DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

February 24, 2022

Administrator
Angel Care Homes
7829 Hampshire Circle North
Brooklyn Park, MN 55445

RE: Project Number(s) SL35222015

Dear Administrator:

On February 1, 2022, the Minnesota Department of Health completed a follow-up evaluation of your agency to determine correction of orders found on the evaluation completed on November 24, 2021. The follow-up evaluation determined your agency had not corrected all of the state licensing orders issued pursuant to the November 24, 2021 evaluation.

In accordance with Minn. Stat. § 144A.474, Subd. 11, state licensing orders issued pursuant to the last evaluation completed on November 24, 2021, found not corrected at the time of the February 1, 2022, follow-up evaluation and/or subject to penalty assessment are as follows:

0650-Employee Records-144g.42 Subd. 8 = $500.00

The details of the violations noted at the time of this follow-up evaluation completed on February 1, 2022 (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. §§ 144A.43 to 144A.482, **the total amount you are assessed is $500.00**. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

Also, at the time of this follow-up evaluation completed on February 1, 2022, we identified the following violation(s):

0485-Minimum Requirements-144g.41 Subd 1. (13) (i) (a) And (c)
1620-Initial Reviews, Assessments, And Monitoring-144g.70 Subd. 2

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

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144A.474, Subd. 8(c), by the correction order date, the licensee

must document in the provider's records any action taken to comply with the correction order by the correction order date. The commissioner may request a copy of this documentation and the home care provider's action to respond to the correction orders in future evaluations, upon a complaint investigation, and as otherwise needed.

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 § 144A.475 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144A.475.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144A.475.

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144A.474, Subd. 12, you have one opportunity to challenge the correction order issued, including the level and scope, and any fine assessed through the correction order reconsideration process. This written request must be received by the Department of Health within 15 calendar days of the correction order receipt date. Please send your written request via email to the following:

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

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144A.474, Subd. 11(g) , a home care 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. § 144A.475, Subd. 4 and Subd. 7, a request for a hearing must be in writing and received by the Department of Health within 15 calendar days of the correction order receipt date. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

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.

We urge you to review these orders carefully. If you have questions, please contact Jess Gallmeier at 651-247-0268.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your agency's Governing Body.

Sincerely,

Jess Gallmeier, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-247-0268 Fax: 651-215-9697

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35222	A. BUILDING: _____ B. WING _____	R 02/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGEL CARE HOMES	**7829 HAMPSHIRE CIRCLE NORTH BROOKLYN PARK, MN 55445**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments Initial comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION 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: Project # SL35222015 On February 1, 2022, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on November 24, 2021. At the time of the survey, there were two active residents 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.	
0 485 SS=C	144G.41 Subd 1. (13) (i) (A) and (C) Minimum Requirements	0 485		

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0 485	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (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; (C) the facility cannot require a resident to include and pay for meals in their contract; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to have menus prepared at least one week in advance and made available to all residents. This had the potential to affect all two residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	0 485		

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0 485	Continued From page 2 On February 1, 2022, at approximately 10:30 a.m., during entrance conference, the surveyor requested the week's meal menu. Licensed assisted living director (LALD)-A pointed to a posted document with the days of the week (Monday through Sunday), but did not have dates on it. On February 1, 2022, at approximately 10:45 a.m., LALD-A acknowledged the posted document served as the menu. LALD-A stated it did not have dates on it, and it lacked to show the menu at least one week in advance. The licensee's Food Service policy, dated August 1, 2021, indicated menus are prepared one week in advance and made available to all residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 485		
{0 650} SS=F	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including	{0 650}		

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{0 650}	Continued From page 3 qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records contained the required orientation content and annual training for three of three employees (unlicensed personnel (ULP)-D, licensed assisted living director (LALD)-A, and registered nurse (RN)-C) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	{0 650}		

