



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
December 8, 2023

Licensee
Bright Path Homes, LLC
6600 Central Avenue Northeast
Fridley, MN 55432

RE: Project Number(s) SL37322015

Dear Licensee:

On November 2, 2023, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on August 18, 2023. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the August 18, 2023 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on August 18, 2023, found not corrected at the time of the November 2, 2023, follow-up survey and/or subject to penalty assessment are as follows:

0480-Minimum Requirements-144g.41 Subd 1 (13) (i) (b) = \$500.00

The details of the violations noted at the time of this follow-up survey completed on November 2, 2023 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal. It is not necessary to develop a plan of correction.

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.

IMPOSITION OF FINES:

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.

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request

for reconsideration must be in writing and received by the MDH within 15 calendar days of the correction order receipt date.

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

To submit a reconsideration request, please visit:

<https://www.web.health.state.mn.us/form/HRD-Appeals-Form>

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 MDH within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. To submit a hearing request, please visit

<https://www.web.health.state.mn.us/form/HRD-Appeals-Form>.

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. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

We urge you to review these orders carefully. If you have questions, please contact Jonathan Hill at 651-201-3993.

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

Sincerely,

A handwritten signature in black ink, appearing to read "Jonathan Hill", is written over a faint, light-colored circular stamp or watermark.

Jonathan Hill, Supervisor
State Evaluation Team
Email: jonathan.hill@state.mn.is
Telephone: 651-201-3993 Fax: 1-866-890-9290

PMB

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37322	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 11/02/2023
NAME OF PROVIDER OR SUPPLIER BRIGHT PATH HOMES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 6600 CENTRAL AVENUE NE FRIDLEY, MN 55432			
(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 In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been 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: SL37322015-1 On October 30, 2023, through November 2, 2023, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on August 18, 2023. At the time of the survey, there were three residents receiving services under the Assisted Living license. As a result of the revisit, the following orders were reissued.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.		
{0 250} SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a	{0 250}			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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{0 250}	Continued From page 1 result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under	{0 250}			

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{0 250}	Continued From page 2 section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: No further action required.	{0 250}			
{0 460} SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's	{0 460}			

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{0 460}	Continued From page 3 unit; This MN Requirement is not met as evidenced by: No further action required.	{0 460}			
{0 470} SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by:	{0 470}			

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{0 470}	Continued From page 4 No further action required.	{0 470}			
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (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 September 15, 2023, 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}			

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{0 485}	Continued From page 5	{0 485}			
{0 485} SS=C	144G.41 Subdivision 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; and (C) the facility cannot require a resident to include and pay for meals in their contract; (ii) weekly housekeeping; (iii) weekly laundry service; This MN Requirement is not met as evidenced by: No further action required.	{0 485}			
{0 495} SS=F	144G.41 Subd. 1 (14) Minimum Requirements (14) provide staff access to an on-call registered nurse 24 hours per day, seven days per week This MN Requirement is not met as evidenced by: No further action required.	{0 495}			
{0 650} SS=E	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of	{0 650}			

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{0 650}	Continued From page 6 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. This MN Requirement is not met as evidenced by: No further action required.	{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	{0 660}			

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{0 660}	Continued From page 7 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: No further action required.	{0 660}			
{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 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.	{0 680}			

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{0 680}	Continued From page 8 (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: No further action required.	{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 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	{0 900}			

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{0 900}	Continued From page 9 existing contract must be executed and signed. This MN Requirement is not met as evidenced by: No further action required.	{0 900}			
{0 970} SS=C	144G.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 required by law. This MN Requirement is not met as evidenced by: No further action required.	{0 970}			
{01060} SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office	{01060}			

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{01060}	Continued From page 10 of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: No further action required.	{01060}			
{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	{01500}			

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{01500}	Continued From page 11 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), 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	{01500}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37322	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 11/02/2023
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{01500}	Continued From page 12 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: No further action required.	{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	{01530}			

Minnesota Department of Health

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{01530}	Continued From page 13 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: No further action required.	{01530}			
{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.	{01620}			

