DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

November 7, 2022

Administrator
Personal Care Management LLC
525 Cutter Street
Anoka, MN 55303

RE: Project Number(s) SL36849015

Dear Administrator:

On October 27, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the August 3, 2022, evaluation were corrected. This follow-up evaluation verified that the facility is in substantial compliance.

It is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. You are encouraged to retain this document for your records.

Please feel free to call me with any questions.

Sincerely,

Jess Gallmeier, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jess.gallmeier@state.mn.us
Phone: 651-201-3789 Fax: 651-215-9697

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Electronically Delivered

August 25, 2022

Administrator
Personal Care Management LLC
525 Cutter Street
Anoka, MN 55303

RE: Project Number(s) SL36849015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on August 3, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

IMPOSITION OF FINES
In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation

that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5)(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this evaluation:

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00

St - 0 - 1750 - 144g.71 Subd. 7 - Delegation Of Medication Administration - $3,000.00

The total amount you are assessed is $3,500.00. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

Please address your cover letter for general reconsideration requests to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

Free from Maltreatment reconsideration requests should be addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both.

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

Sincerely,

Jess Gallmeier, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jess.gallmeier@state.mn.us
Phone: 651-247-0268 Fax: 651-215-9697

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36849	A. BUILDING: _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSONAL CARE MANAGEMENT LLC	525 CUTTER STREET ANOKA, MN 55303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(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#36849015 On August 1, 2022, through August 3, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 24 residents receiving services under the provider's Assisted Living license with dementia care.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 110 SS=F	144G.10 Subdivision 1a Assisted living director license required	0 110		

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0 110	Continued From page 1 Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure licensed assisted living director (LALD)-I was involved in the management of the day-to-day activities of the residents, staff, and visitors to the licensee. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: LALD-I started employment with licensee on July 15, 2022. On August 1, 2022, at approximately 10:30 a.m., the Board of Executives for Long-Term Services and Supports (BELTTS) website indicated LALD-I was director of record for the licensee as of July 15, 2022. On August 1, 2022, during the entrance conference, house manager (HM)-D stated she had made a call to inform LALD-I to be present for the survey, but LALD-I stated it was not possible.	0 110		

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0 110	Continued From page 2 On August 1, 2022, at approximately 10:50 a.m., LALD-C stated on July 15, 2022, she received a call from the licensee's owners requesting her to remove herself from BELTTS as licensee's director of record, stating the licensee had LALD-I to take over management. On August 2, 2022, at approximately 8:30 a.m., unlicensed personnel (ULP)-B stated they had not met, nor did they know LALD-I. On August 2, 2022, at approximately 9:10 a.m., ULP-E stated they had not met, nor did they know LALD-I. On August 2, 2022, at approximately 9:20 a.m., HM-D stated new resident admissions and welcoming to licensee is done by the registered nurse (RN) and HM-D. On August 2, 2022, at approximately 9:30 a.m., HM-D stated in the absence of LALD-I, HM-D was the first go to person, and LALD-I was also available over the phone. HM-D also stated LALD-I had a full-time job as a pharmacist in Duluth, which is approximately 153 miles away, and will probably be available once or twice a week in person at the licensee's facility. On August 2, 2022, at approximately 9:40 a.m., LALD-I was asked how he was running the management of the day-to-day activities of the licensee if he was not present there. LALD-I stated Personal Care Management LLC had a contract with Harbor Health Management to manage the day-to-day activities of the licensee to the end of August 2022. No further information provided.	0 110		

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0 110	Continued From page 3 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 110		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (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 according to the Minnesota Food Code. This had the potential to affect all 28 current residents of the facility. 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	0 480		

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0 480	Continued From page 4 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: Please refer to the additional documentation included in the Food and Beverage Establishment Inspection Reports, dated August 2, 2022. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 485 SS=C	144G.41 Subd 1. (13) (i) (A) and (C) Minimum Requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (A) menus must be prepared at least one week in advance, and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; (C) the facility cannot require a resident to include and pay for meals in their contract; This MN Requirement is not met as evidenced	0 485		

