



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

October 25, 2023

Licensee
Relief Homecare LLC
14420 Hollow Park Lane
Burnsville, MN 55306

RE: Project Number(s) SL36912015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on October 3, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

STATE CORRECTION ORDERS

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

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

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

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.

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

Please address your cover letter for reconsideration requests to:

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

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

If you have any questions, please contact me.

Sincerely,



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

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36912	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/03/2023
NAME OF PROVIDER OR SUPPLIER RELIEF HOMECARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 14420 HOLLOW PARK LANE BURNSVILLE, MN 55306		
(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: SL36912015-0 On October 2, 2023, through October 3, 2023, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there was one active resident; with one receiving services under the Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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.		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that:	0 470			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 470	Continued From page 1 (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the required staffing plan was developed as required, potentially affecting the licensee's residents, staff, and any visitors of the licensee. This practice resulted in a level two violation (a violation that did not harm a licensee'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	0 470		

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0 470	Continued From page 2 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee held and assisted living license and was licensed for a capacity of four residents with a current census of one resident. On October 2, 2023, at 4:30 p.m. the facility staffing plan was requested. Clinical nurse supervisor (CNS)-B stated she and licensed assisted living director (LALD)-A developed the facility staffing plan, but she was not aware she needed to review it twice yearly. The licensee failed to develop and implement a staffing plan for determining its staffing level that: - included an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility. On October 3, 2023, at 12:00 p.m. LALD-A provided the facility's staffing plan and indicated the plan was not dated and lacked evidence of a review date or signature by CNS-B as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 470			
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:	0 480			

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0 480	Continued From page 3 (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 included document titled, Food and Beverage Establishment Inspection Report dated October 3, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480			
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact	0 550			

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0 550	Continued From page 4 information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post the required information related to the contact information for the applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. 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, 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 October 2, 2023, at 3:30 p.m. the surveyor toured the facility with licensed assisted living director (LALD)-A. The surveyor observed several postings in the entryway of the facility, and noted the postings lacked the required contact	0 550			

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0 550	Continued From page 5 information for regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. On October 2, 2023, at 4:00 p.m. LALD-A stated the required posting for the ombudsman for long term care and ombudsman for disabilities and mental health, was not posted, and stated "no, I cannot find these, we don't have this." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
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 observation, interview, and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for the licensee's one current resident (R1).	0 630		

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0 630	Continued From page 6 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's diagnoses included schizoaffective disorder (mental disorder characterized by abnormal thought processes and an unstable mood), bipolar depression (a mental health condition that causes extreme mood swings that include emotional highs and lows, and anxiety. R1 was admitted to the facility under the facility's Assisted Living Facility (ALF) license on November 15, 2021. R1's Service Plan dated November 17, 2021, indicated she received the services of medication administration and behavior management. On October 3, 2023, at 7:45 a.m. unlicensed personnel (ULP)-C was observed to administer medications to R1. R1's IAPP dated August 27, 2023, indicated her vulnerability to abuse by others including other vulnerable adults, but lacked an indication of her susceptibility to abuse others. Her IAPP indicated she could be verbally aggressive and independently went into the community. Additionally, R1's IAPP lacked statements of specific measures to be taken to minimize the risk of abuse to other vulnerable adults.	0 630			

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0 630	Continued From page 7 On October 3, 2023, at 9:30 a.m. clinical nurse supervisor (CNS)-B stated R1's IAPP did not address her susceptibility to abuse others and had not recognized that option in the electronic medical record system used to develop the IAPP. She added, "I understand she [R1] has some mental health concerns which we monitor and intervene and would need to consider that in her IAPP." The licensee's Individual Abuse Prevention policy dated July 20, 2021, indicated the plan would include an individualized review or assessment of the person's risk of abusing other vulnerable adults and specific measures to be taken to minimize the risk to other vulnerable adults. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630			
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	0 680			