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{0 650}	Continued From page 4 On February 1, 2022, at approximately 10:30 a.m., ULP-D screened the surveyor and RN-C when they arrived at the licensee's facility. On February 1, 2022, at approximately 12:45 p.m., ULP-D served R2 lunch in the dinning room. ULP-D had a hire date of December 16, 2021. ULP-D's record lacked new hire orientation to assisted living regulations, to include the review of provider's policies and procedures. LALD-A started employment with the licensee on January 27, 2020, under the comprehensive home care license and began providing assisted living services on August 1, 2021. LALD-A's record lacked new hire orientation to assisted living regulations, to include the review of provider's policies and procedures. RN-C started employment with the licensee on March 4, 2020, under the comprehensive home care license and began providing assisted living services on August 1, 2021. RN-C's record lacked new hire orientation to assisted living regulations, to include the review of provider's policies and procedures. On February 1, 2022, at approximately 12:45 p.m., LALD-A acknowledged the employees were missing the stated content, and further stated the licensee will have them write an acknowledgement to have gone through the licensee's policies and procedures. The licensee's Staff Orientation and Education policy, dated August 1, 2021, indicated the missing content is provided to employees at orientation and annual training.	{0 650}		

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{0 650}	Continued From page 5 No further information provided.	{0 650}		
{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: No further action required.	{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	{0 790}		

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{0 790}	Continued From page 6 Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: No further action required.	{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: No further action required.	{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	{0 810}		

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{0 810}	Continued From page 7 a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: No further action required.	{0 810}		
01620 SS=D	144G.70 Subd. 2 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	01620		

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01620	Continued From page 8	01620		

resident and cannot exceed 90 calendar days from the last date of the assessment.
(d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review.
(e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive reassessment to include all areas identified on the uniform assessment tool for one of one resident (R1) with records reviewed.

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 an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).

The findings include:

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01620	Continued From page 9 R1 admitted to the licensee on November 8, 2021. R1's individual abuse prevention plan (IAPP), dated January 26, 2022, indicated vulnerabilities including a history of suicidal thoughts, history of alcohol abuse, history of drug use (not prescribed), depression and anxiety. R1's IAPP indicated R1 'smokes safely'. R1's assessment titled Master Care Plan, dated November 24, 2021, completed by registered nurse (RN)-C, lacked a smoking assessment including the ability to smoke without causing burns or injury to the resident or others or damage to property. On February 1, 2022, at approximately 12:40 p.m., licensed assisting living director (LALD)-A, and RN-C acknowledged R1 was missing a smoking assessment, but also stated the assessment was not necessary as they had observed R1 smoke safely. The licensee's Comprehensive Nursing Assessment policy, dated August 1, 2021, indicated the RN will conduct a comprehensive assessment for all residents to include smoking, including safety factors. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01620		

Electronically Delivered

January 12, 2022

Administrator
Angel Care Homes
7829 Hampshire Circle North
Brooklyn Park, MN 55445

RE: Project Number(s) SL35222015-0

Dear Administrator:

The Minnesota Department of Health completed an evaluation on November 24, 2021, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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 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.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes 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. The Department of Health 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 (a)(5)(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, no immediate fines are assessed.

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

The correction order documentation should include the following:

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

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

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

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

Free from Maltreatment reconsideration requests should addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place

St. Paul, MN 55164-0970 St. Paul, MN 55164-0970

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

Sincerely,

Jess Gallmeier, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35222	A. BUILDING: _____ B. WING _____	11/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGEL CARE HOMES	7829 HAMPSHIRE CIRCLE NORTH BROOKLYN PARK, MN 55445

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.93, 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: SL#35222015 On November 22, 2021, through November 24, 2021, 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 two (2) residents receiving services under the provider's Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 430 SS=F	144G.40 Subd. 2 Uniform checklist disclosure of services (a) All assisted living facilities must provide to prospective residents:	0 430		

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0 430	Continued From page 1 (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a). This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a copy of the uniform disclosure of assisted living services and amenities (UDALSA) with the required content for two of two residents (R1 and R2) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	0 430		