Minnesota Department of Health

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{01620}	Continued From page 14 This MN Requirement is not met as evidenced by: No further action required.	{01620}			
{01640} SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: No further action required.	{01640}			
{01650} SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided,	{01650}			

Minnesota Department of Health

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{01650}	Continued From page 15 the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: No further action required.	{01650}			
{01730} SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The	{01730}			

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{01730}	Continued From page 16 facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: No further action required.	{01730}			

Minnesota Department of Health

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{01760} SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: No further action required.	{01760}			
{01910} SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name,	{01910}			

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{01910}	Continued From page 18 strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: No further action required.	{01910}			

Type: Follow-Up
Date: 09/15/23
Time: 15:00:00
Report: 1025231215

Food and Beverage Establishment Inspection Report

Page 1

Location:

Bright Path Homes Llc
6600 Central Avenue Ne
Fridley, MN55432
Anoka County, 02

Establishment Info:

ID #: 0037947
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 9526586176
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 previously issued on 08/14/23 have NOT been corrected.

3-200B Food Characteristics:Receiving: temperature, condition

3-202.15 **** Priority 2 ****

MN Rule 4626.0190 Food packages must be in good condition and must protect the food from adulteration and potential contaminants.

Provide storage containers for open food product (e.g. opened sugar packages) to protect from pests and contamination.

Issued on: 08/14/23

Comply By: 08/18/23

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.

Mark the date of opened TCS foods in the refrigerator.

Issued on: 08/14/23

Comply By: 08/14/23

4-300 Equipment Numbers and Capacities

4-301.12A **** Priority 2 ****

MN Rule 4626.0680A Provide a 3 compartment sink with integrally attached drainboards at each end for manually washing, rinsing and sanitizing equipment and utensils.

Provide a 3 compartment sink for the establishment, or a dishwasher rated for the sanitizing of utensils in a residential setting.

Provide 3 basins for W/R/S in the meantime.

Issued on: 08/14/23

Comply By: 08/14/23

Type: Follow-Up
Date: 09/15/23
Time: 15:00:00
Report: 1025231215
Bright Path Homes Llc

Food and Beverage Establishment Inspection Report

Page 2

4-300 Equipment Numbers and Capacities

4-302.12B **** Priority 2 ****

MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.

Provide a food thermometer as indicated above for the kitchens where cooking and food preparation is taking place.

Issued on: 08/14/23

Comply By: 08/18/23

4-300 Equipment Numbers and Capacities

4-302.14 **** Priority 2 ****

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

Provide a test kit for the sanitizer to be used for sanitizing equipment and utensils.

Issued on: 08/14/23

Comply By: 08/18/23

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

Food course certificate posted on wall - obtain and post a CFPM certificate.

Issued on: 08/14/23

Comply By: 09/14/23

4-200 Equipment Design and Construction

4-201.11

MN Rule 4626.0505 Replace equipment or utensils that are not durable or do not retain their characteristic qualities under normal use conditions.

Discontinue use and replace any non-stick pans and utensils which have become scratched or damaged. Do not replace items with non-stick if metal or scouring items are used, or users aren't familiar with the maintenance of non-stick surfaces.

Issued on: 08/14/23

Comply By: 08/18/23

4-200 Equipment Design and Construction

4-202.17

MN Rule 4626.0545 Remove kick plates that are not designed to be easily removed for cleaning and inspection.

Provide cabinetry in the kitchens without hollow enclosed bases. Expose underneath the cabinetry to clean and treat for pests, see additional comments.

Issued on: 08/14/23

Comply By: 08/14/23

4-500 Equipment Maintenance and Operation

4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

Replace/repair the light in the #3 refrigerator, the light is not currently working.

Issued on: 08/14/23

Comply By: 08/18/23

Type: Follow-Up
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Food and Beverage Establishment Inspection Report

Page 3

4-600 Cleaning Equipment and Utensils

4-601.11C

MN Rule 4626.0840C Clean non-food contact surfaces of equipment and maintain free of accumulations of dust, dirt, food residue, and other debris.

