Electronically Delivered

May 23, 2024

Licensee
Maranatha Fka Maranathacommons
5415 69th Avenue North
Brooklyn Center, MN 55429

RE: Project Number(s) SL20024015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on May 1, 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.

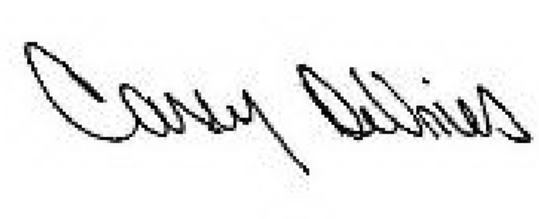
To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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,



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

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20024	A. BUILDING: _____ B. WING _____	05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARANATHA FKA MARANATHACOMMONS	5415 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429

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0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL20024015-0 On April 29, 2024, through May 1, 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 54 residents; 49 receiving services under the provider's Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated April 29, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and	0 510		

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0 510	Continued From page 2 nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program that complied with accepted health care, medical and nursing standards for infection control related to gloving and hand hygiene for one of three unlicensed personnel ((ULP)-G). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On April 30, 2024, at 8:10 a.m., the surveyor observed ULP-G provide morning cares to R6. ULP-G entered R6's room and R6 was in their bedroom sleeping. ULP-G applied gloves and attempted to wake R6. ULP-G then came out of R6's room and removed a soiled disposable chuck pad that was left on the living room couch	0 510		

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0 510	Continued From page 3 with gloved hands. ULP-G disposed of the chuck pad in R6's bathroom waste basket and then cleaned the toilet seat which was covered with dried feces. Without changing gloves or performing hand hygiene, ULP-G went back to R6's room, attempted to wake R6 by touch and touched R6's walker. R6 requested to sleep longer. ULP-G than removed gloves, performed hand hygiene, and exited the room. On April 30, 2024, at approximately 8:30 a.m., the surveyor observed ULP-G provide morning cares to R7. ULP-G entered R7's room, applied gloves, and helped R7 out of bed. R7 walked themselves to the bathroom. ULP-G assisted R7 to change their clothes and completed perineal care. Without changing gloves or performing hand hygiene, ULP-G combed R7's hair, R7 walked to the living room, and ULP-G helped R7 sit in their recliner chair. ULP-G went back to R7's bedroom and looked for a washcloth, made R7's bed, touched and opened closet doors, and bedside drawers. ULP-G located the washcloth and went to the bathroom sink, wet the washcloth, and cleaned R7's face and hands. ULP-G went back to the bathroom, washed the washcloth, hung washcloth to dry, removed gloves, and performed hand hygiene. On April 30, 2024, at approximately 9:10 a.m., the surveyor inquired if ULP-G was trained on infection control. ULP-G stated they did receive education on infection control and hand hygiene. ULP-G stated they were supposed to change gloves in between cares and stated, "I should not do that I was wrong" (referring to not changing gloves). On May 1, 2024, at 9:20 a.m., clinical nurse supervisor (CNS)-C stated they used educational	0 510		

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0 510	Continued From page 4 videos to train staff members on infection control. CNS-C stated nursing conducted audits on handwashing and personal protective equipment (PPE). CNS-C stated they did not complete audits on a schedule however, they increased the number of audits conducted if there was an outbreak in the facility. CNS-C stated during the audit if there was a break in infection control, they would provide reeducation to the staff member. The Centers for Disease Control and Prevention (CDC) Guideline for Hand Hygiene Guidance in Healthcare Settings on the CDC website last reviewed on January 20, 2020, read, "The Core Infection Prevention and Control Practices for Safe Care Delivery in All Healthcare Settings recommendations of the Healthcare Infection Control Practices Advisory Committee (HICPAC) include the following strong recommendations for hand hygiene in healthcare settings. Healthcare personnel should use an alcohol-based hand rub or wash with soap and water for the following clinical indications: - Immediately before touching a patient - Before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices - Before moving from work on a soiled body site to a clean body site on the same patient - After touching a patient or the patient's immediate environment - After contact with blood, body fluids, or contaminated surfaces - Immediately after glove removal Healthcare facilities should: - Require healthcare personnel to perform hand hygiene in accordance with Centers for Disease Control and Prevention (CDC) recommendations - Ensure that healthcare personnel perform	0 510		