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0 485	Continued From page 5 by: Based on observation and interview, the licensee failed to have a menu prepared at least one week in advance and made available to all residents. This had the potential to affect all 24 residents of the licensee. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On August 1, 2022, at approximately 10:20 a.m., the surveyor observed the menu plan on the bulletin board. The observed menu was not prepared at least one week in advance. On August 1, 2022, at 10:22 a.m., director of dining services (DS)-F acknowledged the menu was not prepared at least one week in advance. DS-F also stated in the computer it was prepared for a month, but it would be confusing to the residents if given out two weeks in advance. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that	0 510		

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0 510	Continued From page 6 complies with accepted health care, medical, and 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 follow the Centers for Disease Control (CDC) and the Minnesota Department of Health (MDH) infection control guidance recommendations for masking and eye protection for health care workers related to COVID-19 for four of four employees (house manager (HM)-D, unlicensed personnel (ULP)-E, ULP-G, director of dinning services (DS)-F). 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 client's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the clients). The findings include: On August 1, 2022, at approximately 8:24 a.m., the CDC COVID Data Tracker for current community transmission indicated the licensee's county had a high transmission rate.	0 510		

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0 510	Continued From page 7 The MDH personal protective equipment (PPE) grid for health care workers/direct service providers dated December 16, 2021, indicated when working with residents when community transmission rate is high, employees should wear a facemask and eye protection. On August 1, 2022, at approximately 9:35 a.m., HM-D met surveyor at the licensee's main entrance and walked the surveyor to the office. HM-D later attended the entrance conference, all while wearing a cloth mask. On August 1, 2022, at approximately 10:25 a.m., ULP-G stood by the medication cart with a resident, while not wearing eye protection. On August 1, 2022, at approximately 10:35 a.m., ULP-E sat with residents in the dining area of the memory care unit. ULP-E's mask was below her nose and she was not wearing eye protection. On August 1, 2022, at approximately 11:30 a.m., DS-F walked from the kitchen through licensee's common area to licensed practical nurse (LPN)-H's office and back to the kitchen without a mask and eye protection. On August 1, 2022, at approximately 11:45 a.m., licensed assisted living director (LALD)-C, acknowledged the observations and stated the licensee was not aware they needed to put on eye protection. LALD-C also stated it was confusing to find the right information. The licensee's Infection Control policy dated August 1, 2021, indicated infection control practices are important for the health and safety of staff, residents, and guests. The policy indicated the licensee had a system for	0 510		

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0 510	Continued From page 8 preventing, identifying, reporting and controlling infections. The policy lacked verbiage to include personal protective equipment necessary for infection control. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 510		
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 chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed	0 650		

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0 650	Continued From page 9 by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure employee records included all the required content for one of two employees (unlicensed personnel (ULP)-B) with employee records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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 included: ULP-B started employment with licensee on April 18, 2022. On August 2, 2022, at approximately 7:30 a.m., and 8:18 a.m., ULP-B administered medications to R6 in her room. ULP-B's employee record lacked documentation of a current job description. On August 3, 2022, at approximately 11:20 a.m., house manager (HM)-D acknowledged ULP-B's record was lacking a job description and stated the job description was done but could not understand how it was missing. HM-D further	0 650		

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0 650	Continued From page 10 stated ULP-B was requested to bring her personal copy as evidence. The licensee's Employee Records policy dated August 1, 2021, indicated the licensee will keep employee record of all paid employees. The policy indicated a current signed job description will be maintained. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 660 SS=D	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. (b) 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 ensure employee tuberculosis (TB) history and symptom screen,	0 660		

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PERSONAL CARE MANAGEMENT LLC	525 CUTTER STREET ANOKA, MN 55303

(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
0 660	Continued From page 11 baseline screening and training were completed and documented for one of two employees (unlicensed personnel (ULP)-B) with employee health records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-B started employment with the licensee on April 18, 2022. On August 2, 2022, at approximately 7:30 a.m., and 8:18 a.m., ULP-B administered medications to R6 in her room. ULP-B's employee record lacked a TB history and symptom screen, baseline screening, and TB training at hire. On August 3, 2022, at approximately 10:10 a.m., house manager (HM)-D acknowledged ULP-B's records lacked required TB record. The licensee's Infection Control policy dated August 1, 2021, indicated the licensee will obtain and maintain record of all missing TB records. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		

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0 680	Continued From page 12	0 680		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness plan with all the required content as defined in Appendix Z. This had the potential to affect the licensee's residents, staff, and guests.	0 680		