Clean walls, cabinetry fronts, cabinet interiors, and behind and beneath ranges and refrigerator.

Issued on: 08/14/23

Comply By: 08/18/23

5-200A Plumbing: approved materials/design

5-201.11B

MN Rule 4626.1040B Maintain the plumbing system in good repair.

Sink plumbing in basement #2 kitchen is leaking; repair the plumbing.

Accordion plastic connection used in kitchen #3, ensure plumbing is maintained per MN 4717

Issued on: 08/14/23

Comply By: 08/16/23

6-100 Physical Facility Construction Materials

6-101.11A1

MN Rule 4626.1325A1 Provide smooth, durable, and easily cleanable floor, wall and ceiling surfaces.

Wood cabinetry worn, no longer easily cleanable, chipped/broken in corners, missing knobs, sagging hinges.

Repair cabinetry in kitchen and provide a smooth, durable, and easily cleanable finish for the cabinetry. Provide smooth and cleanable knobs.

Issued on: 08/14/23

Comply By: 09/14/23

6-300 Physical Facility Numbers and Capacities

6-303.11C

MN Rule 4626.1470C Provide at least 50 foot candles (540 LUX) of light intensity for areas where food employees are working with utensils and equipment where safety is a factor.

Light in the downstairs kitchen did not turn on during inspection. Repair the downstairs kitchen light.

Issued on: 08/14/23

Comply By: 08/18/23

6-300 Physical Facility Numbers and Capacities

6-305.11B

MN Rule 4626.1480B Provide lockers or other suitable facilities for the orderly storage of employees' clothing and other possessions.

Provide a container or other means of separating staff items from resident items in the refrigerator and freezers.

Issued on: 08/14/23

Comply By: 08/18/23

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.111ABD

MN Rule 4626.1565ABD Provide control of insects, rodents, and other pests by routinely inspecting incoming food and supply shipments; routinely inspecting the premises for evidence of pests; and eliminating harborage conditions.

Observation strip in basement kitchen contained German cockroaches. Provide control for pests and clean/inspect areas to address harborage conditions.

Type: Follow-Up
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Bright Path Homes Llc

Food and Beverage Establishment Inspection Report

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Issued on: 08/14/23

Comply By: 08/14/23

No NEW orders were issued during this inspection.

Total Orders	In This Report	Priority 1	Priority 2	Priority 3
		0	5	10

No confirmation of violation corrections or other follow-up received from licensee, as requested during inspection.

Report 1025231186

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 1025231215 of 09/15/23.

Certified Food Protection Manager: _____

Certification Number: _____ Expires: ____ / ____ / ____

Signed: _____

Establishment Representative

Signed: _____

Casey Kipping
Public Health Sanitarian III
Freeman Building St Paul
651-201-4513
casey.kipping@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

September 18, 2023

Licensee

Bright Path Homes, LLC

6600 Central Avenue Northeast

Fridley, MN 55432

RE: Project Number(s) SL37322015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 18, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

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 may be 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.31, Subd. 4 (a)(5), the MDH may impose fine amounts of either \$1,000 or \$5,000 to licensees who are found to be responsible for maltreatment.

The MDH may impose 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 MDH

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 (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 survey:

St - 0 - 0820 - 144g.45 Subd. 2 (g) - Fire Protection And Physical Environment = \$3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$3,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

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

Please address your cover letter for reconsideration requests to:

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

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 MDH within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. 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 the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,

A handwritten signature in black ink, appearing to read "Casey Devries". The signature is fluid and cursive, with the first name "Casey" being more prominent and the last name "Devries" following in a similar style.

