Electronically Delivered

October 3, 2024

Licensee
Goodness and Mercy Health Services Incorporated
6319 Indiana Avenue North
Brooklyn Center, MN  55429

RE:  Project Number(s) SL33600015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 29, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the

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

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

To submit a reconsideration request, please visit:
**https://forms.web.health.state.mn.us/form/HRDAppealsForm**

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

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

HHH

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 33600 | A. BUILDING: _____ B. WING _____ | 08/29/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| GOODNESS AND MERCY HEALTH SERV | 6319 INDIANA AVENUE NORTH BROOKLYN CENTER, MN 55429 |

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| 0 000 | Initial Comments<br><br>******ATTENTION******<br><br>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.<br><br>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.<br><br>INITIAL COMMENTS:<br><br>SL# 33600015-0<br><br>On August 26, 2024, through, August 29, 2024, 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 were four residents receiving services under the provider's Assisted Living Facility license. | 0 000 | Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction.<br><br>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.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>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. | |
| 0 630 SS=F | 144G.42 Subd. 6 (b) Compliance with requirements for reporting ma | 0 630 | | |

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| 0 630 | Continued From page 1<br><br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>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 two of two residents (R1, R2).<br><br>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).<br><br>The findings include:<br><br>R1<br>R1 was admitted on May 13, 2024, with a diagnosis of schizophrenia.<br><br>R1's Service Plan dated August 27, 2024, indicated R1 received services including bathing reminders, laundry, management of behaviors, | 0 630 | | |

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| 0 630 | Continued From page 2<br><br>medication administration and set up, vital signs, and safety checks.<br><br>On August 27, 2024, at 6:44 a.m., the surveyor observed unlicensed personnel (ULP)-B prepare and administer medications to R1.<br><br>R1's IAPP dated June 28, 2024, indicated R1 had a history of physical aggression, assault, and threatening behavior. R1's IAPP lacked assessment of the susceptibility to abuse and the risk to abuse other vulnerable adults.<br><br>R2<br>R2 was admitted on May 1, 2024, with a diagnosis of schizophrenia.<br><br>R2's Service Plan dated August 27, 2024, indicated R2 received services including bathing reminders, laundry, management of behaviors, medication administration and set up, vital signs, and safety checks.<br><br>On August 27, 2024, at 6:52 a.m., the surveyor observed ULP-B prepare and administer medications to R2.<br><br>R2's Admission Assessment dated May 1, 2024, under section Vulnerability, indicated R2 had a risk to be abused and was not at risk to abuse other vulnerable adults. The assessment identified R2 had a history of verbal and physical aggression towards others. The assessment lacked identification of specific measures to minimize risk for the identified risk.<br><br>On August 27, 2024, at 12:48 p.m., administrator/registered nurse (A/RN)-D acknowledged the IAPPs lacked the required content and would need to update the IAPPs. | 0 630 | | |

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| 0 630 | Continued From page 3<br><br>The licensee's Vulnerable Adult policy dated August 1, 2021, indicated all residents would be assessed for the susceptibility to abuse by other individuals, which included other vulnerable adults and the risk of abusing other vulnerable adults. Also, the policy indicated there would be specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 630 | | |
| 0 650 SS=F | 144G.42 Subd. 8 Employee records<br><br>(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:<br>(1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules;<br>(2) records of orientation, required annual training and infection control training, and competency evaluations;<br>(3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision;<br>(4) documentation of annual performance reviews that identify areas of improvement needed and training needs;<br>(5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place | 0 650 | | |

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| 0 650 | Continued From page 4<br><br>and the dates of those screenings; and<br>(6) documentation of the background study as required under section 144.057.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) documented training and competencies for two of two unlicensed personnel ((ULP)-A, ULP-B) who would provide medications for residents with unplanned time away from home when a licensed nurse was not available.<br><br>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).<br><br>The findings include:<br><br>ULP-A<br>ULP-A was hired on July 8, 2021.<br><br>On August 27, 2024, at 11:26 a.m., ULP-A stated they had provided medications to residents for unplanned times away from the facility. ULP-A stated the nurse had trained and observed them on this task.<br><br>ULP-A's Medication Administration training at orientation, dated July 10, 2024, included PRN (as needed), med (medication) errors, med storage/reorder/delivery, and controlled meds. | 0 650 | | |