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0 680	Continued From page 13 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: On August 3, 2022, at approximately 10:30 a.m., the surveyor requested to review the licensee's emergency preparedness plan (EP), and a three ringed bidder that contained the licensee's EP was provided. The licensee's EP lacked the following content: - Develop and maintain EP program - Maintain and annual EP updates - EP program patient population - Process for EP collaboration - Development of EP policies and procedures - Subsistence needs for staff and patients - Procedures for tracking of staff and patients - Policies and procedures including evacuation - Policies and procedures for sheltering - Policies and procedures for medical documents - Policies and procedures for volunteers - Arrangement with other facilities - Roles under a waiver declared by Secretary - Development of communication plan - Emergency officials contact information - Primary/alternate means for communication - Methods for sharing information - Sharing information on occupancy/needs - LTC family notifications - Emergency prep training and testing - Emergency prep training program	0 680		

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0 680	Continued From page 14 - Emergency prep testing requirements - LTC emergency power (typically engineering) - Integrated health systems On August 3, 2022, at 10:40 a.m., house manager (HM)-D acknowledged the licensee's EP lacked the content above. HM-D stated the licensee's management staff will update the EP to include missing content. The licensee's Emergency Preparedness Plan-Appendix Z Compliance policy dated August 1, 2021, indicated licensee has an effective plan in place. The policy indicated the plan will include all required elements of Appendix-Z. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 900 SS=D	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a	0 900		

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0 900	Continued From page 15 complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop and execute a written contract with the required content for one of three residents (R1) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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:	0 900		

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0 900	Continued From page 16 R1 was admitted to the licensee on April 27, 2022. R1's record lacked a written contract which included provisions of the following as required: (1) housing (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable On August 1, 2022, at approximately 11:00 a.m., house manager (HM)-D acknowledged the licensee had not executed a current written contract with R1. HM-D further stated the licensee executed a contract with R1's husband, who lives with R1. The licensee's Signing an Assisted Living Contract policy dated August 1, 2021, indicated licensee will execute a contract with all its new residents and they will receive a copy of the same. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 900		
0 970 SS=C	144.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is	0 970		

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0 970	Continued From page 17 required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for the health, safety, or personal property of a resident. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: The licensee's undated assisted living contract included two clauses that indicated the resident would waive the licensee's liability for health, safety, or personal property. - Page 15, section 2 of the contract indicated a resident would indemnify or hold harmless the provider, its employees and agents from and against any and all claims, actions, damages, and liability and expense in connection with loss of life, personal injury or damage to property, arising from or out of the use by resident of the rented premises or any other part of the provider's property, or caused wholly or in part by an act or omission of resident or resident's guests or agents. - Page 15-16, section 4 of the contract indicated the provider was not liable to resident for any injury, death or property damage	0 970		

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0 970	Continued From page 18 occurring in the apartment unit or on provider's premises unless such injury, death or property damage occurred as a result of an equipment malfunction or hazardous conditions within the building not caused by the resident or resident's guests. On August 2, 2022, at approximately 10:45 a.m., house manager (HM)-D acknowledged the assisted living contract required residents to waive the licensee's liability for health, safety, or personal property. HM-D confirmed the same assisted living contract was used for all residents at the licensee. The licensee's Signing an Assisted Living Contract policy dated August 1, 2021, indicated the licensee will execute a contract with all its new residents and receive a copy of the same. The licensee's policy lacked verbiage to include the waiver. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services;	01470		

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01470	Continued From page 19 (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 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	01470		

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01470	Continued From page 20 (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure employees received orientation to assisted living licensing requirements and regulations for one of two employees (unlicensed personnel (ULP)-B) with employee records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-B started employment with the licensee on April 18, 2022. On August 2, 2022, at approximately 7:30 a.m., and 8:18 a.m., ULP-B administered medications to R6 in her room. ULP-B's employee file lacked orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents to include the following topics:	01470		

