			

Minnesota Department of Health

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0 485	Continued From page 8 On December 4, 2023, at 12:20 p.m., the surveyor did not observe a posted menu for the residents. On December 4, 2023, at 12:30 p.m., owner (O)-A stated they did not have a menu posted for the residents due to not being aware of that requirement. The licensee's undated Minimum Requirements for Assisted Living Facilities document indicated menus must be prepared at least one week in advance and made available to all residents. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 485			
0 495 SS=F	144G.41 Subd. 1 (14) Minimum Requirements (14) provide staff access to an on-call registered nurse 24 hours per day, seven days per week This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure that a registered nurse (RN) was available on-call 24 hours a day, seven days per week. This had the potential to affect all five residents and staff of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic	0 495			

Minnesota Department of Health

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0 495	Continued From page 9 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On December 4, 2023, at 10:20 a.m., during the entrance conference, owner (O)-A stated they only had one RN employed by licensee at time of survey. O-A stated clinical nurse supervisor (CNS)-C works for both assisted living houses and is also a manager at a dialysis center but is available 24 hours/day, 7 days/week by phone. O-A stated if the staff are unable to get a hold of CNS-C they call the Allina clinic triage nurse. On December 5, 2023, at 1:45 p.m., CNS-C stated they were available 24 hours seven days a week by phone, and they try to return calls within 15 to 20 minutes. CNS-C also stated on the rare occasion they are sick or unavailable the staff are to call the Allina clinic triage nurse. On December 6, 2023, at 11:25 a.m. the surveyor attempted to reach CNS-C by phone and the call went to a voicemail, the surveyor left a message stating they would call back in about 15 minutes. On December 6, 2023, at 11:45 a.m., the surveyor attempted a second time to reach CNS-C by phone and the call went to a voicemail, the surveyor left a message stating to call back surveyor as soon as they received this message. On December 6, 2023, at 12:45 p.m., the surveyor received a return call from CNS-C who stated they had received the sruveyor's message and was returning the surveyor's call. No further information was provided.	0 495			

Minnesota Department of Health

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0 495	Continued From page 10	0 495			
	TIME PERIOD FOR CORRECTION: Two (2) days				
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to implement and maintain a quality management program appropriate to the size of the facility and relevant to the type of services provided. This had the potential to affect all current 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 the residents). The findings include:	0 580			

Minnesota Department of Health

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0 580	Continued From page 11 On December 4, 2023, during the entrance conference at 10:00 a.m., owner (O)-A stated they have a quality management meeting at least once a year, but they did not have any documentation. The licensee's undated Quality Management document indicated, the facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. Documentation about quality management activity must be available for two years. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 580			
0 630 SS=F	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: Based on interview and record review, the	0 630			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35294	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/06/2023
NAME OF PROVIDER OR SUPPLIER SOURIYATHY HOUSING WITH SERVIC			STREET ADDRESS, CITY, STATE, ZIP CODE 6231 SUNNY LANE BROOKLYN PARK, MN 55428		
(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 12 licensee failed to develop an individual abuse prevention plan (IAPP) with the required content for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client'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 clients). The findings include: R1 R1 was admitted on March 10, 2021, and began receiving assisted living services on August 1, 2021. R1's IAPP dated August 10, 2023, indicated R1 was at risk to be abused and did not include: - statements of specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. R2 R2 was admitted on September 19, 2022. R2's IAPP dated August 10, 2023, indicated R2 was at risk to be abused and did not include: - the person's risk of abusing other vulnerable adults; and - statements of specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. On December 6, 2023, at 12:45 p.m., clinical nurse supervisor (CNS)-C stated they were	0 630			

Minnesota Department of Health

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0 630	Continued From page 13 aware all resident's needing an IAPP but was not aware of the specific requirements of the IAPP and if the requirements were missed it had been an accident. The licensee's Individual Abuse Prevention Plans undated policy, indicated the individual abuse prevention plan will include: a. Individualized review or assessment of the resident's susceptibility to be abused by another individual, including other vulnerable adults. b. The resident's risk of abusing other vulnerable adults. c. Specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. d. Measure to minimize the risk of self-abuse, if applicable. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630			
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide	0 660			

Minnesota Department of Health

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0 660	Continued From page 14 technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included a two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test, for one of one (unlicensed personnel (ULP)-B and a completed health history and symptom screening for one of one employee ULP-B, and an updated TB risk assessment for the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: The facility TB risk assessment was completed March 12, 2021, and indicated the facility was at a low risk for TB transmission. The facility TB risk assessment had not been updated since. ULP-B was hired September 6, 2023, and provided direct care services to licensee residents. ULP-B's record lacked evidence a TB history and symptom screening was completed.	0 660			

Minnesota Department of Health

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0 660	Continued From page 15 ULP-B's record showed the first step of a tuberculin skin test was performed on November 28, 2023, and read on December 1, 2023. On December 5, 2023, at 1:50 p.m., owner (O)-A stated she did not realize the TB risk assessment had not been updated since 202. On December 6, 2023, at 1:15 p.m., O-A stated she was not aware of the history and symptom screening requirement for all employees upon hire. O-A further stated ULP-B wanted to get the two-step Mantoux done with his own insurance and did not go in until last week and knows ULP-B needs to get the second step done. The licensee's undated TB Prevention and Control policy indicated annually a community TB risk assessment will be completed. Upon hire staff will be screened for TB symptoms and tested for TB. Staff will not work in resident care areas or areas where there is potential contact or shared space with residents until TB testing and screening is completed and a negative TB test is provided. If the first step of the two-step TST is negative the employee may begin working with residents (if the TST is dated within 90 days before hire) but must have the second TST test within 21 days after hire. The Minnesota Department of Health guidelines Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, and based on CDC guidelines, indicated a TB infection control program should include an annual facility TB risk assessment. The guidelines also indicated an employee may begin working with patients (residents) after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test)	0 660			

Minnesota Department of Health

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0 660	Continued From page 16 or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW starts working with patients. Baseline TB screening should be documented in the employee's record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional	0 680			

Minnesota Department of Health

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0 680	Continued From page 17 requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness plan with all the required content. This had the potential to impact 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 the residents). The findings include: On December 4, 2023, at 1:50 p.m., owner (O)-A stated the emergency plan had not been fully developed and was not available to residents, staff, or visitors. O-A stated she was answering some questions about it from her consultant, and it is on her computer. The licensee's Disaster Planning and Emergency Preparedness Plan policy dated November 7, 2019, indicated [the facility] will have in place a written plan of action to facilitate the management of clients care and services in response to a natural disaster or other emergencies that may disrupt their ability to provide care and/or services. No additional information provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 680			

Minnesota Department of Health

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0 680	Continued From page 18 (21) days	0 680			
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, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that are interconnected throughout the facility so actuation of one alarm will cause all alarms in the dwelling to actuate. This deficient condition had the ability to affect all staff and residents.	0 780			

