Electronically Delivered

September 19, 2024

Licensee
Love & Care LLC
5324 Boulder Lane
Brooklyn Center, MN 55429

RE: Project Number(s) SL36064015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 20, 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,

Kelly Thorson

Kelly Thorson, Supervisor
State Evaluation Team
Email: kelly.thorson@state.mn.us
Telephone: 320-223-7336 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
	36064	A. BUILDING: _____ B. WING _____	08/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOVE & CARE LLC	5324 BOULDER LANE 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
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: SL# 36064015 On August 19, through, August 20, 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 two resident(s); both receiving services under the provider's Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480		

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0 480	Continued From page 1 following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated August 20, 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		
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this	0 650		

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0 650	Continued From page 2 chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records contained the required content for one of one employee (clinical nurse supervisor (CNS)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to 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: CNS-C began employment as the registered nurse (RN) on January 15, 2023. CNS-C's employee record lacked the following:	0 650		

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0 650	Continued From page 3 - documentation of a current annual performance review that identified areas of improvement needed and training needs. On August 20, 2024, licensed assisted living director (LALD)-A stated he did not complete the annual performance review for the nurse and should have. The licensee's Performance Evaluation policy dated August 1, 2021, indicated a formal performance evaluation will be conducted for all staff providing assisted living services at lest annually. Documentation of the annual performance review will be maintained in the personnel file. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines.	0 660		

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0 660	Continued From page 4 (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included a history and symptom screening for one of two employees (unlicensed personnel (ULP)-D) and initial TB training for one of two employees (clinical nurse supervisor (CNS)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: The facility TB risk assessment completed April 29, 2024, indicated the facility was at a low risk for TB transmission. ULP-D began employment on October 25, 2022, to provide direct care services. ULP-D's record lacked evidence a TB history and symptom screening was completed upon hire. CNS-C began employment on January 15, 2023, to provide direct care services. CNS-C's record indicated CNS-C did not	0 660		

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0 660	Continued From page 5 complete TB training upon hire. On August 20, 2024, at 3:45 p.m., licensed assisted living director (LALD)-A stated he was not aware CNS-C had not completed all her training as it had been assigned to her. LALD-A further stated he was not sure why a history and symptom screening was not completed for ULP-D. The licensee's Tuberculosis Screening/Prevention policy dated August 1, 2021, indicated the facility will observe the recommended precautions related to TB prevention as identified by the Centers for Disease Control and Prevention (CDC) and the Minnesota Department of Health (MDH). The precautions include the following elements: risk assessment, TB screening, and staff education. The Minnesota Department of Health guidelines Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, and based on CDC guidelines, indicated a TB infection control program should include an annual facility TB risk assessment. The guidelines also indicated an employee may begin working with patients (residents) after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW starts working with patients. Baseline TB screening should be documented in the employee's record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		

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0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the facility tour on August 20, 2024, with the licensed assisted living director (LALD)-A, between 9:00 a.m. and 10:30 a.m. the following deficient conditions were observed: LOCKS:	0 800		

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0 800	Continued From page 7 The surveyor observed locks at the top of the front and side exit doors. Both of these doors were identified as exit doors on their emergency evacuation map. The surveyor observed a hasp lock on the basement laundry room door. The surveyor explained to LALD-A, these locks do not meet the Minnesota State Fire Code. WINDOW WELL: The surveyor observed the covers on the window wells for the basement emergency escape windows blocked the window from fully opening. The surveyor explained to LALD-A that the emergency escape windows shall be fully openable at all times. GARAGE WALL: The surveyor observed that the fire rated wall did not go all the way to the ceiling on the garage where a small addition had been added on. The surveyor explained to LALD-A the area shall be covered with minimum ½" gypsum board. The deficient conditions were visually verified by the LALD-A accompanying on the tour. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment	0 810		

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0 810	Continued From page 8 (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: 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 and	0 810		

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0 810	Continued From page 9 drills. 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: A record review and interview were conducted on August 20, 2024, at approximately 10:00 a.m. with the licensed assisted living director (LALD)-A on the fire safety and evacuation plan and fire safety and evacuation training and drills for the facility. EMPLOYEE/RESIDENT TRAINING RECORDS: During an interview on August 20, 2024, LALD stated they only trained their employees and residents on Educare only. The surveyor explained to LALD-A the employees shall be trained specifically on their fire safety and emergency plan at new hire and twice a year thereafter. Also, the residents shall be offered the training once a year. Both shall be documented. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the	01060		

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01060	Continued From page 10 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 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	01060		