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0 510	Continued From page 5 hand hygiene with soap and water when hands are visibly soiled - Ensure that supplies necessary for adherence to hand hygiene are readily accessible in all areas where patient care is being delivered Unless hands are visibly soiled, an alcohol-based hand rub is preferred over soap and water in most clinical situations due to evidence of better compliance compared to soap and water. Hand rubs are generally less irritating to hands and, in the absence of a sink, are an effective method of cleaning hands." The CDC Guideline for Hand Hygiene in Healthcare Settings on the CDC website last reviewed on January 8, 2021, read, "The CDC Guideline for Hand Hygiene in Healthcare Settings [PDF - 1.3 MB] recommends: - When cleaning your hands with soap and water, wet your hands first with water, apply the amount of product recommended by the manufacturer to your hands, and rub your hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. - Rinse your hands with water and use disposable towels to dry. Use towel to turn off the faucet. - Avoid using hot water, to prevent drying of skin. Other entities have recommended that cleaning your hands with soap and water should take around 20 seconds. Either time is acceptable. The focus should be on cleaning your hands at the right times." The licensee's Annual Training Including Infection Control policy and procedure revised on January 18, 2023, read, "d. Infection control techniques used in the home and implementation of infection control standards including: i. Hand washing ii. Need for and use of protective gloves, gowns,	0 510		

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0 510	Continued From page 6 and masks iii. Appropriate disposal of contaminated materials and equipment such as dressings, needles, syringes, and razor blades iv. Disinfecting reusable equipment v. Disinfecting environmental surfaces vi. Reporting communicable diseases". No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to	0 810		

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0 810	Continued From page 7 include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On April 30, 2024, licensed assisted living director (LALD)-D and environmental services director (ESD)-F provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee's FSEP, titled "Fire Emergency	0 810		

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0 810	Continued From page 8 Plan", undated, failed to include the following: The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. On April 30, 2024, at 3:21 p.m. a copy of the resident procedures was emailed to the surveyor after the exit interview that included resident actions. In the email LALD-D indicated that the attachment was from the "Resident Handbook" about fire safety and evacuation. Fire protection actions for residents should be included in the policy. The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation nor did it include instructions for staff to follow in case of relocation. On April 30, 2024, at 3:21 p.m. a copy of a "care sheet" was emailed to the surveyor after the exit interview that included a two page document titled "Daily Assignments", dated 04/30/2024, that did not include any information on assistance during evacuation. In the email LALD-D indicated that the "care sheets" were on the home health aid's (HHA) tablet that is carried with them on their shift. During an interview on April 30, 2024, at 1:00 p.m., LALD-D and ESD-F stated they understood the areas of their policy that were incomplete and would work on bringing them into compliance.	0 810		

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0 810	Continued From page 9 TRAINING Record review indicated the licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. LALD-D and ESD-F were unable to provide documentation showing the required twice-per-year training for staff. During an interview on April 30, 2024, at 1:00 p.m., ESD-F stated they were doing staff training upon hire and annually thereafter. ESD-F stated they did not realize that fire safety required training twice per year and thought it was the same as emergency preparedness training. Survey staff reviewed statute requirements for staff training. LALD-D and ESD-F stated they understood the areas of their training that were insufficient and would work on bringing them into compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01060 SS=D	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of	01060		

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01060	Continued From page 10 Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for a resident's emergency relocation to the resident, legal representative, or designated representative, for one of two residents (R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01060		

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01060	Continued From page 11 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R5 admitted to the licensee on November 11, 2017, under the licensee's former comprehensive license and began receiving assisted living services on August 1, 2021. R5's Service Plan-Attachment E to Residency Agreement signed April 2, 2024, indicated R5 received assistance with homemaking, laundry, medication administration, and shower assistance. R5's Resident Notes dated February 29, 2024, through March 31, 2024, indicated R5 admitted to the hospital on March 1, 2024, for a bowel obstruction and Coronavirus disease 2019 (COVID-19) and returned to the facility on March 4, 2024. R5's medical record lacked evidence the licensee provided the resident or resident's representative a written emergency relocation notice. On May 1, 2024, at 8:01 a.m., licensed assisted living director (LALD)-D stated, "at this point it looks like we don't have one for her on that date. I am going to be transparent." On May 1, 2024, at 9:12 a.m., clinical nurse supervisor (CNS)-C stated if a resident went to the hospital a nurse would fill out an emergency	01060		