Minnesota Department of Health

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0 780	Continued From page 19 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On a facility tour on December 4, 2023, at 3:15 p.m., with owner (O)-A, survey staff observed smoke alarms throughout the facility were not interconnected so actuation of one alarm will cause all alarms in the dwelling to actuate. This was discovered when O-A tested the smoke alarms. On December 4, 2023, at 3:15 p.m., O-A verbally confirmed the failure of the smoke alarms actuating each other during testing. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780			
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest	0 790			

Minnesota Department of Health

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0 790	Continued From page 20 fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide current tags and documentation of annual and monthly inspections of all the fire extinguishers. This deficient condition had the ability to affect all staff and 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 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 a facility tour on December 4, 2023, at 3:15 p.m., with owner (O)-A, survey staff observed the fire extinguishers throughout the facility, did not have current tags or documentation to indicate annual and monthly inspections had been performed as required. Annual and monthly inspections of the fire extinguishers are required to ensure that all systems are maintained and remain in working order. On December 4, 2023, at 3:15 p.m., O-A verbally confirmed fire extinguishers were not inspected as required.	0 790			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35294	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/06/2023
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0 790	Continued From page 21	0 790			
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect some of the residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On December 4, 2023, at 3:15 p.m., survey staff toured the facility with owner (O)-A. During the facility tour, survey staff observed and verified the	0 800			

Minnesota Department of Health

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0 800	Continued From page 22 following maintenance issues. 1. The entryway in the lower level had a hole in ceiling sheetrock, floor transition strips missing, front door was missing the side of its frame and wall heating vents had dust and dirt. 2. Resident room #1 was missing paneling on the wall. 3. Laundry room had an unfinished ceiling with a light fixture hanging down. There was inability to access the hot water heater due to items blocking the way. The dryer plug hung from the ceiling and using a power strip. Floor transitions were missing. 4. Storage room in the lower level had a small hole in the ceiling and wall. Garbage bags were stored all over in the room. 5. Bathroom in the lower level had a hole in the sheetrock on ceiling, a broken mirror, and black mold on the wall by the toilet. 6. Garage doors did not open due to spray foam insulation on the bottom and outer edges of it. The garage appeared to have someone living there as it was set up as a bedroom living space. It had a bed and a living room space with couches, computer desk with computer, large television and clothing hanging along with many other personal items. 7. Upstairs living room window was broken. 8. Office window was broken. 9. The hallway had holes in the sheetrock.	0 800			

Minnesota Department of Health

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0 800	Continued From page 23 10. The house and garage siding had holes. 11. Cigarette butts were found on the ground by the house and on the window trim. Cigarette butts were not being disposed in the proper receptacle. On December 4, 2023, at 3:15 p.m., O-A verbally confirmed each observation of disrepear during the survey tour. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800			
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to	0 810			

Minnesota Department of Health

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0 810	Continued From page 24 include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on a record review and interview, the licensee failed to develop a fire safety and evacuation plan with required elements, failed to provide required employee and resident training on fire safety and evacuation, and failed to conduct required evacuation drills. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On December 4, 2023, at 11:16 a.m., the surveyor emailed owner (O)-A documentation on the licensee's fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. The licensee failed to have created a FSEP,	0 810			