Casey Devries, Supervisor
State Evaluation Team
Email: casey.devries@state.mn.us
Telephone: 651-201-5917 Fax: 651-281-9796

PMB

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37322	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/18/2023
NAME OF PROVIDER OR SUPPLIER BRIGHT PATH HOMES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 6600 CENTRAL AVENUE NE FRIDLEY, MN 55432		
(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: SL37322015-0 On August 14, 2023, through August 18, 2023, 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 three residents; all of whom received services under the Assisted Living license. An immediate correction order was identified on August 15, 2023, issued for SL37322015-0, tag identification 1290. On August 16, 2023, the immediacy of correction order 1290 was removed, however non-compliance remained, and the scope and severity remained unchanged.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a	0 250		

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 250	Continued From page 1 provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter;	0 250			

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0 250	Continued From page 2 (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required with records reviewed. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on August 14,	0 250			

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0 250	Continued From page 3 2023, at 10:19 a.m., licensed assisted living director (LALD)-D stated the licensee's employees in charge of the facility were familiar with the assisted living regulations and the licensee provided medication and treatment management services. The licensee's Application for Assisted Living License, section titled Official Verification of Owner or Authorized Agent, (page four and five of the application), identified, I certify I have read and understand the following: [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17. - I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G. - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659. - Reporting of Maltreatment of Vulnerable Adults. - Electronic Monitoring in Certain Facilities. - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will	0 250			

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0 250	Continued From page 4 use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license. - I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract.	0 250			

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0 250	Continued From page 5 - I have examined this application and all attachments and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required. - I attest to have all required policies and procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page six was electronically signed by LALD-D on February 17, 2023. The licensee had an assisted living license issued on May 1, 2023, with an expiration date of April 30, 2024. The licensee failed to ensure the following policies and procedures were developed and/or implemented: - requirements in section 626.557, reporting of maltreatment of vulnerable adults; - conducting and handling background studies on employees; - orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; - conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; - conducting appropriate screenings, or	0 250			

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0 250	Continued From page 6 documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; - medication management; and - supervision of unlicensed personnel performing delegated tasks. On August 17, 2023, at 2:00 p.m., LALD-D confirmed the licensee provided assisted living services but failed to implement corresponding policies and procedures, as required. As a result of this survey, the following orders were issued 0460, 0470, 0480, 0485, 0495, 0650, 0660, 0680, 0780, 0790, 0800, 0810, 0820, 0900, 0970, 1060, 1290, 1500, 1530, 1620, 1640, 1650, 1730, 1760, 1910, indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250			
0 460 SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a	0 460			

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0 460	Continued From page 7 roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide a means for residents to request assistance for health and safety needs 24 hours a day, seven days a week. 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 14, 2023, at 10:30 a.m., during the entrance conference, clinical nurse supervisor (CNS)-C and licensed assisted living director (LALD)-D stated the licensee staffed two unlicensed personnel (ULP) for all shifts with one ULP stationed in the upper level and one ULP stationed in the lower level. CNS-C and LALD-D stated the facility was small and residents would call out, ambulate to staff, or use their personal phones to call staff members when assistance	0 460			

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0 460	Continued From page 8 was needed. In addition, LALD-D stated if a person was bedridden, they would purchase a pendant for the resident. On August 14, 2023, at 11:10 a.m., during a facility tour, the surveyor observed the facility as a duplex with three active residents, one residing on each side of the duplex and one in the basement separated by closed doorways. In addition, the surveyor observed no bells, call lights, or pendants. On August 14, 2023, at 12:36 p.m., R2 stated they called out when they needed assistance from staff. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 460			
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week,	0 470			

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0 470	Continued From page 9 who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a written staffing plan that included an evaluation completed by a registered nurse (RN) at least twice a year. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living license. The facility was licensed for a bed capacity of seven residents and had a current census of three residents. On August 14, 2023, at 10:55 a.m., during	0 470			

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0 470	Continued From page 10 entrance conference, the surveyor inquired if the licensee developed and implemented a staffing plan and evaluated the plan twice per year. Clinical nurse supervisor (CNS)-C stated, "We have done that, but I don't know there is an actual paper. Usually if there is a high need client [resident] then we have to have two [staff] on shift at all times." On August 14, 2023, at 1:22 p.m., the surveyor received an undated staffing plan from licensed assisted living director (LALD)-D titled Employment / Work Schedule Plan and Delegation of Authorities. The staffing plan lacked an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470			
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (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 residents.	0 480			