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0 430	Continued From page 2 R1 admitted to licensee on November 8, 2021. R1's service plan titled Service Plan (Waiver) - Addendum to Contract dated November 8, 2021, indicated R1 received services, including medication management, nursing assessment, housekeeping, laundry, bathing reminders, meal preparation and shopping assistance. R1's record lacked documentation of acknowledgement or receipt of the UDALSA. R2 admitted to the licensee on April 7, 2021. R2's service plan titled Service Plan (Waiver) dated April 9, 2021, indicated R2 received services, including medication management, housekeeping, meal preparation, laundry, shopping and assessments. R2's record lacked documentation of acknowledgement or receipt of the UDALSA. During an interview on November 24, 2021, at approximately 12:40 p.m., licensed assisted living director/unlicensed personnel (LALD/ULP)-A stated R1 and R2 had not received a UDALSA. The licensee's resident admission policy was requested but was not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 430		
0 630 SS=F	144G.42 Subd. 6 Compliance with requirements for reporting ma	0 630		

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0 630	Continued From page 3 (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 licensee failed to ensure resident individual abuse prevention plans (IAPP) included statements of specific measures to be taken by staff to minimize the risk of abuse for two of two residents (R1 and R2) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: R1 admitted to the licensee on November 8, 2021. R1's IAPP dated November 22, 2021, indicated vulnerabilities including history of suicidal thoughts, history of alcohol abuse, history of drug	0 630		

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0 630	Continued From page 4 use (not prescribed), depression and anxiety. R1's IAPP lacked statements of specific measures to be taken to minimize the risk of abuse to R1. R2 admitted to the licensee on April 7, 2021. R2's IAPP dated October 5, 2021, indicated vulnerabilities including history of drug use (not prescribed), may not report abuse or neglect, and mental illness. R2's IAPP lacked statements of specific measures to be taken to minimize the risk of abuse to R2. During an interview on November 24, 2021, at approximately 12:20 p.m., registered nurse (RN)-C confirmed R1 and R2's IAPPs lacked statements of specific measures to be taken to minimize risk of abuse to the residents and stated she will update the IAPPs to reflect the measures. The licensee's policy, Vulnerable Adult, dated August 1, 2021, indicated employees are required to individually assess residents to determine vulnerability to abuse or neglect and develop a specific plan to minimize the risk of abuse to that resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must	0 650		

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0 650	Continued From page 5 include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure employee records contained the required orientation content for one of two employees (licensed assisted living director/unlicensed personnel ((LALD/ULP)-A) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 650		

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0 650	Continued From page 6 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: LALD/ULP-A started employment with the licensee on January 27, 2020, under the comprehensive home care license and began providing assisted living services on August 1, 2021. LALD/ULP-A's employee record lacked documentation LALD/ULP-A completed orientation at hire and annual training, including the principles of person-centered planning and service delivery. During an observation on November 23, 2021, at approximately 8:30 a.m., LALD/ULP-A passed medications to assisted living residents. On November 24, 2021, at approximately 11:45 a.m., LALD/ULP-A stated the required orientation at hire and annual training topic were not completed. LALD/ULP-A stated the licensee was not aware of the requirement. A policy for employee orientation and annual training was requested but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		

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0 680	Continued From page 7	0 680		
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 tenant 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 requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to have a written emergency preparedness plan with all the required content and to post an emergency preparedness plan prominently. This had the potential to affect all staff, visitors, and residents receiving services under the license.	0 680		

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0 680	Continued From page 8 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On November 22, 2021, at approximately 9:20 a.m., during the entrance conference, the surveyor requested to review the licensee's emergency preparedness plan. During a facility tour on November 22, 2021, at approximately 10:45 a.m., the surveyor did not observe a posting of the licensee's emergency plan, emergency exit diagrams posted in conspicuous places on each floor, or emergency exit diagrams in residents' room. The licensee lacked evidence of the following required content: - a comprehensive program to include infectious diseases and pandemics; - a description of the population served by the licensee; - process for emergency preparedness (EP) cooperation with state and local EP officials/organizations; - procedure for tracking staff and residents; - subsistence needs for staff and residents during emergency situation; - development of policies/procedures to address: - evacuation plan (not customized for the facility); - fire (not customized for the facility);	0 680		