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01470	Continued From page 21 - Overview of assisted living statutes - Review of provider's policies and procedures - Handling emergencies and using emergency services - Reporting maltreatment of vulnerable adults or minors - Handling of resident/clients' complaints, reporting of complaints, where to report - Consumer advocacy services - Review of types of assisted living services the employee will provide and provider's scope of license - Principles of person-centered planning/service delivery On August 3, 2022, at approximately 11:35 a.m., house manager (HM)-D acknowledged ULP-B's employee record lacked orientation to assisted living facility licensing requirements and regulations as required. The licensee's Orientation and Training Competency Training Evaluations policy dated August 1, 2021, indicated prior to delegating tasks, the registered nurse (RN) must make certain the ULP is trained in proper methods to perform the task or procedure. The policy lacked verbiage to include orientation requirement and content. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01540 SS=D	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care,	01540		

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01540	Continued From page 22	01540		

direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 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 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 direct-care staff completed the required amount of dementia care training in the required time frame for one of two employees (unlicensed personnel (ULP)-B) with records reviewed.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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:

The licensee had an assisted living facility with dementia care (ALFDC) license effective August

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01540	Continued From page 23 1, 2021 and expiring July 31, 2022. ULP-B had a hire date of April 18, 2022, and was hired to provide direct care to residents of the licensee. ULP-B's employee training record indicated three hours of dementia care training completed May 26, 2021 (completed at another of the licensee's owner's licenses). ULP-B's employee record lacked the required dementia care training within at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. On August 3, 2022, at approximately 12:21 p.m., house manager (HM)-D acknowledged ULP-B had not completed the initial required hours of dementia care training within the required time frame and before providing direct care services to licensee's residents. The licensee's Dementia Training policy dated August 1, 2021, indicated licensee's staff will complete dementia training at the time of hire and thereafter annually. The policy also indicated the training will meet the above stated requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01540		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must	01620		

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01620	Continued From page 24 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 a registered nurse (RN) conducted a reassessment, not to exceed 14 calendar days from the initiation of services, for three of three residents (R1, R2, R3) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all	01620		

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01620	Continued From page 25 of the residents). The findings include: R1 R1 was admitted to the licensee on April 27, 2022. R1's diagnoses included type II diabetes mellitus and hypertension. R1's Service Plan dated April 7, 2022, indicated R1 received services including medication management, housekeeping, dressing, laundry, bathing assistance, blood glucose monitoring, toileting, ambulation, and TED hose (compression stockings) assist. R1's initial comprehensive assessment was completed on April 27, 2022. The 14-day monitoring and reassessment was completed on May 28, 2022, which was more than the required 14 calendar days after initiation of services. R2 R2 was admitted to the licensee on June 6, 2022. R1's diagnoses included vascular dementia with behavioral disturbance, Alzheimer's disease, type II diabetes mellitus and hypertension. R2's Services Plan dated June 6, 2022, indicated R2 received services including medication management, housekeeping, dressing, laundry, bathing assistance, blood glucose monitoring, toileting, ambulation, incontinent care, transfer assist, grooming, and behavior management. R2's initial comprehensive assessment was completed on June 7, 2022. The 14-day monitoring and reassessment was completed on July 11, 2022, which was more than the required 14 calendar days after initiation of services.	01620		

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01620	Continued From page 26 R3 R3 was admitted to the licensee on April 25, 2022. R3's diagnoses included chronic obstructive pulmonary disease, chronic pain, muscle weakness, and dementia. R3's Service Plan dated September 10, 2022, indicated R3 received services including medication management, housekeeping, dressing, laundry, bathing assistance, activity reminders, weight monitoring, meal assist, and TED hose assist. R3's initial comprehensive assessment was completed on April 26, 2022. The 14-day monitoring and reassessment was completed on May 28, 2022, which was more than the required 14 calendar days after initiation of services. On August 2, 2022, at approximately 2:05 p.m., house manager (HM)-D acknowledged the 14-day resident reassessments were completed more than the required 14-days, and stated there could be more resident records with the same issue. The licensee's Assessments, Reviews, and Monitoring policy dated August 1, 2021, indicated the licensee's RN will complete assessments within required time frame, including more than 14 days from initial assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		

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01750	Continued From page 27	01750		
01750 SS=I	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure that prior to delegating medication administration, the registered nurse (RN) trained the unlicensed personnel (ULP) in the proper methods to perform the task or procedure for each resident and the ULPs were able to demonstrate the ability to competently follow the procedure to perform the tasks for three of three employees (ULP-B, ULP-E and ULP-G). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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:	01750		