Minnesota Department of Health

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0 810	Continued From page 25 training staff and residents on the fire safety and evacuation procedures nor conducted drills for fire safety and similar emergencies. This documentation was requested via email on December 4th and again in a phone conversation on December 5th at 9:01 a.m. Documentation was not provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810			
0 820 SS=I	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 properly sized egress windows for resident rooms that did not create a distinct hazard for residents. This had the potential to directly affect a portion of the residents and staff. This practice resulted in a level three violation (a	0 820	This immediate correction order was identified on December 5, 2023, issued for SL35294015-0, tag identification 0820. On December 7, 2023, the immediacy of correction order 0820 was removed, however non-compliance remained at an		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35294	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/06/2023
NAME OF PROVIDER OR SUPPLIER SOURIYATHY HOUSING WITH SERVIC			STREET ADDRESS, CITY, STATE, ZIP CODE 6231 SUNNY LANE BROOKLYN PARK, MN 55428		
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0 820	Continued From page 26 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: On December 04, 2023, at approximately 3:30 p.m., survey staff conducted a facility tour with Owner (O-A). During facility tour, survey staff observed the following: O-A fully opened the proposed egress window in occupied resident room #1 and survey staff verified the measurement of the openable area of the window to be 18.5" high x 24" wide for a total of 444 square inches. O-A fully opened the proposed egress window in occupied resident room #2 and survey staff verified the measurement of the openable area of the window to be 16" high x 31" wide for a total of 496 square inches. O-A fully opened the proposed egress window in occupied resident room #3 and survey staff verified the measurement of the openable area of the window to be 15" high x 31" wide for a total of 465 square inches. O-A fully opened the proposed egress window in occupied resident room # 4 and survey staff verified the measurement of the openable area of the window to be 15" high x 31" wide for a total of 465 square inches.	0 820	scope and level of I. This was confirmed by the licensee via email and approved by evaluation supervisor.		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35294	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/06/2023
NAME OF PROVIDER OR SUPPLIER SOURIYATHY HOUSING WITH SERVIC			STREET ADDRESS, CITY, STATE, ZIP CODE 6231 SUNNY LANE BROOKLYN PARK, MN 55428		
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0 820	Continued From page 27 Egress windows in existing facilities must have a minimum opening dimension of 648 square inches with an opening height and width dimension of no less than 20". O-A visually verified the deficient condition. TIME PERIOD FOR CORRECTION: Immediate	0 820			
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 facility's liability for 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 the potential to affect a large portion or all the residents).	0 970			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35294	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/06/2023
NAME OF PROVIDER OR SUPPLIER SOURIYATHY HOUSING WITH SERVIC			STREET ADDRESS, CITY, STATE, ZIP CODE 6231 SUNNY LANE BROOKLYN PARK, MN 55428		
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0 970	Continued From page 28 The findings include: The Assisted Living Contract provided included clauses which indicated the resident would waive the facility's liability for health, safety, or personal property of the resident. 27. Miscellaneous Provisions, page 47 of the contract, "INDEMNIFICATION Resident will indemnify and hold harmless Landlord, its employees and agents from and against any and all claims, actions, damages, and liability and expense in connection with loss of life, personal injury or damage to property, arising from or out of the use by Resident of the rented premises or any other part of Landlord's property, or caused wholly or in part by an act or omission of Resident..." Page 47 of the contract, "LIABILITY Landlord is not liable to Resident ... for any injury, death or property damage occurring in the Apartment Unit or on Landlord's premises unless such injury, death or property damage occurs as the result of an equipment malfunction or hazardous conditions within the building not caused by Resident ... Landlord is also not liable for any injury, death or damage occurring as the result of Resident's receipt of health-related, supportive or other services from third party providers. Landlord may be liable to Resident for its own negligent acts or those of its employees or agents. Unless caused by one of the aforementioned excepted reasons, Resident agrees to hold Landlord harmless from any and all claims for injuries, property damage or any other loss resulting from an accident or other occurrence in the Room or on Landlord's premises.	0 970			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35294	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/06/2023
NAME OF PROVIDER OR SUPPLIER SOURIYATHY HOUSING WITH SERVIC			STREET ADDRESS, CITY, STATE, ZIP CODE 6231 SUNNY LANE BROOKLYN PARK, MN 55428		
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0 970	Continued From page 29 On December 1, 2023, at 2:40 p.m., owner (O)-A stated the same contract is used for all resident's and was not aware of the waiver of liability in the contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970			
01300 SS=F	144G.60 Subd. 2 Qualifications, training, and competency All staff persons providing assisted living services must be trained and competent in the provision of services consistent with current practice standards appropriate to the resident's needs; and promote and be trained to support the assisted living bill of rights. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the administration of resident medications by unlicensed personnel (ULP) followed acceptable standards for two of two employees (ULP-B, ULP-D). This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client'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 clients).	01300			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35294	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/06/2023
NAME OF PROVIDER OR SUPPLIER SOURIYATHY HOUSING WITH SERVIC		STREET ADDRESS, CITY, STATE, ZIP CODE 6231 SUNNY LANE BROOKLYN PARK, MN 55428			
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01300	Continued From page 30 The findings include: ULP-B ULP-B began employment on September 6, 2023, to provide direct care services to the Licensee's residents, including medication adminstration. On December 5, 2023, at 1:20 p.m., the surveyor observed ULP-B administer medications to R4. ULP-B performed hand hygiene, donned gloves, and removed R4's monthly medication box from the locked medication closet. ULP-B opened R4's medication box and revealed boxes labeled one through thirty-one. ULP-B removed the box number five and the box contained three openings indicating morning, noon, and night medications. ULP-B opened the tab labeled for morning and placed eight tablets into a medication cup and administered them to R4. ULP-B failed to reference or compare the medication given to the resident's electronic medication administration record (EMAR). On December 5, 2023, at 1:20 p.m., ULP-B stated they were unsure what medications they had administered to R4 without looking in the computer or in the pill bottle, but the nurse was responsible for setting up the medications and the nurse would know what medications where in the box. ULP-B stated they were trained by the registered nurse (RN) on medication administration and completed a demonstration of competency to the nurse. ULP-B's employee record indicated they had been trained on medication administration and passed a competency evaluation upon hire. ULP-D	01300			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35294	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/06/2023
NAME OF PROVIDER OR SUPPLIER SOURIYATHY HOUSING WITH SERVIC			STREET ADDRESS, CITY, STATE, ZIP CODE 6231 SUNNY LANE BROOKLYN PARK, MN 55428		
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01300	Continued From page 31 ULP-D had a hire date of October 10, 2022, and provided direct assisted living services, including medication administration, to the licensee's residents. On December 5, 2023, at 7:27 a.m., the surveyor observed ULP-D administer medications to R3. ULP-D performed hand hygiene, donned gloves, and removed R3's monthly medication box from the locked medication closet. ULP-D opened R3's medication box and revealed boxes labeled one through thirty-one. ULP-D removed the box number five and the box contained three openings indicating morning, noon, and night medications. ULP-D opened the tab labeled for morning and placed three tablets into a medication cup and administered them to R3. ULP-D failed to reference or compare the medication given to the resident's electronic medication administration record (EMAR). On December 5, 2023, at 7:27 a.m., ULP-D stated they were unsure what medications they had administered to R3, but the nurse was responsible for setting up the medications and they just gave the medications out of the box. ULP-D stated they were trained by the registered nurse (RN) on medication administration but does not remember if they completed a demonstration of competency to the nurse. On December 5, 2023, at 1:45 p.m., clinical nurse supervisor (CNS)-C stated all staff had been trained in person and had to demonstrate competency for medication administration including verifying medication with the EMAR before administering them. The licensee's undated Training Unlicensed Personnel for Medication, Treatment and Therapy	01300			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35294	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/06/2023
NAME OF PROVIDER OR SUPPLIER SOURIYATHY HOUSING WITH SERVIC			STREET ADDRESS, CITY, STATE, ZIP CODE 6231 SUNNY LANE BROOKLYN PARK, MN 55428		
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01300	Continued From page 32 Administration policy indicated before the RN delegates the task of medication administration the RN will instruct the unlicensed personnel on performing these tasks and determine the unlicensed personnel as competent to perform the tasks. No further information was provided. Time period for correction: Seven (7) days.	01300			
01530 SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for	01530			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35294	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/06/2023
NAME OF PROVIDER OR SUPPLIER SOURIYATHY HOUSING WITH SERVIC			STREET ADDRESS, CITY, STATE, ZIP CODE 6231 SUNNY LANE BROOKLYN PARK, MN 55428		
(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
01530	Continued From page 33 each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employees received eight hours of initial dementia care training within the first 160 hours worked for one of one employee (unlicensed personnel (ULP)-B). 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: ULP-B began employment on September 6, 2023, to provide services to the licensee's residents. On December 5, 2023, at 1:20 p.m., the surveyor observed ULP-B administer medications to R1. ULP-B's orientation and training record lacked documentation of the required number of hours of dementia care training. ULP-B's training record included: Dementia activities-bathing .75 Dementia activities-chores, working, and volunteering .75 Dementia activities- hydration, nutrition, eating, and dining .75 Dementia activities- leisure and life enriching activities .75 Dementia activities- medications, vitals, and	01530			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35294	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 12/06/2023
NAME OF PROVIDER OR SUPPLIER SOURIYATHY HOUSING WITH SERVIC			STREET ADDRESS, CITY, STATE, ZIP CODE 6231 SUNNY LANE BROOKLYN PARK, MN 55428		
(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
01530	Continued From page 34 treatments .5 Dementia activities- toileting .5 Dementia overview Alzheimer's disease .75 Dementia problem solving overview .75 On December 6, 2023, at 1:15 p.m., owner (O)-A stated ULP-B had 5.5 hours of dementia care training and was not sure of the required number of hours staff should have. The licensee's Dementia Training policy dated August 1, 2021, indicated direct-care staff will complete a minimum of 8 hours of initial training on dementia care topics and initial training would be completed within 160 working hours of the employment start date. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530			
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	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35294	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/06/2023
NAME OF PROVIDER OR SUPPLIER SOURIYATHY HOUSING WITH SERVIC			STREET ADDRESS, CITY, STATE, ZIP CODE 6231 SUNNY LANE BROOKLYN PARK, MN 55428		
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01620	Continued From page 35 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) used the uniform assessment tool and conducted ongoing assessments not to exceed 90 calendar days from the last date of assessment for two of two residents (R1, 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1 admitted to the licensee on March 10, 2021, and began receiving assisted living services on August 1, 2021. R1's diagnoses included diabetes type two, chronic kidney disease, major depression, and cerebrovascular accident (stroke).	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35294	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/06/2023