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0 680	Continued From page 8 (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 requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to develop an all-hazards risk assessment emergency preparedness (EP) program and plan to include Appendix Z required elements and failed to post the plan prominently. 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 the residents). The findings include: On October 3, 2023, at 4:00 p.m. licensed assisted living director (LALD)-A and the surveyor met to review the contents of the licensee's EP plan and appendix Z requirements. The licensee lacked the following required information according to Emergency	0 680			

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0 680	Continued From page 9 Preparedness: Appendix Z: - establish/maintain a comprehensive emergency plan (EP) which describes the facility's approach to meeting health/safety/security needs of staff/residents addressing how they would coordinate with other, health care facilities (HCF), as well as community on a whole during emergency or disaster (natural, man-made, facility, etc.) and be reviewed/updated annually; - risk assessment which considered hazards like care related emergencies, cyber-attacks, normal supply of essential resources and medical supplies, should consider duration of interruptions, consider emerging infectious diseases (EIDs); - document risk assessment for an all-hazards approach, including EIDs as applicable, categorize the various probable risks by likelihood of occurrence, develop strategies for addressing facility and community-based risks (evacuation plans, staffing surges/shortages, back-up plans); - identification of at-risk population needs like maintaining independence, communication, transportation, supervision, medical care; and qualified person authorized in writing to act in the absence of the administrator; - a process for cooperation and collaboration with local, tribal, regional, State and Federal EP to maintain integrated response; - policy and procedure based on the EP risk assessment and communication plan; - policy and procedure addressing whether evacuated or shelter in place for staff/residents for food, water, medical supplies, pharmaceutical supplies; - policy and procedure addressing alternate sources of energy to maintain temperatures to protect resident health/safety, safe and sanitary storage of provisions emergency lighting and sewage and waste disposal;	0 680			

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0 680	Continued From page 10 - policy and procedure for a system to track the location of on duty staff and sheltered residents and if on duty staff and sheltered residents are relocated, the facility must document the specific name/location of the receiving facility or other location; - policy and procedure addressing safe evacuation form facility, including care and treatment needs of evacuees; staff responsibilities; primary/alternate communication means with external sources of assistance; - policy and procedure to shelter in place for residents, staff, and volunteers who remain in the facility; - policy and procedure addressing system of medical documentation that preserves resident information, protects confidentiality, and secures/maintains availability of records; - policy and procedure addressing use of volunteers, including the process/role for integration; - policy and procedures addressing development of arrangements with other facilities/providers to receive residents in the event of limitations/cessation of operations to maintain the continuity of services to residents; - policy and procedure addressing the role of facility under waiver declared by the Secretary in accordance with section 1135 of the ACT; - develop a written communication plan; - communication plan which includes names/contact information: staff, entities providing services under agreement, residents' physicians, other facilities, volunteers; - communication plan which includes contact information for Federal, State, tribal, regional, and local EP staff; State Licensing and Certification Agency; and other sources of assistance; - communication plan which includes alternate means of communication with facility staff and	0 680			

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0 680	Continued From page 11 Federal, State, tribal, regional, and local emergency management agencies; - communication plan which includes method for sharing information and medical documentation for residents under the facility's care, as necessary, with other health care personnel to maintain continuity of care; means, in event of evacuation, to release resident information as permitted under 45 CFR 164.510(b)(1)(ii); means of providing information about general condition/location of residents under facility's care as permitted under 45 CFR 164.510(b)(4); - communication plan which includes means to providing information about the facility occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the incident command center, or designee; and - communication plan which includes method for sharing information from the emergency plan, that the facility has determined appropriate, with residents and their families/representatives; - develop and maintain an EP training and testing program; - training program which includes initial training in EP policy and procedure to all new and existing staff, individuals providing services under arrangement, volunteers consistent with their expected role; provide EP training at least annually; maintain documentation of all EP training; demonstrate staff knowledge of EP; - conduct exercises to test EP at least twice per year, including unannounced staff drills using EP, including participating in an annual full-scale exercise community based or annual individual facility based functional exercise or if facility experiences an actual emergency requiring evacuation of plan, facility is exempt from engaging in its next required full scale exercise; conduct an additional annual exercise that may include a second full scale exercise community	0 680			