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01750	Continued From page 28 ULP-B ULP-B started employment with licensee on April 18, 2022. On August 2, 2022, at approximately 7:30 a.m., and 8:18 a.m., ULP-B administered medications to R6 in her room. ULP-B's employee record lacked evidence ULP-B had been instructed by the RN in the proper methods to administer the medications, and ULP-B had demonstrated the ability to competently follow the procedures. ULP-E ULP-E started employment with licensee April 18, 2022. On August 2, 2022, at approximately 8:50 a.m., ULP-E administered medications to R5 in the dining area. ULP-E's employee record lacked evidence ULP-E had been instructed by the RN in the proper methods to administer the medications, and ULP-E had demonstrated the ability to competently follow the procedures. On August 3, 2022, at approximately 9:30 a.m., ULP-E stated ULP-G is the go-to person for any medication issues before contacting licensed practical nurse (LPN)-H or RN-A. ULP-G ULP-G started employment with licensee March 17, 2021, under the comprehensive license and began providing services under the assisted living license on August 1, 2021.	01750		

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01750	Continued From page 29 ULP-G's job description dated June 23, 2021, indicated ULP-G reports directly to director of health services, RN and/or executive director. The job description also indicated ULP-G's responsibilities included medication administration/assistance as delegated by RN, supervise staff on duty in providing quality care and meeting the needs of residents and assist in training of all resident care employees in accordance to resident policies, training programs and state and federal regulations. ULP-G's untitled and undated document in his employee file indicated ULP-G was the lead medication aide. The document also indicated ULP-G was the medication manager. On August 1, 2022, at approximately 10:20 a.m., house manager (HM)-D introduced ULP-G as the medication lead, and further stated other ULPs contact ULP-G with medication issues if LPN-H is not available. On August 3, 2022, at approximately 11:20 a.m., RN-A stated LPN-H and ULP-G train in new ULPs and RN-A signs them off for their competencies. RN-A further stated LPN-H train ULPs, and ULP-G shadows ULPs on floor, and RN-A signs off their competencies. On August 3, 2022, at approximately 12:10 p.m., HM-D acknowledged ULP-G was lead medication aide and stated RN-A was responsible for competency training. In addition, HM-D stated ULP-E, and ULP-G had not completed medication competency training skills with RN-A. HM-D also stated ULP-E and ULP-G were current with Minnesota Nursing Assistant Registry. The licensee's Competency Training Evaluations	01750		

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01750	Continued From page 30 policy dated August 1, 2021, indicated the RN will determine what nursing services may be delegated to properly trained and competency tested unlicensed personnel. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate Immediacy was removed August 12, 2022, after review and acceptance of a plan of correction by evaulation supervisor, however, non-compliance remains at a scope and level three, widespread (I). TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01890 SS=D	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 ensure medications were maintained bearing the original prescription label with legible information including the expiration date for time sensitive medications. In addition, the licensee failed to dispose of expired medication for one of two residents (R7) with records reviewed.	01890		

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01890	Continued From page 31 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 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 August 2, 2022, at approximately 8:30 a.m., unlicensed personnel (ULP)-B administered medications to R7. On August 2, 2022, at approximately 9:00 a.m., the surveyor observed the contents of R7's medication storage area and noted the following: Unlabeled/Time sensitive medications: - timolol maleate solution 0.5%, one drop both eyes two times daily - latanoprost 0.005% ophthalmic solution 2.5 milliliter (ml) one drop right eye - Lantus Solostar pen 100 units/ml - Systane lubricate eye drops one to two drops as needed - dorzolamide HCL 20 milligram (mg)/ml ophthalmic solution 1% - Preservision eye vitamin and mineral supplement Expired medications: - carbidopa 25-100 mg take one tablet every day as needed expired on January 7, 2022 - pain relief ES 500 mg tablet take two tablets as needed expired on June 24, 2022 - Lax plus stool soft tablet 50 mg- 8.6 mg tablet two tablets once daily expired on June 9, 2022 - acetaminophen 500 mg capsules take one	01890		