NAME OF PROVIDER OR SUPPLIER SOURIYATHY HOUSING WITH SERVIC			STREET ADDRESS, CITY, STATE, ZIP CODE 6231 SUNNY LANE BROOKLYN PARK, MN 55428		
(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 36 R1's Service Plan dated January 16, 2023, indicated R1 received services for medication administration, manage behavior, dressing, bathing assistance, housekeeping, and laundry. R1's record included 90-day assessments dated May 8, 2023, and August 8, 2023, the assessments did not include all the required elements on the uniform assessment tool. R1's record was missing the 90-day assessment due on November 6, 2023. The following R1 90-day assessments were completed late: -August 8, 2023, by 2 days; -November 6, 2023, by 28 days. R2 R2 admitted to the licensee for assisted living services on September 19, 2022. R2's diagnoses included intellectual delay, migraine headaches, hypertension, and prediabetes. R2's record did not include a Service Plan. R2's record included an Individualized Medication Management Plan dated August 10, 2023, which indicated R2 needed full medication management, setup, and needs help taking medications. R2's record included 90-day assessments dated May 8, 2023, and August 8, 2023, the assessments did not include all the required elements on the uniform assessment tool. R2's record was missing the 90-day assessment due on November 6, 2023. The following R2 90-day assessments were	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35294	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/06/2023
NAME OF PROVIDER OR SUPPLIER SOURIYATHY HOUSING WITH SERVIC			STREET ADDRESS, CITY, STATE, ZIP CODE 6231 SUNNY LANE BROOKLYN PARK, MN 55428		
(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 37 completed late: - August 8, 2023, by 2 days; -November 6, 2023, by 28 days. On December 5, 2023, at 1:45 p.m., clinical nurse supervisor (CNS-C), stated the assessments for the residents were late or missing by accident and the assessments were missing portions of the uniform assessment tool because they were switching from paper to electronic and the new electronic form gives them all the options for the uniform assessment tool. The Minnesota Administrative Rule 4659.0150 dated August 11, 1021, indicated each facility must develop a uniform assessment tool to include all the required elements. The licensee's undated Initial Reviews, Assessment and Monitoring policy indicated, 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. Topics listed in the uniform assessment tool must be assessed by an RN. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620			
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must	01640			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35294	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/06/2023
NAME OF PROVIDER OR SUPPLIER SOURIYATHY HOUSING WITH SERVIC			STREET ADDRESS, CITY, STATE, ZIP CODE 6231 SUNNY LANE BROOKLYN PARK, MN 55428		
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01640	Continued From page 38 include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to finalize a current service plan within 14 calendar days after the date services were first provided for one of two residents (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) 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 admitted to the licensee for assisted living services on September 19, 2022.	01640			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35294	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/06/2023
NAME OF PROVIDER OR SUPPLIER SOURIYATHY HOUSING WITH SERVIC		STREET ADDRESS, CITY, STATE, ZIP CODE 6231 SUNNY LANE BROOKLYN PARK, MN 55428			
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01640	Continued From page 39 R2's diagnoses included intellectual delay, migraine headaches, hypertension, and prediabetes. R2's record included an Individual Abuse Prevention Plan dated August 10, 2023, which indicated R2 needed assistance with bathing, dressing, grooming, medication administration, housekeeping, and laundry. R2's record did not include a signed Service Plan. On December 6, 2023, at 2:00 p.m., owner (O)-A stated R2's record is missing the signed service plan due to the incorrect form was sent to R2's guardian for signature. The licensee's undated Resident Record Requirements policy indicated, contents of a resident record include the following for each resident: 1.identifying information, including the resident's name, date of birth, address, and telephone number; 2.the name, address, and telephone number of the residents emergency contact, legal representatives, and designated representative; 3.names, addresses, and telephone numbers of the residents health and medical service providers, if known; 4.health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; 5.the resident's advanced directives, if any; 6.copies of any health care directives, guardianships, powers of attorney, or conservatorships; 7.the facility's is current and previous assessments and service plans;	01640			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35294	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 12/06/2023
NAME OF PROVIDER OR SUPPLIER SOURIYATHY HOUSING WITH SERVIC			STREET ADDRESS, CITY, STATE, ZIP CODE 6231 SUNNY LANE BROOKLYN PARK, MN 55428		
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01640	Continued From page 40 8.all records of communications pertinent to the resident's services; 9.documentation of significant changes in the residence status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; 10.documentation of incidents involving the resident and actions taken in response through the needs of the resident, including reporting to the appropriate supervisor or healthcare professional; 11.documentation that services have been provided as identified in the Service plan; 12.documentation that the resident has received and reviewed the assisted living bill of rights; 13.documentation of complaints received any resolution; 14.a discharge summary, including service termination notice and related documentation, when applicable; and 15.other documentation required under this chapter and relevant to the residence services or status. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640			
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current	01730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35294	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/06/2023
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01730	Continued From page 41 individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an individual medication management plan (IMMP)	01730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35294	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/06/2023
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01730	Continued From page 42 to include all required content for two of two residents (R1, 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On December 4, 2023, at 10:20 a.m., during the entrance conference the owner (O)-A stated they provide medication services for all the residents in the facility. On December 5, 2023, at 8:00 a.m., the surveyor observed the locked medication closet that contained medications boxes for all the residents living at the facility. R1 R1 admitted to the licensee on March 10, 2021, and began receiving assisted living services on August 1, 2021. R1's diagnoses included diabetes type two, chronic kidney disease, major depression, and cerebrovascular accident (stroke). R1's Service Plan dated January 16, 2023, indicated R1 received services for medication administration, manage behavior, dressing, bathing assistance, housekeeping, and laundry. R2 R2 admitted to the licensee for assisted living	01730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35294	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/06/2023
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01730	Continued From page 43 services on September 19, 2022. R2's diagnoses included intellectual delay, migraine headaches, hypertension, and prediabetes. R2's record included an Individual Abuse Prevention Plan dated August 10, 2023, which indicated R2 needed assistance with bathing, dressing, grooming, medication administration, housekeeping, and laundry. R2's record did not include a signed Service Plan. R1 and R2's record lacked an individual medication management plan with the following content: - identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; - procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and - any resident-specific requirements relating to documenting medication administration. On December 6, 2023, at 12:45 p.m., clinical nurse supervisor (CNS)-C stated they were not aware of all the specific requirements of the individual medication management plan and they were missed by accident and this would be the same for all residents. The licensee's undated Individualized Medication, Treatment & Therapy Management Plans policy, indicated the registered nurse (RN) will develop a medications management plan for each resident receiving medication management services. The medication management plan will include:	01730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35294	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/06/2023
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01730	Continued From page 44 a.Statement the medication management services provided to the resident; b.Description of medication storage based upon the residents needs, preferences, risk of diversion, and in keeping with the manufacturer's instructions; c.Documentation of specific resident instructions relating to the administration of medications; d.Identification of persons responsible for monitoring and ensuring timely refills of medications; e.Identification of medication management tasks that may be delegated to an unlicensed person; f.Procedure for notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and g.Resident specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication used to prevent possible complications or adverse reactions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01730			
01760 SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the 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	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35294	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/06/2023
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01760	Continued From page 45 administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to document medication administration for two of two residents (R3, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On December 4, 2023, at 10:20 a.m., during the entrance conference the owner (O)-A stated they provide medication services for all the residents in the facility. On December 5, 2023, at 7:27 a.m. to 8:00 a.m., the surveyor observed unlicensed personnel (ULP)-D administer medications to R3. ULP-D failed to document the medication administration in R3's record. ULP-D stated they documented the medication administration at the end of the shift. On December 5, 2023, at 1:20 p.m., the surveyor	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35294	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/06/2023
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01760	Continued From page 46 observed ULP-B administer medications to R4. ULP-B failed to document the medication administration in R3's record. ULP-B stated they document the medication administration at the end of the shift. R3's service plan signed on June 1, 2020, indicated R3 received services to include medication administration. R4's service plan signed on October 11, 2022, indicated R4 received services to include medication administration. On December 5, 2023, at 1:45 p.m., clinical nurse supervisor (CNS)-C stated all staff were trained to document the medication administration at the time of administration. The licensee's Documentation of Medication, Treatment and Therapy Management Services policy, dated August 1, 2021, indicated registered nurses (RN), licensed practical nurses (LPN), and ULP's will appropriately document all medications, treatments, and therapy management services provided to residents including documentation of requesting and receiving prescription refills. Staff will document each task immediately after that task has been performed. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			
01770 SS=F	144G.71 Subd. 9 Documentation of medication setup	01770			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35294	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/06/2023
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01770	Continued From page 47 Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure documentation of medication setup included all the required content for all five 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 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). Findings include: R1 and R2's records did not have documentation of medication set-ups by the nurse. On December 5, 2023, at 7:27 a.m., the surveyor observed unlicensed personnel (ULP)-D administer medications to R3 from a medication bar set-up. On December 5, 2023, at 1:20 p.m., the surveyor observed ULP-B administer medications to R4 from a medication bar set-up. On December 5, 2023, at 8:00 a.m., the surveyor observed the medication storage closet and found all resident medications were set up in	01770			