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0 680	Continued From page 9 - shelter in place; - a tracking system used to document locations or residents and staff; - the medical record documentation system to preserve resident information; - emergency staff strategies; and - the facilities role in providing care and treatment at alternative sites; - a communication plan that included: - arrangement with other facilities; - names and contact information for staff, resident physicians, other facilities; - contact information for federal, state, tribal, local EP staff, ombudsman; - primary and alternative means for communicating with facility staff, federal, state, regional and local emergency management agencies; - a method of sharing information and medical documentation for residents; - a means to provide information regarding the facility's needs, and its ability to provide assistance to include information about their occupancy; and -a method of sharing information from the emergency plan with residents and their families; - EP training and testing program; - EP training program for staff (including documentation of training provided); and - EP testing/annual testing requirements. During an interview on November 24, 2021, at approximately 12:10 p.m., licensed assisted living director/unlicensed personnel (LALD/ULP)-A stated staff were not familiar with Appendix Z (a section of the Centers for Medicare and Medicaid Services [CMS] State Operations Manual which includes the emergency preparedness guidelines). LALD/ULP-A also stated the licensee had not fully developed and implemented the an	0 680		

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0 680	Continued From page 10 emergency preparedness plan/program. The licensee's policy titled Emergency Preparedness dated August 1, 2021, indicated the licensee will have an identified plan in place to assure the safety and well-being of residents and staff during periods of emergency or disaster that disrupts services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (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,	0 780		

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0 780	Continued From page 11 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 complied with fire protection requirements. This had the potential to affect all residents staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the facility tour with licensed assisted living director/unlicensed personnel (LALD/ULP)-A on November 23, 2021, between 10:30 a.m. and 11:15 a.m., the surveyor observed: - Smoke alarms were not interconnected so that actuation of one alarm caused all alarms in the individual dwelling unit to operate. When smoke alarms were tested in bedrooms, hallways, and common use areas, none of the other smoke alarms within the building were activated. - A smoke alarm was not provided in bedroom three. - On the second level, a smoke alarm was not installed in the common use area living room. During the facility tour interview, LALD/ULP-A stated facility smoke alarms were not interconnected. LALD/ULP-A also stated the	0 780		

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0 780	Continued From page 12 smoke alarm within bedroom three had been removed. LALD/ULP-A stated a smoke alarm was not installed in the common use area living room on the second floor. No further information was provided. 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 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 fire extinguishers that complied with fire protection requirements. This had the potential to affect all residents staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	0 790		

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0 790	Continued From page 13 or has the potential to affect a large portion or all of the residents). The findings include: During a facility tour with licensed assisted living director/unlicensed personnel (LALD/ULP)-A on November 23, 2021, between 10:30 a.m. and 11:15 a.m., the surveyor observed: - Fire extinguishers located in the kitchen and basement were not provided with labels or tags attached indicating when maintenance was performed. The bottom of the fire extinguisher in kitchen was date stamped 2016. - The fire extinguisher located in the basement was rated 1A:10BC. During the exit conference on November 23, 2021, at approximately 12:00 p.m., LALD/ULP-A stated they did not know annual maintenance was required for portable fire extinguishers and that fire extinguishers were required to be 2-A:10BC rated. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	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.	0 800		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 800	Continued From page 14 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the 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 affect all residents staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During a facility tour with licensed assisted living director/unlicensed personnel (LALD/ULP)-A on November 23, 2021, between 10:30 a.m. and 11:15 a.m., the surveyor observed: - The sliding egress window in bedroom three was jammed and would not open when the latch was released. - The sliding egress window in bedroom one measured 16 inches in width. During the facility tour interview, LALD/ULP-A confirmed the window in bedroom three was jammed and would not open in the correct direction. During the exit conference on November 23, 2021, at approximately 12:00 p.m., LALD/ULP-A stated they did not know if the window in bedroom one met the minimum size requirement for	0 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35222	A. BUILDING: _____ B. WING _____	11/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGEL CARE HOMES	7829 HAMPSHIRE CIRCLE NORTH BROOKLYN PARK, MN 55445