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| 0 650 | Continued From page 5<br><br>The training did not include medication administration when a licensed nurse was not available to provide medications for a resident with an unplanned time away from home.<br><br>ULP-B<br>ULP-B was hired on July 17, 2015.<br><br>On August 27, 2024, at 6:44 a.m., the surveyor observed ULP-B assist R1 with medication administration.<br><br>ULP-B's Medication Administration training at orientation, dated July 18, 2015, included PRN, med errors, med storage/reorder/delivery, and controlled meds. The training did not include medication administration when a licensed nurse was not available to provide medications for a resident with an unplanned time away from home.<br><br>ULP-A and ULP-B's records lacked documentation of training and competency evaluations related to medication administration when a licensed nurse was not available to provide medications for a resident with an unplanned time away from home.<br><br>On August 27, 2024, at 8:54 a.m., director of operations (DOO)-E stated the unplanned times away training was included in the licensee's medication administration training; and staff would have this training annually.<br><br>On August 27, 2024, at 10:32 a.m., DOO-E stated the unplanned times away was included in the policy training as well.<br><br>The licensee's Personnel Records policy dated August 1, 2021, indicated all documents related to training and competency evaluations would be | 0 650 | | |

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| 0 650 | Continued From page 6<br>maintained in the personnel record.<br><br>Minnesota Administrative Rule 4659.0190, subpart 6 dated August 11, 2021, indicated a facility must maintain a record for each training and competency evaluation that included the following:<br>- facility name, location, and license number;<br>- name of the training topic or training program, and the training methodology, such as classroom style, web-based training, video, or one-to-one training;<br>- date of the training and competency evaluation, and the total amount of time of the training and competency evaluation;<br>- name and title of the instructor and the instructor's signature, and the name and title of the competency evaluator, if different from the instructor, and the evaluator's signature with a statement attesting that the employee successfully completed the training and competency evaluation; and<br>- name and title of the staff person completing the training, and the staff person's signature with a statement attesting that the staff person successfully completed the training as described in the training documentation.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 650 | | |
| 0 680 SS=F | 144G.42 Subd. 10 Disaster planning and emergency preparedness<br><br>(a) The facility must meet the following requirements:<br>(1) have a written emergency disaster plan that | 0 680 | | |

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| 0 680 | Continued From page 7<br><br>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;<br>(2) post an emergency disaster plan prominently;<br>(3) provide building emergency exit diagrams to all residents;<br>(4) post emergency exit diagrams on each floor; and<br>(5) have a written policy and procedure regarding missing residents.<br>(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.<br>(c) The facility must meet any additional requirements adopted in rule.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to maintain a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. This had the potential to affect all residents, staff, and visitors.<br><br>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). | 0 680 | | |

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| 0 680 | Continued From page 8<br>The findings include:<br><br>The licensee's undated EPP lacked evidence of the following required content:<br>- EPP program patient population;<br>- subsistence needs for staff and patients;<br>- Procedures for tracking pf staff and patients;<br>- policies and procedures for medical documents;<br>- policies and procedures for volunteers;<br>- roles under a wavier declared by secretary;<br>- names and contact information to include staff, residents' physicians;<br>- emergency officials contact information to include local EP staff, state licensing and certification agency;<br>- methods for sharing information;<br>- sharing information on occupancy/needs;<br>- LTC family notifications;<br>- emergency prep training and testing;<br>- emergency prep training program; and<br>- emergency prep testing requirements.<br><br>On August 26, 2024, at 1:32 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C acknowledged the EPP was missing some components and stated they would review Appendix Z to update their EPP to meet the required content.<br><br>The licensee's Emergency Preparedness policy dated August 1, 2021, indicated the licensee would have in place an emergency preparedness plan, that is in alignment with facility's requirement to also comply with CMS (Centers for Medicare and Medicaid Services) Appendix Z.<br><br>No additional information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 680 | | |