Minnesota Department of Health

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01770	Continued From page 48 medication bars. On December 5, 2023, at 1:20 p.m., clinical nurse supervisor (CNS)-C stated he sets all resident medications up in medication bars and was not aware of the documentation requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770			
01820 SS=F	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure written or electronically recorded prescriptions were obtained for two of two residents (R1, 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1	01820			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35294	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/06/2023
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01820	Continued From page 49 R1's Service Plan dated January 16, 2023, indicated R1 received services for medication administration, manage behavior, dressing, bathing assistance, housekeeping, and laundry. R1's current medication administration record dated December 2023, included the following scheduled medications: -aspirin 325 milligrams (mg), take one tablet by mouth daily with meals -atorvastatin 40 mg, take one tablet by mouth every day -cholecalciferol (vitamin D3) 2,000 unit cap, take one capsules by mouth once daily -cyclobenzaprine hydrochloride 10 mg, take one tablet by mouth at bedtime for muscle cramps -diltiazem 180 mg, take one capsule by mouth once a day for high blood pressure -furosemide 20 mg, take one tablet by mouth every day as needed for leg swelling -glimepiride 4 mg, take one tablet by mouth every day -hydralazine 25 mg, take one tablet by mouth two times a day for high blood pressure -hydrocortisone 1% cream, apply topically to affected area two times daily if needed for itching -metoprolol 50 mg, take one tablet by mouth twice a day -paroxetine 20 mg, take one tablet by mouth every morning -tamsulosin 0.4 mg, take one capsule by mouth every day after a meal -trazodone 50 mg, take one tablet by mouth at bedtime. R1's record included an after-visit summary dated November 28, 2023. The after-visit summary was not signed by a provider. R2	01820			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35294	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/06/2023
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01820	Continued From page 50 R2's record included an Individual Abuse Prevention Plan dated August 10, 2023, which indicated R2 needed assistance with bathing, dressing, grooming, medication administration, housekeeping, and laundry. R2's record did not include a signed Service Plan. R2's current medication administration record dated December 2023, included the following scheduled medications: -amlodipine 5 mg, take one tablet by mouth every day -metformin hydrochloride 500 mg, take one tablet by mouth every day. R2's record included an after-visit summary dated March 23, 2023. The after-visit summary was not signed by a provider. On December 5, 2023, at 1:00 p.m., the owner (O)-A stated they do not have current signed orders for any of the resident's because they have been using the after-visit summary as orders. On December 5, 2023, at 1:45 p.m., the clinical nurse supervisor (CNS)-C stated they use the after-visit summary for orders. The licensees undated Medication and Treatment and Therapy Orders policy indicated, all medications provided to a resident by medication supervision/assistance or medication administration procedures are ordered, in writing, by the residence physician/health care provider. Written orders need to be legibly written on a physician's order form, progress note, fax order form, prescription, or telephone order form. the clinical nurse supervisor is responsible for	01820			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35294	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/06/2023
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01820	Continued From page 51 monitoring physician compliance. A valid physicians order must include the date, resident name, name of medication, dose, directions for use, route, parameters, and duration. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01820			
01940 SS=F	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent	01940			