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 800	Continued From page 15 escape. 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 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	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35222	A. BUILDING: _____ B. WING _____	11/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGEL CARE HOMES	7829 HAMPSHIRE CIRCLE NORTH BROOKLYN PARK, MN 55445

(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
0 810	Continued From page 16 drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide the required training to residents and staff for fire safety and evacuation and failed to provide evacuation maps. This had the potential to affect all residents staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the facility tour with licensed assisted living director/unlicensed personnel (LALD/ULP)-A on November 23, 2021, between 10:30 a.m. and 11:15 a.m., the surveyor did not observe evacuation maps posted within the facility. On November 23, 2021, between 11:15 a.m. and 11:45 a.m., the surveyor reviewed the following records: an emergency preparedness manual; a fire safety policy dated August 1, 2021; an emergency preparedness plan; and an employee training record. The surveyor noted residents did not receive annual fire safety and evacuation training plan. The staff received fire safety and evacuation training upon hire but there were no plans for staff to receive training at least twice per year thereafter.	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35222	A. BUILDING: _____ B. WING _____	11/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGEL CARE HOMES	7829 HAMPSHIRE CIRCLE NORTH BROOKLYN PARK, MN 55445

(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
0 810	Continued From page 17 During an interview on November 23, 2021, between 11:45 a.m. and 12:00 p.m., LALD/ULP-A confirmed the licensee did not provide evacuation maps and that the training frequency for staff and residents was not met. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01650 SS=C	144G.70 Subd. 4 Service plan, implementation, and revisions t (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35222	A. BUILDING: _____ B. WING _____	11/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGEL CARE HOMES	7829 HAMPSHIRE CIRCLE NORTH BROOKLYN PARK, MN 55445

(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
01650	Continued From page 18 medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident service plan included the fees for services for two of two residents (R1 and R2) with records reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 was admitted to the licensee on November 8, 2021. R1's service plan titled Service Plan (Waiver) - Addendum to Contract dated November 8, 2021, indicated R1 received services, including medication management, assessment, housekeeping, laundry, bathing reminder, meal preparation and shopping assistance. During an interview on November 24, 2021, at approximately 9:45 a.m., R1 stated she received services from the licensee, and she enjoyed the company of other residents and staff. R2 was admitted to the licensee on April 7, 2021.	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35222	A. BUILDING: _____ B. WING _____	11/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGEL CARE HOMES	**7829 HAMPSHIRE CIRCLE NORTH BROOKLYN PARK, MN 55445**

(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
01650	Continued From page 19 R2's service plan titled Service Plan (Waiver) dated April 9, 2021, indicated R2 received services, including medication management, housekeeping, meal preparation, laundry, shopping and assessments. During an interview on November 23, 2021, at approximately 12:40 p.m., licensed assisted living director/unlicensed personnel (LALD/ULP)-A stated resident service plans were missing the fees for services, but the licensee would update the service plans. The licensee's policy titled Service Plan dated August 1, 2021, indicated the fees for services should be included in the service plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		

Minnesota Department of Health
Division of Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *11/22/21*
Time: 12:00:00
Report: 1025211326

Food and Beverage Establishment Inspection Report

Location:
Angel Care Homes
7829 Hampshire Circle North
Brooklyn Park, MN55445
Hennepin County, 27

Establishment Info:
ID #: 0038348
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 6124236690
ID #:

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

The following orders were issued during this inspection.

4-300 Equipment Numbers and Capacities

4-301.12A ***** Priority 2 *****

MN Rule 4626.0680A Provide a 3 compartment sink with integrally attached drainboards at each end for manually washing, rinsing and sanitizing equipment and utensils.