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0 480	Continued From page 11 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: Please refer to the additional documentation included in the Food and Beverage Establishment Inspection Reports, dated August 14, 2023. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480			
0 485 SS=C	144G.41 Subdivision 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; and (C) the facility cannot require a resident to include and pay for meals in their contract;	0 485			

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0 485	Continued From page 12 (ii) weekly housekeeping; (iii) weekly laundry service; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the assisted living contract did not require any resident to include and pay for meals as a part of their assisted living package fee. In addition, 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 residents of the facility. 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: CONTRACT The licensee's Assisted Living Contract page 3 included: "Subject to the Resident's needs, Bright Path Homes will provide the following services which are included in the basic monthly fee: 1. Food Service: Three (3) meals/day are served in the dining area as planned and prepared by Bright Path Homes staff at the following times: 8:00 AM Breakfast 12:00 PM Lunch 5:00 PM Dinner Two snacks in between."	0 485			

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0 485	Continued From page 13 On August 15, 2023, at 10:20 a.m. licensed assisted living director (LALD)-D stated the above content was in all resident contracts. In addition, LALD-D stated they were unaware of the requirement and the residents they serve have financial assistance that pay for meals. MENU On August 14, 2023, at 11:10 a.m., during facility tour, the surveyor did not observe a menu plan prepared at least one week in advance. On August 14, 2023, at 1:51 p.m., clinical nurse supervisor (CNS)-C stated they did not have a set menu because it depended on what the resident wanted. CNS-C stated the licensee had each resident create a grocery list the staff would shop for, and the staff cooked what the resident requested off of the grocery lists. CNS-C stated they do not provide resident with menus or post menu options. On August 15, 2023, at 11:42 a.m., the surveyor received an undated meal menu from LALD-D which contained seven days of meals that did not meet the nutritional requirements with a registered nurse (RN) name and number who no longer worked for the company. The licensee's Food Service policy dated August 1, 2021, indicated at least three nutritious meals were served daily seven days per week with snacks available and menus were prepared one week in advance and made available to all residents. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485			

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0 495 SS=F	144G.41 Subd. 1 (14) Minimum Requirements (14) provide staff access to an on-call registered nurse 24 hours per day, seven days per week This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure that a registered nurse (RN) was available on-call 24 hours a day, seven days per week. This had the potential to affect all three residents and staff 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 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 14, 2023, at approximately 10:22 a.m., during the entrance conference, clinical nurse supervisor (CNS)-C stated that they were the only registered nurse employed by licensee at the time of survey, however, a second nurse just recently separated from their employment with the licensee. CNS-C stated the licensee's company had a pharmacist who could be reached for medication concerns. In addition, CNS-C stated they held an overnight on call position at a hospital. The surveyor inquired what would occur if a ULP called during a night shift they worked at the hospital. CNS-C stated the ULP were instructed to leave a message or call 911 if it was an emergency and they would call the ULP back	0 495			

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0 495	Continued From page 15 as soon as possible. On August 15, 2023, at 6:58 a.m., ULP-E, an overnight employee, stated when they called the on-call nurse, they "normally" answer the phone. On August 15, 2023, at 7:02 a.m., ULP-F, an overnight employee, stated they have not had to contact an on-call nurse in the night. The licensee's undated Employment / Work Schedule Plan and / Delegation of Authorities document indicated CNS-C and RN-G were the current nurses "for all four houses." On August 16, 2023, via email correspondence, licensed assisted living director (LALD)-D stated RN-G was on "indefinite absence from work" in order to care for a child and RN-G would notify the licensee when they want to return to work. In addition, LALD-D stated they only have "one RN for now." No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 495			
0 650 SS=E	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;	0 650			

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0 650	Continued From page 16 (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 observation, interview, and record review, the licensee failed to ensure employee records contained the required content for two of three employees (unlicensed personnel (ULP)-A and 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 a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-A ULP-A was hired on November 1, 2020, to provide direct services to the residents.	0 650			