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	20024	A. BUILDING: _____ B. WING _____	05/01/2024

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01060	Continued From page 12 relocation form and LALD-D would contact the ombudsman if the resident was hospitalized for greater than four days. The licensee's Housing Termination, Relocation, and Transfer Policy and Procedure dated February 4, 2024, read, "An "Emergency Relocation" is an emergency removal of an assisted living resident from a licensed Minnesota assisted living facility, initiated by the facility, necessitated by a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member, if the resident does not return within the day. An emergency relocation is not a termination but may trigger a termination as set forth below. 1. To do so, the facility must provide a written notice (Template B-4) that states: a. the reason for the relocation; b. the name and contact information for the location to which the Resident has been relocated and any new service provider; c. contact information for the Office of Ombudsman for Long-Term Care; d. if known and applicable, the approximate date or range of dates within which the Resident is expected to return to the facility, or a statement that a return date is not currently known; and e. a statement that, if the facility refuses to provide housing or services after a relocation, the Resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the Resident may submit an appeal." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		

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01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed a reassessment with a change in the resident's condition using the uniform assessment tool for one of two residents (R5). 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	01620		

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01620	Continued From page 14 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R5 admitted to the licensee on November 11, 2017, under the licensee's former comprehensive license and began receiving assisted living services on August 1, 2021. R5's Service Plan-Attachment E to Residency Agreement signed April 2, 2024, indicated R5 received assistance with homemaking, laundry, medication administration, and shower assistance. On April 30, 2024, at 9:12 a.m., the surveyor observed a cast on R5's left hand extending to the forearm. Unlicensed personnel (ULP)-E assisted R5 with upper and lower body dressing. After getting R5 dressed, ULP-E stated they were going to go and obtain a wheelchair to transport R5 to the beauty shop. R5's Resident Notes dated February 29, 2024, through March 31, 2024, indicated R5 admitted to the hospital on March 1, 2024, for a bowel obstruction and Coronavirus disease 2019 (COVID-19) and returned to the facility on March 4, 2024. R5's Resident Notes dated April 1, 2024, through April 30, 2024, indicated on April 25, 2024, at 5:55 a.m., R5 fell in the bathroom, had no injury, and was lifted off the floor. At 2:19 p.m., the RN completed a fall follow up where R5 reported	01620		

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01620	Continued From page 15 difficulty with dressing and pain to their left hand and the RN observed a bruised and swollen left hand. The RN called R5's family and sent R5 to the hospital for an evaluation. R5 was sent back from the hospital at 5:07 p.m. and was diagnosed with nondisplaced fracture of fourth and second metacarpal bone and urinary tract infection (UTI). R5's was prescribed an antibiotic to treat the UTI and a cast was applied to the left hand. R5's AL Falls Follow up form completed April 25, 2024, indicated R5 had no change in sensory, elimination, gait, pain, activity, and change in condition. In addition, the analysis and summary of casual factors indicated R5 fell when attempting to toilet and their legs gave out. The RN's short-term intervention for the fall was to send R5 to the emergency room and long-term intervention was to add toileting assistance. R5's record included ongoing nursing assessments completed on January 4, 2024, and April 2, 2024. R5's record lacked a reassessment with change of condition after March 4, 2024, hospitalization and after a fall with fracture on April 25, 2024. On May 1, 2024, at 7:51 a.m., clinical nurse supervisor (CNS)-C stated change of condition assessments were completed if there was a change in a resident's condition including a change in urination, skin, resident's normal routine, or if a resident began to cough. The surveyor inquired if the licensee completed change of condition assessments for residents with falls. CNS-C stated they did not complete a change of condition reassessment if a resident fell, they would just complete an incident report. The surveyor inquired if they would complete a change of condition reassessment on someone	01620		

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01620	Continued From page 16 who has fallen who sustained a fracture. CNS-C stated, "I have not personally." As the interview continued, CNS-C stated there should have been an assessment titled clinical update after R5 fell and sustained a fracture. CNS-C sat with the surveyor and reviewed the documentation on RTasks (a documenting software) and verified they did not see a change of condition reassessment for R5 and stated they would have to ask another RN why the assessment was not completed. The licensee's MN AL Nursing Assessment Policy dated May 3, 2022, read," a. Licensed staff must determine if a resident's status has changed enough to warrant a change in status assessment. b. Facility Definition of Change of Condition: resident has a major decline or improvement in their status that will not normally resolve itself without further intervention by staff or family. Examples which require further review for potential change in condition (this is not a comprehensive list): i. Fall with injury requiring a change in service agreement or a pattern of falls ii. Decline in functional ability requiring a change in service agreement iii. Medically unstable requiring clinical intervention on on-going basis for monitoring or supervision iv. Change in mobility - related to weakness, stroke, or disease progression v. Pressure Ulcer/Injury development vi. Hospitalization vii. Unanticipated weight gain or loss viii. Elopement." No further information was provided.	01620		