Establishment has a 2 compartment sink. Provide a 3 compartment sink; until a 3 compartment sink is provided, provide a substitute compartment for sanitizing. See additional comments.

Comply By: 11/22/21

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.

Bimetal dial thermometer available; provide a thin-type probe thermometer for taking temperatures of thin foods to verify final cooking temperature.

Comply By: 11/26/21

5-200C Plumbing: Maintenance, fixture location

5-205.11AB ***** Priority 2 *****

MN Rule 4626.1110AB The handwashing sink must be accessible at all times for employee use, and must be used only for handwashing.

Provide a dedicated handwashing sink; see additional comments.

Comply By: 11/22/21

4-100 Equipment Construction Materials

4-101.17

MN Rule 4626.0490 Discontinue using wood and wood wicker as a food contact surface.
Discontinue use of the bamboo wood cutting board; provide a non-porous cutting board for food preparation.

Comply By: 11/22/21

Food and Equipment Temperatures

Process/Item: Ambient
Temperature: 39 Degrees Fahrenheit - Location: Upstairs refrigerator
Violation Issued: No

Process/Item: Ambient
Temperature: 40 Degrees Fahrenheit - Location: Downstairs refrigerator
Violation Issued: No

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

General discussion and observations:
Reviewed 4626.0506 section G for equipment, and definition for serving TCS foods for same-day service (not cooling and retaining facility provided TCS foods, residents do have own separate personal food on occasion); training manual for staff; supervising residents/volunteers when they participate in food preparation; cook temperatures for raw animals foods, and "fully cooked" temperature on frozen food labels; recalls (reported receiving recall information via email); food sources mainly Sam's Club and Cub, provide food only from licensed sources; resident illness reporting, reporting illness potentially caused by food prepared or consumed during restaurant visits or food delivery; staff health, hygiene, illness reporting and exclusion policy; measuring final cook temperature of foods using a thin-type probe thermometer; ambient temperature of upstairs refrigerator monitored and recorded (if the dial thermometer is dropped or damaged, it should be replaced, as if the backing with the numbers is moved, the calibration will be off). Downstairs refrigerator used for bread during inspection. CFPM information provided below (a food manager safety course was completed within the past 6 months, course certificate on display); pest control; dry food storage (entry-way pantry has suitable finishes, dry foods in their original containers); chemical storage (chemicals stored away from food products).

Search "MDH CFPM" or visit https://www.health.state.mn.us/communities/environment/food/cfpm/index.html

Sanitizing equipment, 3 compartment sink:
Facility has a 2 compartment sink in the kitchen. 4626.0680 A requires a 3 compartment sink be provided, and 4626.0680 C permits use of a receptacle that substitutes for the compartments of a multicompartment sink with regulatory approval. Provide an additional compartment (bus tub, etc) as a substitute 3rd sink compartment until a 3 compartment sink is provided, or formal regulatory approval is provided by the licensing agency exempting an installed 3 compartment sink. If the dishwasher is used for washing and rinsing utensils (dishwasher does not sanitize, does not reach an internal contact temperature of 160 deg F (NSF residential rating only, 156 deg F)), one of the sink compartments could be used (clean, rinsed) to prepare a sanitizing solution, although it may be easiest just to maintain the substitute compartment for all chemical sanitizing of utensils. Discussed preparation and testing of a bleach sanitizing solution, and use

(50-100 PPM, with a 60 sec contact time, and air dry).

Handwashing sink:
Dedicated handwashing sinks are required by 4626.1110. Until a dedicated handwashing sink is provided, wash hands in the available 2 compartment sink; ensure sink is clean and sanitizing to prevent recontamination of hands.

Handwashing reminder sinks provided at kitchen sink; soap and paper towels available, glove available.

Inspection findings reviewed with MDH B Nyangena on-site.

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1025211326 of 11/22/21.