Minnesota Department of Health

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01940	Continued From page 52 possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of two residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On December 4, 2023, at 10:20 a.m., the owner (O)-A stated they have one resident that is diabetic and they monitor the blood glucose daily using a Freestyle Libre (a glucose monitoring system) that they had purchased. R1 admitted to the licensee on March 10, 2021, and began receiving assisted living services on August 1, 2021. R1's diagnoses included diabetes type two, chronic kidney disease, major depression, and cerebrovascular accident (stroke). R1's Assessment Updates, completed by clinical nurse supervisor (CNS)-C on August 10, 2023, under the section: Physical indicated, Diabetes	01940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35294	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/06/2023
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01940	Continued From page 53 Management needs assistance with blood sugar checks only, uses free style, managed by staff. Diabetes control with food - no changes. Under the section: Summary indicated, Review Medical review of vital signs and weight: yes daily vital signs and BS monitoring. R1's daily recorded vital signs dated November 6, 2023 through December 5, 2023 indicated a daily blood glucose reading that ranged between 99 milligrams per deciliter (mg/dl) and -295 mg/dl. R1's Treatment and Therapy Plan Assessment dated (as of) December 5, 2023, did not indicate R1 was receiving treatments or therapies to include blood glucose monitoring. The treatment and therapy plan lacked the following regarding these treatment or therapies: - a statement of the type of services that will be provided; -documentation of specific resident instructions relating to the treatments or therapy administration; -identification of treatment or therapy tasks that will be delegated to unlicensed personnel; -procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and -any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. On December 6, 2023, CNS-C stated they were not aware of the requirements for the individualized treatment and therapy plan, that a plan was needed, or that a signed provider's	01940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35294	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/06/2023
NAME OF PROVIDER OR SUPPLIER SOURIYATHY HOUSING WITH SERVIC		STREET ADDRESS, CITY, STATE, ZIP CODE 6231 SUNNY LANE BROOKLYN PARK, MN 55428			
(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
01940	Continued From page 54 order was needed for the treatment and therapies provided. The licensee's undated Medication Treatment and Therapy Orders policy indicated, prior to providing any medication, treatment and therapy reminders, a RN will: a. Conduct a nursing assessment of the resident's functional status and need for medication, treatment and therapy reminders or other medication, treatment and therapy management services; b. Develop an individualized medication management plan and/or treatment and therapy individualized plan where the resident based on the residents needs and preferences; c. Communicate information about the medication, treatment, or therapy to the resident and provided education if needed. - Staff will provide medication, treatment and therapy reminders as appropriate according to the assessed needs of the resident and consistent with the MAR/TAR and the assignment sheets for the unlicensed personnel. - Unlicensed staff will chart in each residents medication administration record any problems with medication, treatment and therapy reminders and will notify the nurse about the problem. staff will document any notification of problems with medication reminders to the nurse. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940			
01970 SS=F	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or	01970			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35294	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/06/2023
NAME OF PROVIDER OR SUPPLIER SOURIYATHY HOUSING WITH SERVIC			STREET ADDRESS, CITY, STATE, ZIP CODE 6231 SUNNY LANE BROOKLYN PARK, MN 55428		
(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
01970	Continued From page 55 electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to ensure up-to-date written or electronic treatment orders were maintained for one of one resident (R1) who had a treatment. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On December 4, 2023, at 10:20 a.m., the owner (O)-A stated they have one resident that is diabetic and they monitor the blood glucose daily using a Freestyle Libre (a glucose monitoring system) that they had purchased. R1's diagnoses included diabetes type two, chronic kidney disease, major depression, and cerebrovascular accident (stroke). R1's Assessment Updates, completed by clinical nurse supervisor (CNS)-C on August 10, 2023,	01970			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35294	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/06/2023
NAME OF PROVIDER OR SUPPLIER SOURIYATHY HOUSING WITH SERVIC			STREET ADDRESS, CITY, STATE, ZIP CODE 6231 SUNNY LANE BROOKLYN PARK, MN 55428		
(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
01970	Continued From page 56 under the section: Physical indicated, Diabetes Management needs assistance with blood sugar checks only, uses free style, managed by staff. Diabetes control with food - no changes. Under the section: Summary indicated, Review Medical review of vital signs and weight: yes daily vital signs and BS monitoring. R1's daily recorded vital signs dated November 6, 2023 through December 5, 2023 indicated a daily blood glucose reading that ranged between 99 milligrams per deciliter (mg/dl) and -295 mg/dl. R1's record included an after-visit summary dated November 28, 2023. The after-visit summary was not signed by a provider. R1's record lacked up-to-date written or electronic orders authenticated by R1's provider. On December 6, 2023, CNS-C stated they were not aware of the requirements for the individualized treatment and therapy plan, that a plan was needed, or that a signed provider's order was needed for the treatment and therapies provided. The licensee's undated Medication Treatment and Therapy Orders policy indicated, prior to providing any medication, treatment and therapy reminders, a RN will: a. Conduct a nursing assessment of the resident's functional status and need for medication, treatment and therapy reminders or other medication, treatment and therapy management services; b. Develop an individualized medication management plan and/or treatment and therapy individualized plan where the resident based on the residents needs and preferences;	01970			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35294	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/06/2023
NAME OF PROVIDER OR SUPPLIER SOURIYATHY HOUSING WITH SERVIC			STREET ADDRESS, CITY, STATE, ZIP CODE 6231 SUNNY LANE BROOKLYN PARK, MN 55428		
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01970	Continued From page 57 c. Communicate information about the medication, treatment, or therapy to the resident and provided education if needed. - Staff will provide medication, treatment and therapy reminders as appropriate according to the assessed needs of the resident and consistent with the MAR/TAR and the assignment sheets for the unlicensed personnel. - Unlicensed staff will chart in each residence medication administration record any problems with medication, treatment and therapy reminders and will notify the nurse about the problem. staff will document any notification of problems with medication reminders to the nurse. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970			
02240 SS=C	144G.90 Subdivision 1 Assisted living bill of rights; notification (a) An assisted living facility must provide the resident a written notice of the rights under section 144G.91 before the initiation of services to that resident. The facility shall make all reasonable efforts to provide notice of the rights to the resident in a language the resident can understand. (b) In addition to the text of the assisted living bill of rights in section 144G.91, the notice shall also contain the following statement describing how to file a complaint or report suspected abuse: "If you want to report suspected abuse, neglect, or financial exploitation, you may contact the Minnesota Adult Abuse Reporting Center (MAARC). If you have a complaint about the facility or person providing your services, you may	02240			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35294	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/06/2023
NAME OF PROVIDER OR SUPPLIER SOURIYATHY HOUSING WITH SERVIC			STREET ADDRESS, CITY, STATE, ZIP CODE 6231 SUNNY LANE BROOKLYN PARK, MN 55428		
(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
02240	Continued From page 58 contact the Office of Health Facility Complaints, Minnesota Department of Health. If you would like to request advocacy services, you may contact the Office of Ombudsman for Long-Term Care or the Office of Ombudsman for Mental Health and Developmental Disabilities." (c) The statement must include contact information for the Minnesota Adult Abuse Reporting Center and the telephone number, website address, email address, mailing address, and street address of the Office of Health Facility Complaints at the Minnesota Department of Health, the Office of Ombudsman for Long-Term Care, and the Office of Ombudsman for Mental Health and Developmental Disabilities. The statement must include the facility's name, address, email, telephone number, and name or title of the person at the facility to whom problems or complaints may be directed. It must also include a statement that the facility will not retaliate because of a complaint. (d) A facility must obtain written acknowledgment from the resident of the resident's receipt of the assisted living bill of rights or shall document why an acknowledgment cannot be obtained. Acknowledgment of receipt shall be retained in the resident's record. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the current Minnesota Bill of Rights (BOR) for Assisted Living Residents was provided to all five residents. This practice resulted in a level one violation (a violation that has not 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	02240			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35294	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/06/2023
NAME OF PROVIDER OR SUPPLIER SOURIYATHY HOUSING WITH SERVIC		STREET ADDRESS, CITY, STATE, ZIP CODE 6231 SUNNY LANE BROOKLYN PARK, MN 55428			
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02240	Continued From page 59 or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: The licensee transitioned from a comprehensive home care license to an assisted living license on August 1, 2021. On December 4, 2023, at 1:35 p.m., the surveyor was given the Minnesota Patient's Bill of Rights dated July 1, 2007, by owner (O)-A. O-A stated that was the bill of rights given to every resident. On December 6, 2023, at 1:15 p.m., O-A stated that bill of rights was old but thought there was only one version of the bill of rights and did not know the wrong version had been given. The licensee's Notice of Resident Rights policy dated August 1, 2021, indicated the assisted living will notify residents of their rights before the initiation of services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02240			

Type: Full
Date: 12/04/23
Time: 11:00:00
Report: 1031231315

Food and Beverage Establishment Inspection Report

Page 1

Location:

Souriyathy Housing With Servic
6231 Sunny Lane
Brooklyn Park, MN55428
Hennepin County, 27

Establishment Info:

ID #: 0037481
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6123681236
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: 12/04/23

3-500B Microbial Control: hot and cold holding

3-501.16A2

**** Priority 1 ****

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

TURKEY STORED IN FOOD WARMER OUTSIDE ESTABLISHMENT ON PORCH WAS NOT UNDER MECHANICAL REFRIGERATION. ***DISCARD TURKEY AND DISCONTINUE PRACTICE.***
STORE ALL TCS FOODS IN REFRIGERATOR.