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01620	Continued From page 17 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plan included a signature or other authentication by the resident or resident's designated representative to document agreement on the services to be provided for one of five residents (R5).	01640		

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01640	Continued From page 18 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R5 admitted to the licensee on November 11, 2017, under the licensee's former comprehensive license and began receiving assisted living services on August 1, 2021. R5's Service Plan-Attachment E to Residency Agreement signed April 2, 2024, indicated R5 received assistance with homemaking, laundry, medication administration, and shower assistance. On April 30, 2024, at 9:12 a.m., the surveyor observed a cast on R5's left hand extending to the forearm. Unlicensed personnel (ULP)-E assisted R5 with upper and lower body dressing. After getting R5 dressed, ULP-E stated they were going to go and obtain a wheelchair to transport R5 to the beauty shop. R5's current services in RTasks (a documenting software program) as of the dates of the survey indicated R5 received assistance with incontinent care one to six times per day, extensive assist in the morning and in the evening, homemaking, laundry, medication set up, medication administration, shower assistance, weekly fridge temps, and meal tray delivery.	01640		

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01640	Continued From page 19 R5's medical record lacked a service plan with a signature or other authentication by the resident or resident's designated representative indicating agreement on services to be provided when revisions occurred. On May 1, 2024, 7:51 a.m., clinical nurse supervisor (CNS)-C stated nursing may add scheduled services if the service would be short term. CNS-C stated if the service was still indicated after a short period of time, it would be added to the service plan and the resident and/or family would sign the new service plan. CNS-C stated after R5's fall with fracture there were multiple services added to the services scheduled. The surveyor inquired if a new service plan was signed plan was signed for R5. CNS-C stated R5 had low vision and would need R5's family member to sign the service plan however, they lived in a different city. The surveyor inquired if the licensee discussed the new services with R5 and/or R5's family. CNS-C stated they would have to look into the situation. On May 1, 2024, at 10:30 a.m., CNS-C stated they spoke with another nurse who stated they contacted R5's family member prior to adding services however, they were unable to find documentation of the conversation. The licensee's MN AL Service Plan Policy dated August 21, 2021, indicated all assisted living residents have an up-to-date service plan identifying services to be provided based on the assessment by the registered nurse (RN) and/or licensed health professional. Service plans and any revisions to service plans would have a signature or other authentication by the facility and by the resident. Other authentication could be email confirmation accepting terms of a service	01640		

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01640	Continued From page 20 agreement or other methods deemed appropriate by the assisted living. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure prescription medications were stored according to the manufacturer's directions for one of five residents (R5). In addition, the licensee failed to store all prescription medications securely to permit only authorized personnel to have access for three of five residents (R3, R4, R6). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include:	01880		

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01880	Continued From page 21 MANUFACTURER'S DIRECTIONS R5 R5 admitted to the licensee on November 11, 2017, under the licensee's former comprehensive license and began receiving assisted living services on August 1, 2021. R5's Service Plan-Attachment E to Residency Agreement signed April 2, 2024, indicated R5 received assistance with homemaking, laundry, medication administration, and shower assistance. On April 30, 2024, at 9:10 a.m., the surveyor observed three bottles of latanoprost 0.005 percent (%) in cup in R5's refrigerator. The surveyor inquired if the licensee monitored medication temperatures. Unlicensed personnel (ULP)-E stated they did not monitor the refrigerator temperatures in residents' apartments, and they have never been trained on how to monitor the refrigerator. R5's Med Admin Summary- Month dated April 1, 2024, through April 30, 2024, indicated latanoprost 0.005% was administered by the licensee's staff in the evenings. The manufacturer's instructions for latanoprost 0.005% eye drop dated August 2011 recommended an unopened eye drop bottle should be kept under refrigeration at 36 degrees Fahrenheit (F) to 46 degrees F. On May 1, 2024, at 9:13 a.m., clinical nurse supervisor (CNS)-C stated all medications were stored per manufacturers' guidelines and the licensee received information on the manufacturer's guidelines from pharmacy. CNS-C stated the licensee monitored resident	01880		