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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
0 680	Continued From page 12 based or an individual; facility based functional exercise or mock disaster drill or table top exercise. On October 3, 2023, at 5:00 p.m. LALD-A indicated, although he had a few things in place, some plans as known responses, and had attended a training, the EP plan was lacking written evidence to include all the required elements. The licensee's Emergency Preparedness policy dated July 20, 2021, indicated [licensee name] emergency preparedness plan will include all required elements of appendix Z. The plan will be in writing and reviewed annually. The plan is based on our assisted living-based and community-based risk assessments, utilizing an all-hazards approach. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680			
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	0 790			

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0 790	Continued From page 13 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed maintain portable fire extinguishers as required for the facility. 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). Findings include: On a facility tour on October 2, 2023, at approximately 3:00 p.m. with Licensed Assisted Living Director (LALD)-A it was observed that the fire extinguishers maintenance tag monthly inspections were not completed. LALD-A visually verified this deficient finding at the time of discovery. 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	0 800			

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0 800	Continued From page 14 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 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. This deficient condition 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). Findings include: On a facility tour on October 2, 2023, at approximately 3:00 p.m. with Licensed Assisted Living Director (LALD)-A it was observed that vanity light bar with open energized light bulb sockets was installed on the ceiling in the laundry room. LALD-A visually verified these deficient findings at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800			

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0 810	Continued From page 15	0 810			
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by:	0 810			

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0 810	Continued From page 16 Based on a record review and interview, the licensee failed to develop a fire safety and evacuation plan with required elements 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). Findings include: A record review and interview were conducted on October 3, 2023, at approximately 10:35 a.m. with Licensed Assisted Living Director (LALD)-A on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review of the available documentation indicated that the licensee did not maintain the fire safety and evacuation plan for the facility. Review of the document provided titled "9.06 Fire Policy" with no effective date contained the following discrepancies: The policy states that residents should be evacuated to the safest exit or nearest set of smoke compartment doors away from fire and smoke. This facility is a residential home and does contain any sort of smoke compartments or smoke compartment doors to contain fire and smoke. The policy states that sprinklers will activate in the	0 810			

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0 810	Continued From page 17 facility if necessary. The facility also does not contain automatic fire sprinklers as indicated. The policy states that when the fire alarm is triggered all fire doors on magnetic holders will automatically close to contain smoke and fire and that residents are to remain behind these doors. The facility does not have any doors that are on magnetic door holders or that are rated for smoke and fire. The facility also does not have a fire alarm system that supports the use of magnetic door holders. Record review of available documentation indicated that the licensee did not provide employee training on the fire safety and evacuation plan twice per year after the training it initial hire. The document titled "Emergency Preparedness 144G.42 subd. 10" indicated that training will be offered to employees at orientation and annually thereafter. The document titled "9.06 Fire Policy" with no effective date stated that employees will be trained at hire and twice per year thereafter. No supporting documentation was provided showing that training was conducted supporting the employees receiving training twice per year after initial hire. Record review of the available documentation indicated that the licensee did not conduct evacuation drills twice per year per shift and every other month as required by statute. Provided documentation indicated evacuation drills were not conducted twice per year per shift and were not conducted every other month as required. Documentation did show that fire drill were provided, but did not indicate if evacuation protocols were part of this drill. During interview, LALD-A verified these deficient	0 810			

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0 810	Continued From page 18 conditions.	0 810		
01290 SS=F	TIME PERIOD FOR CORRECTION: Twenty-one (21) days. 144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure two of two employees (unlicensed personnel (ULP)-C, ULP-D) were affiliated with the assisted living license as required. This had the potential to affect the licensee's one current resident. 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	01290		