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| 0 950 SS=C | 144G.50 Subd. 3 Designation of representative<br><br>(a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract:<br><br>"RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES.<br><br>You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable."<br><br>(b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure the assisted living contract included the designation of representative statutory language notice for two of two residents (R1, R2). | 0 950 | | |

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| 0 950 | Continued From page 10<br><br>This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents).<br><br>The findings include:<br><br>R1<br>R1 was admitted on May 13, 2024.<br><br>R1's Assisted Living Contract dated May 13, 2024, lacked the verbatim designated representative notice, a location to identify a designated representative, or a space for the resident to initial if they wished to decline to name one.<br><br>R2<br>R2 was admitted on May 1, 2024.<br><br>R2's Assisted Living Contract dated May 1, 2024, lacked the verbatim designated representative notice, a location to identify a designated representative, or a space for the resident to initial if they wished to decline to name one.<br><br>On August 26, 2024, at 11:52 a.m., director of operations (DOO)-E stated the licensee has a separate page with the language verbatim that all residents would get when signing a contract with licensee.<br><br>On August 27, 2024, at 12:17 p.m., DOO-E stated the designated representative was missed for [R1 and R2]. DOO-E stated the last page of the | 0 950 | | |

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|---|---|---|---|---|
| 0 950 | Continued From page 11<br><br>contract that included the designated representative may have been missed with printing.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 950 | | |
| 01290 SS=E | 144G.60 Subdivision 1 Background studies required<br><br>(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.<br>(b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12.<br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure a background study was associated with the licensee's current assisted living health facility identification (HFID) number for two of five unlicensed personnel ((ULP)-F, ULP-G).<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or | 01290 | | |

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|---|---|---|---|
| | 33600 | A. BUILDING: _____ B. WING _____ | 08/29/2024 |

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| 01290 | Continued From page 12<br><br>safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).<br><br>The findings include:<br><br>ULP-F<br>ULP-F was hired on September 8, 2008.<br><br>ULP-F's Background Study Clearance dated September 8, 2008, indicated ULP-F could provide direct contact services for licensee but was associated to a different address of where the facility is located at another licensee owned by the same owner. ULP-F's Background Study Clearance lacked an affiliation to the licensee's current HFID.<br><br>ULP-G<br>ULP-G was hired on May 25, 2007.<br><br>ULP-G's Background Study Clearance dated May 16, 2007, indicated ULP-G could provide direct contact services for licensee but was associated to a different address of where the facility is located at another licensee owned by the same owner. ULP-G's Background Study Clearance lacked an affiliation to the licensee's current HFID.<br><br>On August 26, 2024, at 2:34 p.m., director of operations (DOO)-E stated the licensee recently became aware of the need to have an employee's background study affiliated to the licensee's HFID; and they had been working on affiliating | 01290 | | |

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| 01290 | Continued From page 13<br>their staff to the correct HFID.<br><br>The licensee's Recruitment and Hiring policy dated August 1, 2021, indicated licensee would complete a Minnesota Department of Human Services (DHS) background study on all employees following the step-by-step procedure established by DHS.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Two (2) days | 01290 | | |
| 01650 SS=D | 144G.70 Subd. 4 (f) Service plan, implementation and revisions to<br><br>(f) The service plan must include:<br>(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;<br>(2) the identification of staff or categories of staff who will provide the services;<br>(3) the schedule and methods of monitoring assessments of the resident;<br>(4) the schedule and methods of monitoring staff providing services; and<br>(5) a contingency plan that includes:<br>(i) the action to be taken if the scheduled service cannot be provided;<br>(ii) information and a method to contact the facility;<br>(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; | 01650 | | |

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| 01650 | Continued From page 14<br><br>and<br>(iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure the service plan included the required content for one of two residents (R1).<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).<br><br>The findings include:<br><br>R1 was admitted to licensee on May 13, 2024, with diagnoses of schizophrenia, psychotic disorder, delusions, and depression.<br><br>R1's Service Plan dated May 10, 2024, but signed on May 13, 2024, lacked the following: description of services, frequency of each service, and identification of staff who will provide services.<br><br>On August 27, 2024, at 12:04 p.m., administrator/registered nurse (A/RN)-D acknowledged R1's service plan did not have all the required information and stated this was due to a new system the licensee used for documentation. | 01650 | | |