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01060	Continued From page 11 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 required content for an emergency relocation and failed to notify the Office of Ombudsman for Long-Term Care of the emergency relocation for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: R1 started receiving services on February 23, 2023. R1's record indicated R1 went to the emergency room on January 9, 2024, and was admitted to the hospital. R1 returned to the facility on February 8, 2024. R1's record lacked a written notice including: - the name and contact information for the location to which the resident has been relocated and any new service provider - contact information for the Office of Ombudsman for Long-Term Care - 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	01060		

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01060	Continued From page 12 that a return date is not currently known; and - 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. R1's record lacked notification to the Office of Ombudsman for Long-Term Care that the resident had been relocated and had not returned to the facility within four days. On August 21, 2024, at 3:30 p.m., licensed assisted living director (LALD)-A stated he was not aware of this requirement, and they did notify OOLTC that she went to the hospital but did not send the emergency relocation notifications as required. The licensee's Discharge and Transfer of Residents policy dated August 1, 2021, indicated in the event of an emergency relocation, the facility will, as soon as possible, provide written notice of Emergency Relocation to the following: the resident, the resident's legal representitives, the resdient's designated representitives, the resdient's case manager, if the resdient has been relocated and not returned to the facility within four days, the Office of Ombudsman for Long-Term Care. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01470 SS=F	144G.63 Subd. 2 Content of required orientation	01470		

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	36064	A. BUILDING: _____ B. WING _____	08/20/2024

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01470	Continued From page 13 (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must	01470		

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01470	Continued From page 14 include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure orientation to assisted living facility licensing requirements and regulations included all required content for two of two employees (clinical nurse supervisor (CNS)-C) and (unlicensed personnel (ULP)-D). 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: CNS-C had a hire date of January 15, 2023. ULP-D had a hire date of October 25, 2022.	01470		

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01470	Continued From page 15 CNS-C's and ULP-D's employee records lacked the following required orientation content: -overview of assisted living statutes -handling of resident complaints, reporting of complaints, where to report -consumer advocacy services -review of the types of assisted living services the employee will provide and provider's scope of license -principles of person-centered planning/service delivery On August 20, 2024, at 3:45 p.m., licensed assisted living director (LALD)-A stated all the classes had been assigned to CNS-C and ULP-D, they did not complete them. The licensees Staff Orientation and Education policy dated August 1, 2021, indicated all staff providing assisted living through [the facility] will be prepared to provide safe, effective services to all residents through a thorough orientation and education program pertinent to the needs of the residents. Orientation topics will include: -an overview of Minnesota Assisted Living Statute 144G and Minnesota Rules Chapter 4659 -grievance policy/process, including reports to the Office of Health Facility Complaints -consumer advocacy services -the principles of person-centered planning and service delivery and how they apply to direct support services provided by staff -the types of assisted living services the employee will be providing based on the Uniform Checklist Disclosure of Services and the organization's category of licensure. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	01470		

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01470	Continued From page 16 (21) days	01470		
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a),	01500		

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01500	Continued From page 17 annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an employee received at least eight hours of annual training for each 12 months of employment for two of two employees (clinical nurse supervisor (CNS)-C) and (unlicensed personnel (ULP)-D). 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:	01500		

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01500	Continued From page 18 CNS-C had a hire date of January 15, 2023. CNS-C's record lacked evidence of annual training to include: -infection control techniques -effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders -review of provider's policies and procedures -principles of person-centered planning and service delivery ULP-D had a hire date of October 25, 2022. ULP-D's record lacked evidence of annual training to include: -assisted living bill of rights -principles of person-centered planning and service delivery On August 20, 2024, at 3:45 p.m., licensed assisted living director (LALD)-A stated the training had been assigned were not completed by CNS-C and ULP-D. The licensee's Staff Orientation and Education policy dated August 1, 2021, indicated all staff providing assisted living services will complete at least eight (8) hours of education for every twelve (12) months of employment. Education topics will include: -review of assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights -infection control techniques -effective approaches to use to problem solve when working with a resident's challenging	01500		

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01500	Continued From page 19 behaviors and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders -review of the organization's policies and procedures related to provision of assisted living services and how to implement them -the principles of person-centered planning and service delivery and how they apply to direct support services provided by staff. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		
01530 SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be	01530		

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01530	Continued From page 20 available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received eight hours of initial dementia care training within the first 120 hours worked for one of one employee (clinical nurse supervisor (CNS)-C and eight hours of initial dementia care training within the first 160 hours worked for one of one employee (unlicensed personnel (ULP)-D). 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: CNS-C began employment on January 15, 2023. CNS-C's employee training record which showed completion dates of May 9, 2024, and May 14, 2024, included: -dementia activities- bathing 0.75 -dementia activities- dressing and grooming 0.75 -dementia activities- hydration, nutrition, eating, and dining 0.75 -dementia activities- medications, vitals, and treatments 0.50 -dementia activities- toileting 0.50	01530		