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01290	Continued From page 19 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: ULP-C ULP-C was hired on September 2, 2021, to provide direct care services to the licensee's residents. On October 3, 2023, at 7:45 a.m. ULP-C was observed to administer medications to R1. ULP-C's employee record contained a background study dated March 29, 2021, for a separate location (the licensee's other assisted living facility) ULP-C's record lacked evidence the licensee affiliated a background study for their assisted living facility. ULP-D ULP-C was hired on March 10, 2020, to provide direct care services to the licensee's residents. ULP-D's employee record contained a background study dated March 8, 2020, for a separate location (the licensee's other assisted living facility). ULP-C's record lacked evidence the licensee affiliated a background study for their assisted living facility. On October 3, 2023, at 1:15 p.m. licensed assisted director (LALD)-A stated both ULP-C and ULP-D background studies were associated with his other licensed facility. The licensee's Background Studies policy dated July 20, 2021, indicated the licensee would conduct a background stud on all employees and	01290		

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01290	Continued From page 20 volunteers and contractors. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290			
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and	01470			

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01470	Continued From page 21 (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of one employee (unlicensed personnel (ULP)-C) received orientation to assisted living facility licensing requirements and regulations before providing services. 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	01470			

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01470	Continued From page 22 limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-C was hired on September 2, 2021, to provide direct care services to the licensee's residents. On October 3, 2023, at 7:45 a.m. ULP-C was observed to administer medications to R1. ULP-C's record lacked evidence she received orientation to assisted living facility to include the following required content: -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; and -a review of the types of assisted living services the employee will be providing and the facility's category of licensure On October 3, 2023, at 3:30 p.m. licensed assisted living director (LALD)-A stated some trainings had been sent to ULP-C as an attachment through the licensee's electronic medical record system, but was unable to verify the trainings were completed by ULP-C. Regarding the required training, principles of person centered planning and delivery, LALD-A asked what the training was and stated he thought it meant something different. He then stated he would need to search the training program used and make sure to assign the training. The licensee's Employee General Orientation policy dated July 20, 2021, indicated each new	01470			

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01470	Continued From page 23 employee and volunteer would be oriented in accordance with State and Federal regulations, as well as company policy and procedure. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01470			
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures	01500			

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01500	Continued From page 24 relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment for one of one employee (unlicensed personnel (ULP)-C). 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	01500			

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01500	Continued From page 25 cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-C was hired on September 2, 2021, to provide direct care services to the licensee's residents. On October 3, 2023, at 7:45 a.m. ULP-C was observed to administer medications to R1. ULP-C's record lacked the required annual training content to include: -review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; -review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person On October 3, 2023, at 3:35 p.m. license assisted living director (LALD)-A stated some training had been sent via attachments through the licensee's electronic medical record system, but could not verify the training had been completed and added he would work with the program to see if there was a better way to track or would develop a completion form to be placed in the employee file. LALD-A stated since he was not aware of what the person-centered planning training was, it was not completed.	01500			

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01500	Continued From page 26 The licensee's Annual Required Staff Training policy dated July 20, 2021, indicated annual training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The following training elements MUST be included every 12 months to all staff who performs direct care services: -Review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; -Review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures -Principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		
01710 SS=F	144G.71 Subd. 3 Individualized medication monitoring and reassessment The assisted living facility must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted an assessment	01710		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36912	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/03/2023
NAME OF PROVIDER OR SUPPLIER RELIEF HOMECARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 14420 HOLLOW PARK LANE BURNSVILLE, MN 55306			
(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
01710	Continued From page 27 for self-administration of medications for the licensee's one current resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on October 2, 2023, at 1:45 p.m. clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated the licensee provided medication management services to the licensee's one current resident at the facility. R1's diagnoses included schizoaffective disorder (mental disorder characterized by abnormal thought processes and an unstable mood), bipolar depression (a mental health condition that causes extreme mood swings that include emotional highs and lows, and anxiety. R1's Service Plan dated November 17, 2021, indicated she received the services of medication administration and behavior management. On October 3, 2023, at 7:45 a.m. unlicensed personnel (ULP)-C was observed to administer medications to R1. R1's Medication Administration Record (MAR) dated September 2023, indicated she received one medication for cholesterol, six for	01710			