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01890	Continued From page 32 capsule three times daily as needed expired on April 2022 - Tylenol extra strength 500 mg tablets take two tablets once daily as needed expired on May 11, 2022 On August 2, 2022, at approximately 10:05 a.m., house manager (HM)-D acknowledged the findings and stated the licensee will have the nurse to audit the medication storage areas. The licensee's Medications- Prescribed, Not Prescribed & OTC policy dated August 1, 2022, indicated the licensee will maintain over the counter drugs and supplements in original labeled containers. The licensee's undated Storage of Medications policy, indicated drugs must be kept in original container with all needed information including expiration date for time dated drugs. 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 management record for each resident which must	01940		

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01940	Continued From page 33 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 interview and record review, the licensee failed to develop a treatment management plan to include all required content for one of three residents (R1) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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 34 The findings include: R1 was admitted on April 27, 2022, with a diagnosis of diabetes mellitus type II. R1's Vital Sign-Blood Glucose record dated July 2022, indicated R1 had blood glucose checks three time a day. R1's individual treatment management plan lacked the following: - a statement of the type of services that will be provided; - documentation of specific resident instructions relating to the treatments or therapy administration; - identification of treatment or therapy tasks that will be delegated to unlicensed personnel; - 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. On August 3, 2022, at approximately 10:10 a.m., house manager (HM)-D acknowledged R1's record lacked the above required content. The licensee's Treatment & Therapy Management Plan policy dated August 1, 2022, indicated all the missing content will be included in the resident records. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		

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02040	Continued From page 35	02040		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to conduct a hazard vulnerability or safety risk assessment on or around the facility property. 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 the potential to affect a large portion or all residents). The findings include: During an interview on August 2, 2022, at 2:07 p.m., House Manger (HM)-D was unable to provide a hazard vulnerability assessment plan for this facility.	02040		

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02040	Continued From page 36 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
02240 SS=D	144G.90 Subdivision 1 Assisted living bill of rights; notification (a) An assisted living facility must provide the resident a written notice of the rights under section 144G.91 before the initiation of services to that resident. The facility shall make all reasonable efforts to provide notice of the rights to the resident in a language the resident can understand. (b) In addition to the text of the assisted living bill of rights in section 144G.91, the notice shall also contain the following statement describing how to file a complaint or report suspected abuse: "If you want to report suspected abuse, neglect, or financial exploitation, you may contact the Minnesota Adult Abuse Reporting Center (MAARC). If you have a complaint about the facility or person providing your services, you may contact the Office of Health Facility Complaints, Minnesota Department of Health. You may also contact the Office of Ombudsman for Long-Term Care or the Office of Ombudsman for Mental Health and Developmental Disabilities." (c) The statement must include contact information for the Minnesota Adult Abuse Reporting Center and the telephone number, website address, e-mail address, mailing address, and street address of the Office of Health Facility Complaints at the Minnesota Department of Health, the Office of Ombudsman for Long-Term Care, and the Office of Ombudsman for Mental Health and Developmental Disabilities. The statement must	02240		

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02240	Continued From page 37 include the facility's name, address, e-mail, telephone number, and name or title of the person at the facility to whom problems or complaints may be directed. It must also include a statement that the facility will not retaliate because of a complaint. (d) A facility must obtain written acknowledgment from the resident of the resident's receipt of the assisted living bill of rights or shall document why an acknowledgment cannot be obtained. Acknowledgment of receipt shall be retained in the resident's record. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the current Minnesota Bill of Rights for Assisted Living Residents was provided and a written acknowledgement was received. In addition, the licensee failed to provide the process for filing a complaint for one of three residents (R1) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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 and started receiving assisted living services on April 27, 2022. R1's record lacked evidence the current Minnesota Bill of Rights for Assisted Living Residents and the process for filing a complaint	02240		

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02240	Continued From page 38 were provided and a written acknowledgement received. On August 3, 2022, at approximately 10:10 a.m., house manager (HM)-D acknowledged R1's record lacked the current Minnesota Bill of Rights for Assisted Living Residents and the process for filing a complaint. HM-D also stated the licensee will have R1 sign the documents. The licensee's Bill of Rights policy dated August 1, 2022, indicated the licensee will provide each resident with the assisted living bill of rights. The policy lacked verbiage for process of filing complaint. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02240		
02310 SS=D	144G.91 Subd. 4 Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide care and services according to acceptable health care standards, medical or nursing standards with bed rails, for one of one resident (R1) with records reviewed. This practice resulted in a level two violation (a	02310		

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02310	Continued From page 39	02310		

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 and started receiving assisted living services on April 27, 2022. R1 had a diagnosis of diabetes mellitus.