Certified Food Protection Manager: Sadie H

Certification Number: TBD Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed: _____
Sadia H

Signed: _____
Casey Kipping
Public Health Sanitarian II
Freeman Building St Paul
651-201-4513
casey.kipping@state.mn.us

Report #: 1025211326

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Division of Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975

No. of RF/PHI Categories Out	1	Date	11/22/21
No. of Repeat RF/PHI Categories Out	0	Time In	12:00:00
Legal Authority MN Rules Chapter 4626		Time Out	

Angel Care Homes	Address: 7829 Hampshire Circle North	City/State: Brooklyn Park, MN	Zip Code: 55445	Telephone: 6124236690
License/Permit #: 0038348	Permit Holder	Purpose of Inspection: Full	Est Type	Risk Category

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item — Mark "X" in appropriate box for COS and/or R

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

Compliance Status		COS	R
Supervision			
1	IN OUT — PIC knowledgeable; duties & oversight		
2	IN OUT N/A — Certified food protection manager, duties		
Employee Health			
3	IN OUT — Mgmt/Staff;knowledge,responsibilities&reporting		
4	IN OUT — Proper use of reporting, restriction & exclusion		
5	IN OUT — Procedures for responding to vomiting & diarrheal events		
Good Hygenic Practices			
6	IN OUT N/O — Proper eating, tasting, drinking, or tobacco use		
7	IN OUT N/O — No discharge from eyes, nose, & mouth		
Preventing Contamination by Hands			
8	IN OUT N/O — Hands clean & properly washed		
9	IN OUT N/A N/O — No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10	IN OUT — Adequate handwashing sinks supplied/accessible		
Approved Source			
11	IN OUT — Food obtained from approved source		
12	IN OUT N/A N/O — Food received at proper temperature		
13	IN OUT — Food in good condition, safe, & unadulterated		
14	IN OUT N/A N/O — Required records available; shellstock tags, parasite destruction		
Protection from Contamination			
15	IN OUT N/A N/O — Food separated and protected		
16	IN OUT N/A — Food contact surfaces: cleaned & sanitized		
17	IN OUT — Proper disposition of returned, previously served, reconditioned, & unsafe food		

Compliance Status		COS	R
Time/Temperature Control for Safety			
18	IN OUT N/A N/O — Proper cooking time & temperature		
19	IN OUT N/A N/O — Proper reheating procedures for hot holding		
20	IN OUT N/A N/O — Proper cooling time & temperature		
21	IN OUT N/A N/O — Proper hot holding temperatures		
22	IN OUT N/A — Proper cold holding temperatures		
23	IN OUT N/A N/O — Proper date marking & disposition		
24	IN OUT N/A N/O — Time as a public health control: procedures & records		
Consumer Advisory			
25	IN OUT N/A — Consumer advisory provided for raw/undercooked food		
Highly Susceptible Populations			
26	IN OUT N/A — Pasteurized foods used; prohibited foods not offered		
Food and Color Additives and Toxic Substances			
27	IN OUT N/A — Food additives: approved & properly used		
28	IN OUT — Toxic substances properly identified, stored, & used		
Conformance with Approved Procedures			
29	IN OUT N/A — Compliance with variance/specialized process/HACCP		

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

GOOD RETAIL PRACTICES

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

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

			COS	R
Safe Food and Water				
30	IN OUT N/A	Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32	IN OUT N/A	Variance obtained for specialized processing methods		
Food Temperature Control				
33		Proper cooling methods used; adequate equipment for temperature control		
34	IN OUT N/A N/O	Plant food properly cooked for hot holding		
35	IN OUT N/A N/O	Approved thawing methods used		
36	X	Thermometers provided & accurate		
Food Identification				
37		Food properly labled; original container		
Prevention of Food Contamination				
38		Insects, rodents, & animals not present		
39		Contamination prevented during food prep, storage & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
Proper Use of Utensils				
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
Utensil Equipment and Vending				
47	X	Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48	X	Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
Physical Facilities				
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) **Date:** 11/24/21

Inspector (Signature) Cory Kruse