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01880	Continued From page 22 refrigerators weekly. Licensed assisted living director (LALD)-D stated if the refrigerator did not work properly, they would put in a work order and replace the food and medication in the refrigerator. The surveyor inquired how the ULPs would know if the refrigerator was out of range and not to administer medication if the refrigerator was not checked daily. CNS-C stated ULPs were trained not to administer medication from the refrigerator if it was not working properly and there is a thermostat located in every refrigerator. SECURED MEDICATION R3 R3 admitted to the licensee on November 30, 2017, under the licensee's former comprehensive license and began receiving assisted living services on August 1, 2021. R3's Service Plan-Attachment E to Residency Agreement signed September 29, 2023, indicated R3 received assistance with blood glucose monitoring, homemaking, laundry, medical appointment assistance, medication administration, thromboembolism-deterrent (TED)stocking/compression bandage (ACE) wrap application, showering, morning and evening care, and vital sign monitoring. On April 30, 2024, at 7:13 a.m., the surveyor observed fluticasone propionate 50 micrograms (mcg) on R3's bathroom sink. R3's ongoing nursing assessment dated March 28, 2024, indicated R3 was unable to self-administer medications. R3's Individualized Medication Management Plan dated March 28, 2024, indicated medications	01880		

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01880	Continued From page 23 were locked in a cabinet in the apartment. On April 30, 2024, at 7:50 a.m., ULP-E stated residents' medications were locked in the medication cabinet in each resident's room unless they self-administered the medication. ULP-E stated they were not sure why R3 had the medication because it had a different prescription label than what their pharmacy supplied. ULP-E inquired where R3 received the medication from. R3 stated they received the medication after a hospitalization and asked ULP-E what it was used for. R3 stated they did not use the medication since they received it from the hospital. R4 R4 admitted to the licensee on December 18, 2023, and began receiving assisted living services. R4's Service Plan-Attachment E to Residency Agreement signed February 1, 2024, indicated R4 received assistance with blood sugar, homemaking, laundry, medication administration, showering, special medication management, and blood pressure monitoring. On April 30, at 8:34 a.m., the surveyor observed Blink lubricating eye drop 3-1 extended release by the kitchen table and Pepto-Bismol by the bathroom sink. On April 30, 2024, at 8:53 a.m., ULP-E stated R4 did not self-administer medications and the licensee provided all medications. R4's ongoing assessment dated January 3, 2024, indicated R4 was unable to self-administer medications.	01880		

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01880	Continued From page 24 R4's Individualized Medication Management Plan indicated medications were locked in a cabinet. On April 20, 2024, at 9:01 a.m., R4 stated they self-administered the Pepto-Bismol for diarrhea and administered the eye drop twice a day in the morning and at night. R4 stated they would ask for help from the staff occasionally when administering the eye drops because they have difficulty administering them independently. R6 R6 was admitted to the licensee on July 27, 2015, under the licensee's former comprehensive license and began receiving assisted living services on August 1, 2021. R6's Service Plan-Attachment E to Residency Agreement signed December 14, 2023, indicated R6 received assistance with blood pressure monitoring, homemaking, laundry, showering, grooming, and weight monitoring. On April 30, 2024, at 10:07 a.m., surveyor observed a Biotiene liquid dry mouth swish and spit bottle seating on the kitchen counter. ULP-H stated the Biotiene was always kept on the kitchen counter. R6's Med Admin Summary- Month dated April 1, 2024, through April 30, 2024, indicated Biotiene was administered by the licensee's staff four times a day. R6's ongoing assessment dated December 14, 2023, indicated R6 was unable to self-administer medications. R6's Service Plan-Attachment E to Residency Agreement signed December 14, 2023, under	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20024	A. BUILDING: _____ B. WING _____	05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARANATHA FKA MARANATHACOMMONS	5415 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429

(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
01880	Continued From page 25 Medication Management indicated, medications were kept in the apartment in a locked box or cabinet. On April 30, 2024, at 8:30 a.m., CNS-C stated all medication should be kept in the locked medication cabinet unless they have an order to keep the medication at bedside. The licensee's Medication Management Policy dated June 6, 2023, indicated all medications would be stored in a locked box in a cabinet or refrigerator in the resident's unit in areas in which the temperature may not fluctuate to levels that are unsuitable for medication storage. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=E	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to discard expired medication for two of five residents (R3, R5). In addition, the licensee failed to ensure time-sensitive medications were labeled with the date opened for one of two residents (R5).	01890		