R1's vulnerability assessment dated April 27, 2022, indicated R1 had vulnerabilities to include risk to be abused by other vulnerable adults, risk for falls and bed safety.

R1's Bed Safety Assessment dated May 28, 2022, indicated R1 had a partial side rail cane bars on bed to promote increased independence with mobility. In addition, the assessment included the bed rail measurements as follows; zone 1 less than 4 3/4 inches, zone 2 not available, zone 3 less than 4 3/4 inches.

On August 2, 2022, at approximately 11:20 a.m., the surveyor observed R1's bed to have bilateral side rails. R1 stated the bed rails help her transfer to and from bed and when turning in bed.

R1's record lacked a documented risks verses benefits discussion with the resident or the resident's representative before installing and using bed rail.

On August 3, 2022, at approximately 10:45 a.m., house manager (HM)-D acknowledged R1 had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36849	A. BUILDING: _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSONAL CARE MANAGEMENT LLC	525 CUTTER STREET ANOKA, MN 55303

(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
02310	Continued From page 40 not been educated on risks verses benefits before using bed rails. The licensee's Assessments, Reviews & Monitoring policy dated August 1, 2022, indicated the licensee will conduct nursing assessment of the physical and cognitive needs, but lacked the verbiage to include bed rails. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	02310		

Minnesota Department of Health
Food, Pools, and Lodging Services
625 Robert Street North
St. Paul
6512014500

Type: Full
Date: *08/02/22*
Time: 10:30:46
Report: 1029221242

Food and Beverage Establishment Inspection Report

Location:
Personal Care Management Llc
525 Cutter Street
Anoka, MN55303
Anoka County, 02

Establishment Info:
ID #: 0037457
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7633359590
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.

GROUND BEEF IN 3-DOOR COOLER MEASURED 44°F AND HAD BEEN IN COOLER FOR GREATER THAN 6 HOURS. BUTTER ON COUNTER FROM BREAKFAST (W/OUT TPHC & NOT UNDER REFRIGERATION) MEASURED 64°F. BOTH ITEMS DISCARDED.

Comply By: 08/02/22

3-800 Highly Susceptible Populations

3-801.11C ***** Priority 1 *****

MN Rule 4626.0447C Discontinue serving raw or partially cooked animal foods or sprouts to a highly susceptible population.

UNPASTEURIZED EGGS SERVED OVER EASY AND SUNNY SIDE UP TO RESIDENTS. INSTRUCTED TO DISCONTINUE PRACTICE WITH RAW EGGS, AND TO COOK RAW EGGS TO AT LEAST 145°F FOR 15 SECONDS.

Comply By: 08/02/22

3-500C Microbial Control: date marking

3-501.17A ***** Priority 2 *****

MN Rule 4626.0400A Mark the refrigerated, ready-to-eat, TCS food prepared and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded.

SLICED TURKEY AND SLICED HAM OPENED W/OUT DATE MARKINGS. NO ONE COULD IDENTIFY WHEN THE MEAT HAD BEEN OPENED. DISCARDED.

Comply By: 08/02/22

3-500E Microbial Control: time as a control

3-501.19A ***** Priority 2 *****

MN Rule 4626.0408A Develop written procedures prior to using time as a public health control for time/temperature control for safety food and maintain the procedures in the food establishment.

BUTTER ON COUNTER WITHOUT TIME AS A PUBLIC HEALTH CONTROL. DISCARDED.

Comply By: 08/02/22

2-100 Supervision

2-102.12DMN

MN Rule 4626.0033D Post the certified food protection manager certificate.

CFPM CERTIFICATE NOT POSTED. INSTRUCTED TO POST.