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0 650	Continued From page 17 On August 15, 2023, at 2:03p.m., the surveyor observed ULP-A administer oral medications to R2. ULP-A's employee record lacked performance evaluations. CNS-C CNS-C was hired on June 10, 2022, to provide supervision and oversight to unlicensed personnel and to provide direct services to residents. CNS-C's employee record lacked orientation trainings and a performance evaluation. On August 16, 2023, at 10:10 a.m., Licensed assisted living director (LALD)-D and CNS-C stated they completed orientation for CNS-C and performance evaluations for ULP-A and CNS-C however, they were unable to locate the documentation. The licensee's Staff Orientation and Education policy dated August 1, 2021, indicated the licensee would maintain proof of orientation and education in the personnel files. The licensee's Performance Evaluation policy dated August 1, 2021, indicated a formal performance evaluation would be conducted for all staff providing assisted living services at least annually. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650			

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0 660	Continued From page 18	0 660			
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. (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), to include an updated facility TB risk assessment. In addition, the licensee failed to complete a health history and symptom screening and provide TB training upon hire 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, 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	0 660			

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0 660	Continued From page 19 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The facility TB risk assessment was completed August 20, 2021, and indicated the facility was at a low risk for TB transmission and the licensee would conduct or update the TB risk assessment annually. The licensee lacked an updated TB risk assessment. CNS-C was hired on June 10, 2022, to provide supervision and oversight to unlicensed personnel and to provide direct services to residents. CNS-C's employee record included a chest x-ray dated November 2, 2021, completed after a positive two-step tuberculin skin test (TST). CNS-C's record lacked a completed health history and symptom screening and TB training. On August 16, 2023, at 10:10 a.m., licensed assisted living director (LALD)-D and CNS-C stated they provide TB training through EduCare (a training software) and CNS-C had not received the training. In addition, LALD-D and CNS-C stated they did not know symptom screening was required since CNS-C provided a chest x-ray. The CDC Tuberculosis Screening, Testing, and Treatment of U.S. Health Care Personnel dated May 17, 2019, indicated all health personnel should have a baseline screening and an individual risk assessment, which is necessary for interpreting any test result. The Facility Tuberculosis (TB) Risk Assessment Instructions and Worksheet for Health Care Settings Licensed by MDH dated June 2023	0 660			

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0 660	Continued From page 20 indicated facilities should perform a facility risk assessment on an annual basis. The licensee's Tuberculosis Screening / Prevention policy dated August 1, 2021, indicated for all direct care providers and anyone who visits the residents including volunteers they would baseline screening which included an assessment for TB history and current TB symptoms. In addition, all staff who provide care or visits residents including volunteers would receive education including the following: 1. All staff who provide care or visit residents (including volunteers) will receive education, including the following: - general training on TB; - the importance of evaluation of symptoms or signs of TB disease for early detection and treatment of TB disease; -the role of the caregiver in educating residents regarding the importance of reporting symptoms or signs of TB disease; and - the importance of reporting any adverse effects to treatment for LTBI or TB disease. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660			
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	0 680			

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0 680	Continued From page 21 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 residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to have a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all residents receiving services under the assisted living license. 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:	0 680			

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0 680	Continued From page 22 On August 14, 2023, at 11:10 a.m., during a facility tour, the surveyor observed a posting which included procedures for medical emergency, power outage, fire, threat to violence, tornado, suspicious person, hazardous material, emergency lock down, and phone numbers for staff members, gas company, phone service, and transportation. On August 14, 2023, at 1:29 p.m., the surveyor requested the licensee's EPP. Licensed assisted living director (LALD)-D stated there was an emergency plan (EP) posting on the wall and the licensee had purchased an EPP manual that they had not customized to the facility because "I got sidetracked." In addition, LALD-D stated they would send what they had for the EPP from the computer system. The licensee's emergency disaster preparedness plan lacked evidence of the following required content: - quarterly review of missing resident policy; - annual review of EPP; - communication plan containing all required elements; - hazard vulnerability assessment; - process for EP collaboration; - subsistence needs for staff and residents; - policies and procedures for medical documents; - policies and procedures for volunteers; - roles under a wavier declared by secretary; - names and contact information; - emergency officials contact information; - methods for sharing information; - sharing information on occupancy / needs; - long term care family notifications; - emergency prep training program which includes maintain documentation of all EP	0 680			