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	20024	A. BUILDING: _____ B. WING _____	05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARANATHA FKA MARANATHACOMMONS	5415 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429

(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
01890	Continued From page 26 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R3 On April 30, 2024, at 7:13 a.m., the surveyor observed R3's locked medication cabinet which contained the following expired medications: - Zilactin-B gel for mouth sores with an expiration date of April 12, 2024: - fluticasone propionate nasal spray 50 micrograms (mcg) with an expiration date of April 12, 2024; - Refresh Plus eye drops 8 single dose vials with an expiration date of January 8, 2024; and - lubricating plus carboxymethylcellulose 0.5 percent (%) with two unopened packets of single dose vials with an expiration date of April 12, 2024. R5 On April 30, 2024, at 9:15 a.m., the surveyor observed R5's refrigerator and locked medication cabinet which contained the following opened time-sensitive medication: - one bottle of dorzolamide/timolol solution 22.3 milligrams (mg)/ 6.8 mg eye drop opened without a date open label; -one bottle latanoprost 0.005 % eye drop date opened December 17, 2023, expired January 28,	01890		

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	20024	A. BUILDING: _____ B. WING _____	05/01/2024

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01890	Continued From page 27 2024; and -one bottle of latanoprost 0.005 % eye drop opened without a date opened label. On April 30, 2024, at 7:49 a.m., unlicensed personnel (ULP)-E stated they were not trained on what to do if they discovered an expired medication in the cabinet however, due to previous work experience they would take the medication to the nurse for destruction. ULP-E stated the nurses completed a weekly check on the medication cabinets and they believed they removed expired medications at that time. On April 30, 2024, at 8:30 a.m., clinical nurse supervisor (CNS)-C stated they were not sure if ULPs were trained on what to do with expired medication however, the nurses completed a weekly check on the medication cabinets. CNS-C stated the floor R3 and R5 were located on the nurse observed the medication cabinets every Tuesdays. CNS-C stated, "the aides typically are not looking for expired dates in their normal routines." On April 30, 2024, at 9:10 a.m., ULP-E stated they were trained the staff member who opened the eye drops was responsible for labeling the bottle with the date opened. ULP-E stated the eye drops came with a yellow date open sticker however, recently they have not come with them. On May 1, 2024, at 9:13 a.m., CNS-C stated ULPs were trained to write a date on the sticker of the bottle once opened and after 30 days the eye drop should be discarded. CNS-C stated weekly medication cabinet checks completed by the nurse would monitor the expiration date of the eye drops.	01890		

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MARANATHA FKA MARANATHACOMMONS	5415 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429

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01890	Continued From page 28 The manufacturer's instructions for latanoprost 0.005 % eye drop dated August 2011, recommended eye drops be discarded six weeks after opening. The manufacturer's instructions for dorzolamide/timolol solution 22.3 mg/6.8 mg dated January 2023, recommended eye drops be discarded 28 days after opening. The licensee's MN AL Medication Destruction Policy dated March 11, 2023, indicated pharmaceutical waste included any medication remaining after discontinuation, expiration, discharge, or death of resident that is not able to be returned to the dispensing pharmacy for credit and re-use. The licensee's AL Medication Management Policy dated June 6, 2023, indicated medication set-up required an expiration date to be added to the new label. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20024	A. BUILDING: _____ B. WING _____	05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARANATHA FKA MARANATHACOMMONS	5415 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01940	Continued From page 29 management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of four residents (R3) who received treatments. 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).	01940		