Comply By: 12/04/23

3-500D Microbial Control: disposition of food

3-501.18A

**** Priority 1 ****

MN Rule 4626.0405A Discard all TCS food prepared in the establishment or opened commercially packaged food when the time exceeds 7 days from the preparation or opening date or if the container or package is not marked.

TURKEY FOUND IN FOOD WARMER OUTSIDE ESTABLISHMENT WAS PREPARED PAST 7 DAYS AGO (THANKSGIVING). ***DISCARD TURKEY.***

Comply By: 12/04/23

Type: Full
Date: 12/04/23
Time: 11:00:00
Report: 1031231315
Souriyathy Housing With Servic

Food and Beverage Establishment Inspection Report

Page 2

7-200 Toxic Supplies and Applications

7-204.11 **** Priority 1 ****

MN Rule 4626.1620 Discontinue using chemical sanitizers, including chemical sanitizing solutions generated on site and other chemical antimicrobials on food-contact surfaces that do not meet the requirements specified in 40 CFR part 180, section 180.940, or part 180, subpart E, section 180.2020.

LYSOL SPRAY USED FOR FOOD CONTACT SURFACES MEASURED > 400PPM. ***DISCONTINUE USING PRODUCT IN KITCHEN.*** USE ONLY WIPES/SPRAYS THAT TEST 150-400PPM QUAT OR SIMILAR SANITIZER CONCENTRATION WITH TEST STRIPS.

Comply By: 12/04/23

3-500C Microbial Control: date marking

3-501.17A **** Priority 2 ****

MN Rule 4626.0400A Mark the refrigerated, ready-to-eat, TCS food prepared and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded.

MULTIPLE ITEMS IN BOTH REFRIGERATORS NOT DATE MARKED. FOLLOW ABOVE DIRECTION.

Comply By: 12/04/23

4-300 Equipment Numbers and Capacities

4-302.12B **** Priority 2 ****

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

ESTABLISHMENT DOES NOT HAVE THIN PROBE THERMOMETER.

Comply By: 12/07/23

4-300 Equipment Numbers and Capacities

4-302.13B **** Priority 2 ****

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

ESTABLISHMENT MISSING IRREVERSIBLE MEASURING DEVICE OR WAX TEST STRIPS.

PROVIDE IRREVERSIBLE MEASURING DEVICE OR WAX STRIPS AND MEASURE UTENSIL TEMPERATURE (160F REQUIRED) AT REGULAR INTERVALS.

Comply By: 12/07/23

4-300 Equipment Numbers and Capacities

4-302.14 **** Priority 2 ****

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

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

Comply By: 12/07/23

Type: Full
Date: 12/04/23
Time: 11:00:00
Report: 1031231315
Souriyathy Housing With Servic

Food and Beverage Establishment Inspection Report

Page 3

4-600 Cleaning Equipment and Utensils

4-601.11A ** *Priority 2* **

MN Rule 4626.0840A Equipment food-contact surfaces and utensils must be clean to sight and touch.

AIR FRYERS HAVE DEPOSITS OF GREASE IN FOOD COMPARTMENTS. CLEAN AIR FRYERS PRIOR TO USE. CLEAN AFTER EVERY USE.

Comply By: 12/04/23

2-100 Supervision

2-102.12AMN

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

ESTABLISHMENT DOES NOT HAVE A CERTIFIED FOOD PROTECTION MANAGER (CFPM).
ESTABLISHMENT DOES HAVE SAFESERV OR SIMILAR POSTED.

Comply By: 12/04/23

4-100 Equipment Construction Materials

4-101.17

MN Rule 4626.0490 Discontinue using wood and wood wicker as a food contact surface.

MULTIPLE KITCHEN DRAWERS HAVE RAW WOOD BOTTOMS. COVER DRAWERS HOLDING FOOD CONTACT ITEMS IN CONTACT PAPER.

Comply By: 12/25/23

4-500 Equipment Maintenance and Operation

4-501.11AB

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

KITCHEN SINK HAS CHIPS/PITS. REPAIR OR REPLACE SINK.

Comply By: 12/25/23

4-600 Cleaning Equipment and Utensils

4-602.12

MN Rule 4626.0850 Clean the food contact surfaces of cooking and baking equipment and interior cavities of microwave ovens at least every 24 hours.

INTERIOR OF MICROWAVE HAS SPLATTERS AND/OR FOOD DEBRIS. CLEAN AND MAINTAIN CLEAN.

Comply By: 12/08/23

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.12A

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

CUPBOARDS HAVE FOOD DEBRIS IN SHELVES. REMOVE ALL ITEMS AND CLEAN SHELVES.

Comply By: 12/18/23

Surface and Equipment Sanitizers

Type: Full
Date: 12/04/23
Time: 11:00:00
Report: 1031231315
Souriyathy Housing With Servic

Food and Beverage Establishment Inspection Report

Quaternary Ammonia: > 400 at Degrees Fahrenheit
Location: Lysol Spray
Violation Issued: Yes

Quaternary Ammonia: = 200 at Degrees Fahrenheit
Location: Chlorx Wipes
Violation Issued: No

Hot Water: = at 160 Degrees Fahrenheit
Location: Dish Machine
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Hold/Deli Ham
Temperature: 41 Degrees Fahrenheit - Location: Upstairs Refrigerator
Violation Issued: No

Process/Item: Cold Hold/Stuffing
Temperature: 39 Degrees Fahrenheit - Location: Downstairs Refrigerator
Violation Issued: No

Process/Item: Cold Hold/Turkey
Temperature: 35 Degrees Fahrenheit - Location: Warmer Outside Establishment on Porch
Violation Issued: No

Process/Item: Delivery/Duck
Temperature: 85 Degrees Fahrenheit - Location: Food Delivery on Counter
Violation Issued: No

Total Orders	In This Report	Priority 1	Priority 2	Priority 3
		4	5	5

Inspection conducted by Chris F.

All violations discussed with Phinhsaykeo during the inspection.