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0 680	Continued From page 23 training and EP training annually; and - emergency prep testing requirements. The licensee's Emergency Preparedness policy dated August 1, 2021, indicated the licensee would have an identified plan in place to assure the safety and well-being of resident and staff during periods of an emergency or disaster that disrupts services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing	0 780			

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0 780	Continued From page 24 smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the provisions of the Minnesota State Fire Code and failed to provide smoke alarms in the resident sleeping rooms and outside the immediate vicinity of these sleeping rooms. Smoke alarms throughout the facility were not interconnected so that actuation of one alarm will cause all alarms in the dwelling to actuate. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On a facility tour on August 15, 2023, at approximately 12:50 p.m. with clinical nurse supervisor (CNS)-C, observed that Sleeping room V on the main floor, and sleeping room 98 in the basement, did not have smoke alarms installed. It was also observed that there were no smoke alarms provided outside and in the immediate vicinity of any of the resident sleeping rooms. Smoke alarms throughout the facility were not interconnected so that actuation of one alarm will	0 780			

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0 780	Continued From page 25 cause all alarms in the dwelling to actuate. CNS-C verbally confirmed survey staff observations during the facility tour. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 780			
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide current tags and documentation of annual inspections of all the fire extinguishers. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when	0 790			

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0 790	Continued From page 26 problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On a facility tour on August 15, 2023, at approximately 12:45 p.m. with licensed assisted living director (LALD)-D, it was observed that the fire extinguishers throughout the facility, had an annual maintenance tag with a date of March 2022, indicating that annual inspections had not been performed as required. Maintenance records were requested to verify compliance but were not provided. Annual inspections of the fire extinguishers are required by NFPA standards and Minnesota State Fire Code to ensure that all systems are maintained and remain in working order. On August 15, 2023, at approximately 12:45 p.m., LALD-D verbally confirmed survey staff observations. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 790			
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of 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.	0 800			

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0 800	Continued From page 27 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility 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 the potential to affect a large portion or all residents). The findings include: On August 15, 2023, from approximately 12:05 p.m. to 1:30 p.m., survey staff toured the facility with clinical nurse supervisor (CNS)-C. During the facility tour, survey staff observed and verified the following maintenance issues: It was observed that the exhaust vent in resident sleeping room #102 was full of black dust. It was observed the floors and carpets throughout the facility were soiled and stained. It was observed the walls throughout the facility had stains on them. It was observed that basement resident bathroom towel holder was falling off the wall.	0 800			

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0 800	Continued From page 28 It was observed that the caulk was missing around the toilet and bathtub in the main floor and basement bathrooms. Light switch cover in main floor bathroom was missing. Power strips were used in resident sleeping room #102 to plug in refrigerators and space heaters. Burn marks were observed on the front deck handrail and floorboards due to burning cigarette butts and ashes. CNS-C verbally confirmed survey staff observations during the facility tour. No further information provided. 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 (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	0 810			

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0 810	Continued From page 29 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 a record review and interview, the licensee failed to develop a fire safety and evacuation plan with required elements, failed to provide required employee and resident training on fire safety and evacuation, and failed to conduct required evacuation drills. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include:	0 810			

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0 810	Continued From page 30 A record review and interview were conducted on August 15, 2023, at approximately 2:30 p.m. with licensed assisted living director (LALD)-D on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review of the available documentation indicated that the licensee did not have employee actions to be taken in the event of a fire or similar emergency. The facility plan indicated to use RACE acronym but was very vague and did not provide complete actions for employees to take in the event of a fire or similar emergency. Record review of the available documentation indicated that the licensee did not have fire protection procedures necessary for residents included in the fire safety and evacuation plan. Record review of the available documentation indicated that the fire safety and evacuation plan did not include 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. The facility plan did include some provisions for relocation of residents but did not specify how to move or evacuate residents or identify the unique and unusual needs of the residents. Record review of available documentation indicated that the licensee did not provide employee training on the fire safety and evacuation plan twice per year after the training it initial hire. Record review of the available documentation indicated that the licensee did not provide annual	0 810			