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01940	Continued From page 30 The findings include: R3 admitted to the licensee on November 30, 2017, under the licensee's former comprehensive license and began receiving assisted living services on August 1, 2021. R3's Service Plan-Attachment E to Residency Agreement signed September 29, 2023, indicated R3 received assistance with blood glucose monitoring, homemaking, laundry, medical appointment assistance, medication administration, thromboembolism-deterrent (TED) stocking/compression bandage (ACE) wrap application, showering, morning and evening care, and vital sign monitoring. On April 30, 2024, at 7:44 a.m., the surveyor observed ULP-E apply compression stockings to R3's bilateral lower extremities. ULP-E stated stockings were what was available. R3's prescriber order dated November 20, 2023, included graduated compression stocking 20-30 millimeter of mercury (mmHg). R3's ongoing nursing assessment completed March 28, 2024, indicated R3 used compression stockings. R3's Service Recap Summary- Month dated April 1, 2024, through April 30, 2024, read, "Ted Assist/Ace Wraps inc. w/AM or PM car [sic]." When opened on the electronic medical record it read, "assistance putting on or taking off ted socks or ace wraps. After removing wash and hang to dry. Do Not use metal fastners [sic] on ace bandages."	01940		

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01940	Continued From page 31 R3's record lacked the following requirements of a treatment management plan: - documentation of specific resident instructions relating to the treatments or therapy administration; - procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and - any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. On April 30, 2024, at 12:59 p.m., the surveyor inquired if compression stockings or ace bandages were to be applied to R3. Clinical nurse supervisor (CNS)-C stated it should be documented under the service for TEDs. CNS-C stated, "it looks like they did not remove the ace wrap on that one." The surveyor inquired where the information related to when the ULP should contact the nurse if a problem arose with the compression stockings was located. CNS-C stated it should be on the assignment. CNS-C left to obtain their computer. When they returned, they provided the surveyor a document which showed nursing and administration phone numbers. The surveyor inquired if they had anything specific related to compression stockings. CNS-C stated they did not have anything specific to compression stockings however, the ULPs were trained on how to apply the stockings and contact a nurse if there was a change to the skin. The surveyor requested the	01940		

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01940	Continued From page 32 competency related to compression stockings. The licensee's undated Delegation of Support/Anti-embolytic Stocking Application competency, indicated to notify a nurse of any change of condition but was not specific to complications or adverse reactions related to compression stockings. The licensee's MN AL Treatment and Therapy Management Policy dated March 7, 2023, read, "the RN may delegate to resident assistants the task of providing assistance with treatment and therapy if the resident assistants have satisfied the training requirements listed above and if: a. Before performing the procedures, the RN has instructed the resident assistant in the proper methods to administer the treatment and therapy and the resident assistants have demonstrated the ability to competently follow the procedures b. The RN has developed written, specific instruction for each resident c. The RN has communicated with the resident assistants about the individual needs of the resident; and d. The RN has documented that the resident assistants have been trained and have demonstrated competency to follow the procedures." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health	02320		

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02320	Continued From page 33 care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure residents received appropriate care and services from one of two unlicensed personnel ((ULP)-G) during medication administration. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R6's Service Plan-Attachment E to Residency Agreement signed December 14, 2023, indicated R6 received assistance with blood pressure monitoring, homemaking, laundry, showering, grooming, and weight monitoring. On April 30, 2024, at approximately 9:40 a.m., the surveyor observed ULP-G complete blood pressure monitoring on R6. ULP-G applied a digital wrist blood pressure monitoring device to R6's upper left arm. The blood pressure reading was 221/164. ULP-G stated the blood pressure reading was too high. ULP-G then took different	02320		

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02320	Continued From page 34 digital wrist blood pressure monitoring device from ULP-H, who was assisting R6 with other cares, and applied the device to the upper right arm. The blood pressure reading was 182/120. ULP-H then directed ULP-G to apply the device to R6's wrist, ULP-G applied the device to the left wrist and the blood pressure reading was 150/76. On April 30, 2024, at approximately 10:10 a.m., the surveyor inquired if ULP-G was trained on how to use blood pressure monitoring device listed above. ULP-G stated they were not trained on how to check blood pressure by the licensee. ULP-G stated they were a trained medication aide (TMA) and certified nursing assistant (CNA) and did receive training on how to check blood pressure on their certification training. On April 30, 2024, at approximately 11:00 a.m., clinical nurse supervisor (CNS)-C stated all ULPs were trained on how to check blood pressure using the digital wrist cuff. CNS-C stated ULP-G was a CNA and TMA. ULP-G's employee record included a Minnesota Nursing Assistant Registry Verification of Registration certificate dated January 20, 2023, indicating ULP-G was a certified nursing assistant. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		

Minnesota Department of Health
Food, Pools and Lodging Services Section
625 N Robert St
St Paul, MN 55164
651-201-4500

Type: Full
Date: *04/29/24*
Time: 08:33:08
Report: 7963241045

Food and Beverage Establishment Inspection Report

Location:

Maranatha Fka Maranathacommons
5415 69th Avenue North
Brooklyn Center, MN55429
Hennepin County, 27

Establishment Info:

ID #: 0038213
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7635499600
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.