NOTES:

- Establishment has a residential kitchen (4626.0506(G)(2)) Same-day service only. No saving and reheating of foods or preparation of foods the day prior to eating. Any remaining food from meals to be removed/discarded at end of day.
- Make sure to datemark any deli meats and prepared cold items that are kept in refrigerator.
- Employee food needs to be labeled and separated from residents food.
- Staff and residents should be washing hands every time they prepare foods in kitchen; Right side of 2-comp sink is designated for handwashing.
- Cutting boards should be utilized as food contact surfaces and not counters or plates.
- Extra care needs to be taken when cleaning behind cabinet hardware so debris does not build up on or behind handles.

Type: Full
Date: 12/04/23
Time: 11:00:00
Report: 1031231315
Souriyathy Housing With Servic

Food and Beverage Establishment Inspection Report

Page 5

- If grilling outside, establishment must leave doors open so hands can be washed in kitchen without opening doors or have gravity handwash setup (discussed in site during inspection) at grill area.
- Establishment does not have 3-comp sink or commercial dishwasher - can use residential dishwasher to wash, rinse, and sanitize (use sanitize setting on washer).
- - 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.
- When preparing food, make sure to use a thin-probe thermometer to check temperatures.

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 1031231315 of 12/04/23.

Certified Food Protection Manager: _____

Certification Number: _____ Expires: ____ / ____ / ____

Inspection report reviewed with person in charge and emailed.

Signed: _____

Phinhsaykeo Souriyathy
Person in Charge

Signed: _____

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

Report #: 1031231315

DEPARTMENT OF HEALTH

Environmental Health

Food, Pools, and Lodging

625 Robert St. N

St. Paul

No. of RF/PHI Categories Out

5

No. of Repeat RF/PHI Categories Out

0

Legal Authority MN Rules Chapter 4626

Date

12/04/23

Time In

11:00:00

Time Out

Souriyathy Housing With Servic

Address

6231 Sunny Lane

City/State

Brooklyn Park, MN

Zip Code

55428

Telephone

6123681236

License/Permit #

0037481

Permit Holder

Purpose of Inspection

Full

Est Type

Risk Category

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item

Mark "X" in appropriate box for COS and/or R

IN=in compliance OUT= not in compliance N/O= not observed N/A= not applicable COS=corrected on-site during inspection R= repeat violation

Compliance Status

COS

R

Supervision

1

IN

OUTPIC knowledgeable; duties & oversight

2

IN

OUT

N/ACertified food protection manager, duties

Employee Health

3

IN

OUT

Mgmt/Staff;knowledge,responsibilities&reporting

4

IN

OUTProper use of reporting, restriction & exclusion

5

IN

OUTProcedures for responding to vomiting & diarrheal events

Good Hygienic Practices

6

IN

OUT

N/O

Proper eating, tasting, drinking, or tobacco use

7

IN

OUTN/ONo discharge from eyes, nose, & mouth

Preventing Contamination by Hands

8

IN

OUTN/ONHands clean & properly washed

9

IN

OUTN/AN/ONo bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed

10

IN

OUTAdequate handwashing sinks supplied/accessible

Approved Source

11

IN

OUTFood obtained from approved source

12

IN

OUTN/AN/OFood received at proper temperature

13

IN

OUTFood in good condition, safe, & unadulterated

14

IN

OUT

N/A

N/ONequired records available; shellstock tags, parasite destruction

Protection from Contamination

15

IN

OUTN/AN/OFood separated and protected

16

IN

OUT

N/AFood contact surfaces: cleaned & sanitized

17

IN

OUTProper disposition of returned, previously served, reconditioned, & unsafe food

Compliance Status

COS

R

Time/Temperature Control for Safety

18

IN

OUTN/ADiv>OUT

Proper cooking time & temperature

19

IN

OUT

N/A

OUTN/OProper reheating procedures for hot holding

20

IN

OUT

N/A

OUTN/OProper cooling time & temperature

21

IN

OUTN/ADiv>OUT

Proper hot holding temperatures

22

IN

OUT

N/AFood in good condition, safe, & unadulterated

23

IN

OUT

N/AN/OProper date marking & disposition

24

IN

OUT

N/A

OUTN/OTime as a public health control: procedures & records

Consumer Advisory

25

IN

OUT

N/A

OUTConsumer advisory provided for raw/undercooked food

Highly Susceptible Populations

26

IN

OUTN/AFood in good condition, safe, & unadulterated

Food and Color Additives and Toxic Substances

27

IN

OUT

N/A

OUTFood additives: approved & properly used

28

IN

OUT

OUTToxic substances properly identified, stored, & used

Conformance with Approved Procedures

29

IN

OUT

N/A

OUTCompliance with variance/specialized process/HACCP

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

GOOD RETAIL PRACTICES

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

Mark "X" in box if numbered item is not in compliance

Mark "X" in appropriate box for COS and/or R

COS=corrected on-site during inspection

R= repeat violation

COS

R

Safe Food and Water

30

IN

OUT

N/A

OUTPasteurized eggs used where required

31

IN

OUTN/AFood in good condition, safe, & unadulterated

32

IN

OUT

N/A

OUTVariance obtained for specialized processing methods

Food Temperature Control

33

IN

OUTN/AFood in good condition, safe, & unadulterated

34

IN

OUTN/AN/OPlant food properly cooked for hot holding

35

IN

OUTN/AN/OFood in good condition, safe, & unadulterated

36

IN

OUTN/AN/OFood in good condition, safe, & unadulterated

Food Identification

37

IN

OUTN/AFood in good condition, safe, & unadulterated

Prevention of Food Contamination

38

IN

OUTN/AFood in good condition, safe, & unadulterated

39

IN

OUTN/AFood in good condition, safe, & unadulterated

40

IN

OUTN/AFood in good condition, safe, & unadulterated

41

IN

OUTN/AFood in good condition, safe, & unadulterated

42

IN

OUTN/AFood in good condition, safe, & unadulterated

COS

R

Proper Use of Utensils

43

IN

OUTN/AFood in good condition, safe, & unadulterated

44

IN

OUTN/AFood in good condition, safe, & unadulterated

45

IN

OUTN/AFood in good condition, safe, & unadulterated

46

IN

OUTN/AFood in good condition, safe, & unadulterated

Utensil Equipment and Vending

47

IN

OUTN/AFood in good condition, safe, & unadulterated

48

IN

OUTN/AFood in good condition, safe, & unadulterated

49

IN

OUTN/AFood in good condition, safe, & unadulterated

Physical Facilities

50

IN

OUTN/AFood in good condition, safe, & unadulterated

51

IN

OUTN/AFood in good condition, safe, & unadulterated

52

IN

OUTN/AFood in good condition, safe, & unadulterated

53

IN

OUTN/AFood in good condition, safe, & unadulterated

54

IN

OUTN/AFood in good condition, safe, & unadulterated

55

IN

OUTN/AFood in good condition, safe, & unadulterated

56

IN

OUTN/AFood in good condition, safe, & unadulterated

57

IN

OUTN/AFood in good condition, safe, & unadulterated

58

IN

OUTN/AFood in good condition, safe, & unadulterated

Food Recalls:

Person in Charge (Signature)

Date: 12/06/23

Inspector (Signature)