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| 01650 | Continued From page 15<br><br>The licensee's Service Plan policy, dated August 1, 2021, indicated the service plan would include a description of the services provided, frequency of each service, and identification of staff who would provide the service.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01650 | | |
| 01790 SS=F | 144G.71 Subd. 10 Medication management for residents who will<br><br>(2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days;<br>(3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and<br>(4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled.<br>(b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if:<br>(1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and<br>(2) the registered nurse has developed written procedures for the unlicensed personnel, | 01790 | | |

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| 01790 | Continued From page 16<br><br>including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address:<br>(i) the type of container or containers to be used for the medications appropriate to the provider's medication system;<br>(ii) how the container or containers must be labeled;<br>(iii) written information about the medications to be provided;<br>(iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information;<br>(v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative;<br>(vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and<br>(vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure the registered nurse (RN) developed written procedures for the unlicensed personnel (ULP) providing | 01790 | | |

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| 01790 | Continued From page 17<br><br>medications for residents having unplanned time away when the licensed nurse was not available. This had the potential to affect all residents who would need medications for an unplanned time away.<br><br>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).<br><br>The findings include:<br><br>On August 28, 2024, at 9:01 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated the licensee had a policy but did not have a written procedure for unlicensed staff to follow as they were not aware the licensee needed this.<br><br>The licensee's Medication Management Plan for Residents Away from Home policy dated August 1, 2021, indicated the registered nurse (RN) could delegate to unlicensed personnel (ULP) if the RN had developed written procedures/protocols for the ULP that also included controlled substances.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01790 | | |

Minnesota Department Of Health
Food, Pools, and Lodging Services
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *08/26/24*
Time: 10:30:43
Report: 1050241152

# Food and Beverage Establishment Inspection Report



**Location:**

Goodness And Mercy Health Serv
6319 Indiana Avenue North
Brooklyn Center, MN55429
Hennepin County, 27

**Establishment Info:**

ID #: 0039138
Risk:
Announced Inspection: No

**License Categories:**

Expires on: / /

**Operator:**

Phone #: 6516312535
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.

No NEW orders were issued during this inspection.

**Surface and Equipment Sanitizers**

Hot Water: = at 165F Degrees Fahrenheit
Location: Kitchen Dishwasher
Violation Issued: No

**Food and Equipment Temperatures**

Process/Item: Cold Holding/ Tomatoes
Temperature: 39F Degrees Fahrenheit - Location: Reach-In Cooler
Violation Issued: No

Process/Item: Cold Holding/ Milk
Temperature: 39F Degrees Fahrenheit - Location: Reach-In Cooler
Violation Issued: No

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

Inspection was completed by MDH Andrew Spaulding and Eniola Ogundipe. Rhawnie Quinehan was the lead Health Regulation Division Nurse Evaluator. Facility had four residents on site at time of inspection. Meals are prepared on site.

This establishment has a residential kitchen. The kitchen has wood cabinets with a hollow base and tile flooring, . All found to be in good condition. A two basin sink is located in the kitchen and a residential dishwasher. A puck is used to track temperature which is also logged.

Current pest management services are used during the summers on a as needed basis. No pests were scene on site during time of inspection.

Discussed the following:

-Employee illness policy and logging requirements
-Hand Washing
-Glove-use and bare hand contact
-Food storage and preventing cross contamination
-Date marking
-Vomit clean up procedures
-Restrictions concerning serving a highly susceptible population

**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 1050241152 of 08/26/24.

Certified Food Protection Manager: Eniola O. Ogundipe

Certification Number: FM124395 Expires: 04/18/27

**Inspection report reviewed with person in charge and emailed.**

Signed: _____

Eniola O. Ogundipe
Operator

Signed: _____

Andrew Spaulding
Public Health Sanitarian 2
FPLS Metro
651-201-5298
andrew.spaulding@state.mn.us