3-500B Microbial Control: hot and cold holding

3-501.16A2 ***** Priority 1 *****

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

1/2 GALLON MILK ON COUNTER IN BACK KITCHEN TEMPED AT 61 DEG F. PARTIAL 1/2 GALLON OF MILK IN COOLER AFTER SERVICE AT 47 DEG F. PRODUCT DISCARDED AT TIME OF INSPECTION.

Comply By: 04/30/24

Surface and Equipment Sanitizers

Acid: = 700PPL at Degrees Fahrenheit
Location: SANI BUCKET
Violation Issued: No

Hot Water: = at 162 Degrees Fahrenheit
Location: DISHWASHER RINSE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: CAULIFLOWER SOUP
Temperature: 93 Degrees Fahrenheit - Location: SOUP KETTLE
Violation Issued: No

Process/Item: ROAST BEEF
Temperature: 167 Degrees Fahrenheit - Location: HOT HOLDING
Violation Issued: No

Food and Beverage Establishment Inspection Report

Process/Item: CKD CHICKEN
Temperature: 72 Degrees Fahrenheit - Location: COUNTERTOP
Violation Issued: No

Process/Item: MILK
Temperature: 61 Degrees Fahrenheit - Location: COUNTERTOP
Violation Issued: Yes

Process/Item: YOGURT
Temperature: 34 Degrees Fahrenheit - Location: TRUE COOLER
Violation Issued: No

Process/Item: MILK
Temperature: 33 Degrees Fahrenheit - Location: TRUE COOLER
Violation Issued: No

Process/Item: MILK
Temperature: 47 Degrees Fahrenheit - Location: TRUE COOLER
Violation Issued: Yes

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

MET WITH MDH NURSE SURVEYOR ASHLEY CREWS AND FACILITY REPRESENTATIVES DOUGLAS COLLINS AND LINDA KRENTZ. DISCUSSED THE FOLLOWING-

-EMPLOYEE ILLNESS POLICY AND LOG
-REPORTABLE DISEASES
-USE OF TIME AS A PUBLIC HEALTH CONTROL
-HIGHLY SUSCEPTIBLE POPULATION RESTRICTIONS
-BEVERAGE SERVICE

THE ASSISTED LIVING SERVICE KITCHEN IS PROVIDED FOOD FROM THE MAIN PRODUCTION KITCHEN (PART OF NURSING HOME AREA). LIMITED FOOD HANDLING DONE AT THIS AREA. A STEAM TABLE IS USED FOR HOT HOLDING BULK FOODS. NO COLD HOLDING TABLE PRESENT SO TIME AS A PUBLIC HEALTH CONTROL IS USED AND FOOD IS DISCARDED AT THE END OF EACH MEAL SERVICE.

Type: Full
Date: *04/29/24*
Time: 08:33:08
Report: 7963241045
Maranatha Fka Maranathacommons

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 7963241045 of 04/29/24.

Certified Food Protection Manager: Pilar Ramirez-Rowlette

Certification Number: FM 94690 Expires: 06/29/24

Inspection report reviewed with person in charge and emailed.

Signed: _____
Douglas Collins
PIC

Signed: Peggy Spadafore
Peggy Spadafore
Sanitarian Supervisor
metro
651-201-4500
peggy.spadafore@state.mn.us

Report #: 7963241045

Food Establishment Inspection Report

Minnesota Department of Health
Food, Pools and Lodging Services Section
625 N Robert St
St Paul, MN 55164

No. of RF/PHI Categories Out	1	Date	04/29/24
No. of Repeat RF/PHI Categories Out	0	Time In	08:33:08
Legal Authority MN Rules Chapter 4626		Time Out	

Maranatha Fka Maranathacommons	Address: 5415 69th Avenue North	City/State: Brooklyn Center, MN	Zip Code: 55429	Telephone: 7635499600
License/Permit #: 0038213	**Permit Holder**	**Purpose of Inspection:** Full	**Est Type**	**Risk Category**

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

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

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

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

GOOD RETAIL PRACTICES

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

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

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

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

Food Recalls:

Person in Charge (Signature) **Date:** 04/30/24

Inspector (Signature) Peggy Spudy