Minnesota Department of Health

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01710	Continued From page 28 mood/behavior, one for dry mouth, one for acid reflux, one for constipation, one for high blood pressure, one supplement, one skin cream, and two inhalers for wheezing. R1's MAR notes included entries where R1 had medications set up in medication envelopes for her to self-administer while away from home. R1's Individualized Medication Management Plan dated August 27, 2023, indicated Medication self-administration is not applicable, staff will administer all of R1's medications. The plan indicated R1 had behavioral issues, disease symptoms which "interfered with performing tasks and forgets to take her medications. R1 makes poor judgement and has a history of refusing some of her scheduled medications." Additionally, the plan indicated R1 had 6:00 p.m. medications, but most of the time she was not at the facility due to work or social outings, so she always asks staff to give her 6:00 p.m. medications to take with her. R1 also preferred to keep her topical ointment with her, and staff reminded her to apply it and then documented on the MAR. R1 has her albuterol with her in case she needs it immediately. R1's Medication Assessment dated August 27, 2023, indicated R1 required full medication management and set up. R1's record lacked evidence the RN assessed R1's ability to self-administer medications. On October 3, 2023, at 9:45 a.m. clinical nurse supervisor (CNS)-B stated R1 did leave the facility often with medications packed and had her as needed inhaler with her. She stated R1 had a history of not taking her medications and although	01710			

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER RELIEF HOMECARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 14420 HOLLOW PARK LANE BURNSVILLE, MN 55306			
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01710	Continued From page 29 she brought back the empty envelope, she could not be assured R1 always took her medications while away. CNS-A also stated she now recognized the need to complete an assessment for R1's ability to self-administer some of her medications. The licensee's Medication Management Individualized Plan dated July 20, 2021, indicated the licensee would develop and maintain a current individualized medication management record for each resident based on the resident's assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01710			
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 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;	01730			

Minnesota Department of Health

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01730	Continued From page 30 (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 ensure an individualized medication management plan included all required content for the licensee's one current resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect	01730			

Minnesota Department of Health

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01730	Continued From page 31 a large portion or all of the residents). The findings include: R1's diagnoses included schizoaffective disorder (mental disorder characterized by abnormal thought processes and an unstable mood), bipolar depression (a mental health condition that causes extreme mood swings that include emotional highs and lows, and anxiety. R1's Service Plan dated November 17, 2021, indicated she received the services of medication administration and behavior management. On October 3, 2023, at 7:45 a.m. unlicensed personnel (ULP)-C was observed to administer medications to R1. R1's Medication Administration Record (MAR) dated September 2023, indicated she received one medication for cholesterol, six for mood/behavior, one for dry mouth, one for acid reflux, one for constipation, one for high blood pressure, one supplement, one skin cream, and two inhalers for wheezing. R1's MAR notes included entries where R1 had medications set up in medication envelopes for her to self-administer while away from home. R1's Individualized Medication Management Plan dated August 27, 2023, indicated Medication self-administration was not applicable, staff will administer all R1's medications. R1's Medication Management Plan lacked the indication R1 self-administered some medications while away from the facility. Additionally, the plan lacked the required content to include identification of	01730			