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01530	Continued From page 21 -dementia problem solving- anger and aggression 0.50 -dementia problem solving- anxiety 0.50 -dementia problem solving- mood swings and personality changes 0.50 -dementia problem solving-wandering and elopement 0.75 -dementia 2- communication 1.25 -dementia 3- activities of daily living 1.00 ULP-D began employment on October 25, 2022. ULP-D's employee training record which showed completion dates of May 17, 2024, and May 19, 2024, included: -dementia activities- bathing 0.75 -dementia activities- chores, working, and volunteering 0.75 -dementia activities- dressing and grooming 0.75 -dementia activities- hydration, nutrition, eating, and dining 0.75 -dementia activities- medications, vitals, and treatments 0.50 -dementia activities- toileting 0.50 On August 20, 2024, at 3:45 p.m., licensed assisted living director (LALD)-A stated he knew 8 hours was required and was not aware staff had not completed their assigned classes. The licensee's Staff Orientation and Education policy dated August 1, 2021, indicated all direct care staff and supervisors providing direct services must receive training on dementia. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		

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01620	Continued From page 22	01620		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to ensure the registered nurse (RN) used the uniform assessment tool for ongoing assessments and monitoring for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	01620		

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01620	Continued From page 23 resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On August 19, 2024, at 10:30 a.m., licensed assisted living director (LALD)-A stated the licensee completed initial, 14-day, 90-day, and change in condition assessments. R1 was admitted and began receiving services on February 3, 2023. R1's most recent assessment dated July 18, 2024, did not include all the required elements on the uniform assessment tool. R1's assessment lacked: -personal lifestyle preferences, including sleep schedule, dietary and social needs, leisure activities, and any other customary routine that is important to the resident's quality of life, spiritual and cultural preferences, and advance health care directives and end-of-life preferences -activities of daily living, including toileting pattern, bowel, and bladder control, dressing, grooming, bathing, and personal hygiene, mobility, including ambulation, transfers, and assistive devices, and eating, dental status, oral care, and assistive devices and dentures -instrumental activities of daily living including ability to self-manage medications, housework and laundry and transportation -physical health status including a review of relevant health history and current health conditions, including medical and nursing diagnoses, allergies and sensitivities related to medication, seasonality, environment, and food	01620		

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01620	Continued From page 24 and if any of the allergies or sensitivities are life threatening, infectious conditions, a review of medications according to Minnesota Statutes section 144G.71 subdivision 2 including prescriptions, over-the-counter medications, and supplements, and for each, the reason taken, any side effects, contraindications, allergic or adverse reactions and actions to address these issues, the dosage, the frequency of use, the route administered or taken, any difficulties the resident faces in taking the medication, whether the resident self-administers the medication, the resident's preferences in how to take the medication, interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications, and provide instructions to the resident and resident's legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications, a review of medical, dental, and emergency room visits in the past 12 months, including visits to a primary health care provider, hospitalizations, surgeries, and care from a post-acute care facility, a review of any reports from a physical therapist, occupational therapist, speech therapist, or cognitive evaluations within the last 12 months, weight and initial vital signs if indicated by health conditions or medications -emotional and mental health conditions, including review of history of and any diagnoses of mood disorders, including depression, anxiety, bipolar disorder, and thought or behavioral disorders, current symptoms of mental health conditions and behavioral expressions of concerns and effective treatment and nonmedication interventions -cognition, including a review of any neurocognitive evaluations and diagnoses and current memory, orientation, confusion, and	01620		

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01620	Continued From page 25 decision-making status and ability -communication and sensory capabilities, including hearing, vision, speech, assistive communication, and sensory devices including hearing aids and the ability to understand and be understood -skin conditions -nutritional and hydration status and preferences -list of treatments including type, frequency, and level of assistance needed -nursing needs, including potential to receive nursing-delegated services -risk indicators, including risk for falls including history of falls, emergency evacuation ability, complex medication regimen, risk for dehydration, including history of urinary tract infections and current fluid intake pattern, risk for emotional or psychological distress due to personal losses, unsuccessful prior placements, elopement risk including history or previous elopements, smoking including the ability to smoke without causing burns or injury to the resident or others or damage property and alcohol and drug use, including the resident's alcohol use or drug use not prescribed by a physician. -who has decision-making authority for the resident, including the presence of any advance health care directive or other legal document that establishes a substitute decision maker and the scope of decision-making authority of a substitute decision maker -the need for follow up referrals for additional medical or cognitive care by health professionals On August 20, 2024, at 3:40 p.m., clinical nurse supervisor (CNS)-C stated she had looked at the uniform assessment tool requirements but was still using old forms for all residents and was not aware she was supposed to be following the	01620		