Comply By: 08/02/22

Surface and Equipment Sanitizers

HOT WATER: = at 160 Degrees Fahrenheit
Location: DISHMACHINE
Violation Issued: No

LACTIC ACID: = 704 PPM at Degrees Fahrenheit
Location: DISPENSER
Violation Issued: No

Food and Equipment Temperatures

Process/Item: GROUND BEEF
Temperature: 44 Degrees Fahrenheit - Location: 3-DOOR UPRIGHT COOLER
Violation Issued: Yes

Process/Item: APPLE SAUCE
Temperature: 40 Degrees Fahrenheit - Location: 3-DOOR UPRIGHT COOLER
Violation Issued: No

Process/Item: BUTTER
Temperature: 41 Degrees Fahrenheit - Location: 3-DOOR UPRIGHT COOLER
Violation Issued: No

Process/Item: INTERNAL THERMOMETER
Temperature: 41 Degrees Fahrenheit - Location: 3-DOOR UPRIGHT COOLER
Violation Issued: No

Process/Item: SHELL EGGS
Temperature: 37 Degrees Fahrenheit - Location: 1-DOOR UPRIGHT COOLER
Violation Issued: No

Process/Item: SLICED CHEESE
Temperature: 38 Degrees Fahrenheit - Location: 2-DOOR UNDER GRILL COOLER
Violation Issued: No

Type: Full
Date: *08/02/22*
Time: 10:30:46
Report: 1029221242
Personal Care Management Llc

Food and Beverage Establishment Inspection Report

Process/Item: SLICED TURKEY
Temperature: 37 Degrees Fahrenheit - Location: 2-DOOR UNDER GRILL COOLER
Violation Issued: No

Process/Item: BUTTER
Temperature: 64 Degrees Fahrenheit - Location: AMBIENT W/OUT TPHC
Violation Issued: Yes

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

THIS INSPECTION WAS CONDUCTED IN CONJUNCTION WITH AN HRD SURVEY AT PERSONAL CARE MANAGEMENT, LLC LOCATED AT 525 CUTTER STREET, ANOKA, MN 55303.

THE INSPECTION WAS CONDUCTED IN THE PRESENCE OF CHRISTINA AMDAHL, CULINARY SERVICE DIRECTOR & CFPM, AS WELL AS OTHER STAFF. ALL ISSUES WERE DISCUSSED WITH CHRISTINA AND/OR OTHER STAFF DURING AND AFTER THE INSPECTION. EMPLOYEE ILLNESS REPORTING AND EXCLUSION PROCEDURES WERE ALSO DISCUSSED. ALL ISSUES WERE COMMUNICATED TO LEAD HRD SURVEYOR AND NURSE EVALUATOR II, BENARD NYANGENA, BSN, RN, FOLLOWING THE INSPECTION.

KITCHEN IS COMMERCIAL GRADE AND IN EXCELLENT CONDITION. FLOORS ARE CERAMIC TILE, WALLS ARE FRP AND STAINLESS STEEL, AND CEILINGS ARE PLASTIC COMPOSITE MATERIAL. ALL SURFACES ARE SMOOTH, DURABLE, EASILY CLEANABLE, AND NON-ABSORBENT.

THE IMPORTANCE OF DATE MARKING, COLD HOLDING, AND TIME AS A PUBLIC HEALTH CONTROL (TPHC) WAS EMPHASIZED. SOFT-COOKED UNPASTEURIZED EGGS WERE OFFERED TO RESIDENTS. I INSTRUCTED THE OPERATORS TO DISCONTINUE SERVING SOFT-COOKED EGGS THAT ARE NOT PASTEURIZED. TPHC INFORMATION WAS EMAILED TO CHRISTINA FOLLOWING THE INSPECTION.

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 1029221242 of 08/02/22.

Certified Food Protection Manager CHRISTINA MARIE AMDAHL

Certification Number: FM95951 Expires: 10/16/24

Inspection report reviewed with person in charge and emailed.

Signed: _____

CHRISTINA AMDAHL
CULINARY SERVICE DIRECTOR

Signed: _____

Trevor McCliment
Public Health Sanitarian
Metro District Office
651-201-3957
trevor.mccliment@state.mn.us

Report #: 1029221242

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Food, Pools, and Lodging Services
625 Robert Street North
St. Paul

No. of RF/PHI Categories Out	5	Date	08/02/22
No. of Repeat RF/PHI Categories Out	0	Time In	10:30:46
Legal Authority MN Rules Chapter 4626		Time Out	

Personal Care Management Llc	Address: 525 Cutter Street	City/State: Anoka, MN	Zip Code: 55303	Telephone: 7633359590
License/Permit #: 0037457	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
Surpervision						
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:** 08/05/22

Inspector (Signature)