Minnesota Department of Health

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01730	Continued From page 32 medication management tasks that may be delegated to unlicensed personnel. On October 3, 2023, at 9:45 a.m. clinical nurse supervisor (CNS)-B stated R1 left the facility often with medications packed and had her as needed inhaler with her. On October 3, 2023, at 9:50 a.m. CNS-B indicated she was not aware of the requirement for the delegated tasks for medications to be included in the medication plan. The licensee's Medication Management Individualized Plan dated July 20, 2021, indicated the licensee would develop and maintain a current individualized medication management record for each resident based on the resident's assessment and would include identification of medication management tasks that may be delegated to unlicensed personnel. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730			



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

Type: Full
Date: 10/03/23
Time: 14:17:47
Report: 1018231173

Food and Beverage Establishment Inspection Report

Page 1

Location:

Relief Homecare Llc
14420 Hollow Park Lane
Burnsville, MN55306
Dakota County, 19

Establishment Info:

ID #: 0038399
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5072026082
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.

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

3-302.11A(1)

**** Priority 1 ****

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

RAW EGGS OBSERVED TO BE STORED OVER READY TO EAT FOODS IN THE REFRIGERATOR.
CORRECTED ON SITE.

Corrected on Site

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.11

MN Rule 4626.1515 Maintain the physical facilities in good repair.

COUNTER TOPS IN THE KITCHEN WERE OBSERVED TO BE CHIPPING. DISCUSSED WITH
OPERATOR TO HAVE THE COUNTER TOPS REPAIRED.

Comply By: 10/03/24

Food and Equipment Temperatures

Process/Item: Cold Holding/ DELI MEAT

Temperature: 40 Degrees Fahrenheit - Location: REFRIGERATOR

Violation Issued: No

Type: Full
Date: 10/03/23
Time: 14:17:47
Report: 1018231173
Relief Homecare Llc

Food and Beverage Establishment Inspection Report

Page 2

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

ESTABLISHMENT IS A RESIDENTIAL HOUSE WITH A RESIDENTIAL KITCHEN. ESTABLISHMENT HAS ONLY ONE RESIDENT AT THIS TIME.

PHYSICAL FACILITIES WERE OBSERVED TO BE IN GOOD CONDITION. DISCUSSED WITH THE OPERATOR TO HAVE THE COUNTERTOPS RESURFACES AS THEY ARE CHIPPING.

DISHWASHER WAS OBSERVED WITH SANITIZING FUNCTION.

ESTABLISHMENT SERVES FOOD FOR ONLY SAME DAY SERVICE.

DISCUSSED PEST CONTROL AND EMPLOYEE ILLNESS POLICIES.

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 1018231173 of 10/03/23.

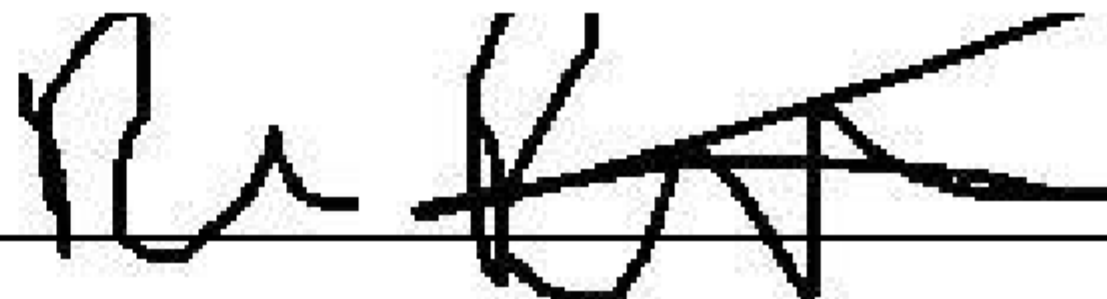
Certified Food Protection Manager EMEKA ANYANWU

Certification Number: FM113864 Expires: 11/03/25

Inspection report reviewed with person in charge and emailed.

Signed: _____

EMEKA ANYANWU

Signed:  _____

2204 Rebecca Prestwood
Sanitarian 3
6512013777
rebecca.prestwood@state.mn.us