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01620	Continued From page 26 uniform assessment tool. The Minnesota Administrative Rule 4659.0150 dated August 11, 2021, indicated each facility must develop a uniform assessment tool to include all the required elements. The licensee's Comprehensive Nursing Assessment policy dated August 1, 2021, indicated the registered nurse (RN) will conduct a comprehensive assessment for all residents. The assessment addresses the resident's physical, mental, and cognitive needs. The RN will conduct a comprehensive assessment utilizing a uniform assessment tool that addresses all the above. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
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 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;	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36064	A. BUILDING: _____ B. WING _____	08/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOVE & CARE LLC	5324 BOULDER LANE 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 27 (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 include a written statement of a treatment service on the resident's service plan for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: R1 was admitted on February 3, 2023. R1's Treatment Plan dated February 3, 2024, indicated R1 received daily blood sugar checks.	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36064	A. BUILDING: _____ B. WING _____	08/20/2024

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01940	Continued From page 28 On August 20, 2024, at 8:30 a.m., the surveyor observed owner (O)-B check R1's blood glucose. R1's Service Plan dated February 1, 2024, lacked identification of treatment services related to R1's blood glucose monitoring. On August 20, 2024, at 2:20 p.m., clinical nurse supervisor (CNS)-C stated blood glucose monitoring was a verbal order from her primary and was taken off the service plan because she was refusing. R1 had a hospital stay and when she returned in May they started doing blood glucose checks again. CNS-C stated she missed putting it back on the service plan and was aware the service plan should have been updated right away. The licensee's Treatment and Therapy Management policy dated August 1, 2021, indicated the registered nurse or licensed health professional is responsible for assessing and developing the treatment and/or therapy service plan for residents. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01940		

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

Type: Full
Date: *08/20/24*
Time: 17:15:29
Report: 1018241120

Food and Beverage Establishment Inspection Report

Location:
Love & Care Llc
5324 Boulder Lane
Brooklyn Center, MN55429
Hennepin County, 27

Establishment Info:
ID #: 0039090
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7637446280
ID #:

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

The following orders were issued during this inspection.

2-200 Employee Health

2-201.11C ***** Priority 1 *****

MN Rule 4626.0040C The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority.

ESTABLISHMENT WAS UNABLE TO PRODUCE AN ILLNESS LOG AT THE TIME OF INSPECTION. ILLNESS LOG SENT WITH REPORT. DISCUSSED ILLNESS REPORTING.

Comply By: 08/20/24

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

3-302.11A(1) ***** Priority 1 *****

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

EGGS OBSERVED TO BE STORED OVER READY TO EAT FOODS IN THE REFRIGERATOR. DISCUSSED PROPER STORAGE WITH MANAGER.

Comply By: 08/20/24

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

INSPECTION CONDUCTED WITH WENDY ROBARGE (MDH) PRESENT

ESTABLISHMENT IS A RESIDENTIAL HOME WITH RESIDENTIAL EQUIPMENT, RESIDENTIAL CABINETS/COUNTER TOPS, AND RESIDENTIAL STYLE FLOORS, WALLS AND CEILINGS. ALL APPEAR TO BE IN GOOD CONDITION.

ESTABLISHMENT HAS A DISHWASHER THAT HAS A SANITIZE FUNCTION AVAILABLE FOR DISHES.

SINK HAS TWO COMPARTMENTS THAT ARE DESIGNATED ONE FOR HAND WASHING AND ONE FOR RINSING DISHES.

ESTABLISHMENT DOES ALL SAME DAY FOOD SERVICE FOR CLIENTS, AND NO LEFTOVERS ARE SAVED.

DISCUSSED EMPLOYEE ILLNESS REPORTING AND ILLNESS LOGS.

DISCUSSED PEST CONTROL MANAGEMENT.

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 1018241120 of 08/20/24.

Certified Food Protection Manager: TANVEER GULZAR

Certification Number: FM116792 Expires: 05/20/26

Inspection report reviewed with person in charge and emailed.

Signed: _____
Establishment Representative

Signed: _____
Rebecca Prestwood
Sanitarian 3
6512013777
rebecca.prestwood@state.mn.us