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0 810	Continued From page 31 training to residents who can assist in their own evacuation on the proper actions to take in the event of a fire to include movement, evacuation, or relocation as required by statute. Record review of the available documentation indicated that the licensee did not conduct evacuation drills twice per year per shift and every other month as required by statute. Provided documentation indicated that the only drills were not conducted every other month and failed to provide two drills on second shift and two drills on third shift. During interview, LALD-D verified that the fire safety and evacuation plan for the facility lacked these provisions. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810			
0 820 SS=I	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction.	0 820			

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0 820	Continued From page 32 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide properly sized egress windows and door locking arrangements that did not constitute a distinct hazard to life. This had the potential to directly affect all residents and staff. 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). EGRESS WINDOW The findings include: On August 15, 2023, between the hours of 12:05 p.m. and 1:30 p.m., survey staff toured the home with clinical nurse supervisor (CNS)-C. At approximately 1:15 p.m., survey staff measured the windows in occupied sleeping room V- (36Wx14H), and unoccupied sleeping room K- (19Wx 19H). It was explained to the CNS-C that the window in these bedroom's did not meet the minimum size egress window openings required for safe egress. At least one window in each resident sleeping room must meet the minimum window opening size of at least 20 inches in height and, a minimum height of 20 inches, with a total of at least 648 square inches (4.5 square feet) required for egress. CNS-C verbally confirmed survey staff observations during the facility tour.	0 820	This immediate correction order identified on August 15, 2023, has had the immediacy lifted as of August 15,2023. This was confirmed by the surveyor's on-site observation and approved by evaluation supervisor.		

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0 820	Continued From page 33 No further information provided. TIME PERIOD FOR CORRECTION: Immediate EXIT DOOR LOCKING On August 15, 2023, from approximately 12:10 p.m. to 1:30 p.m., survey staff toured the facility with clinical nurse supervisor (CNS)-C. During the facility tour, survey staff observed and verified front exit door on the 6600 side, and front exit door on the 6604 side, had locking hardware that requires more than one operation to release and open. Exit door latch hardware is required to release, unlock, and open for the purpose of exiting in one operation. CNS-C verbally confirmed survey staff observations during the facility tour. No further information provided. TIME PERIOD FOR CORRECTION: 7 days	0 820			
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:	0 900			

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0 900	Continued From page 34 (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a 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 interview and record review, the licensee failed to execute a written contract with the required content post implementation of 144G Statutes for one of two residents (R2). 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: R2 admitted to licensee on November 2, 2022,	0 900			

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0 900	Continued From page 35 and began receiving assisted living services. R2's unsigned service plan dated November 2, 2022, indicated R2 received 24/7 home health aide services per care plan which included assistance with dressing, grooming, showers, nail care, toileting as needed (PRN), wheelchair assistance, standby assistance for ambulation, assistance in the community, meals, medication administration, weekly blood pressure, behavior management, housekeeping, and laundry. R2's record included an unsigned Assisted Living Contract dated November 12, 2022, signed by the licensee. R2's record lacked an executed written contract that included a signature by the resident or resident's representative. On August 15, 2023, licensed assisted living director (LALD)-D stated R2 had multiple guardian changes since admission, and they had been unable to get the guardian to sign the contract. In addition, LALD-D stated R2 refused to sign the contract upon admission. The surveyor inquired if the licensee documented the attempts made to have contract signed. LALD-D stated they did not document the attempts. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 900			
0 970 SS=C	144G.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	0 970			

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0 970	Continued From page 36 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 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 facility's liability for health, safety, or personal property of a resident. This had the potential to affect all residents living within the assisted living facility. 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 15, 2023, at approximately 10:20 a.m., licensed assisted living director (LALD)-D stated the blank Assisted Living Contract provided to the surveyor was used by the licensee for all residents. The blank Assisted Living Contract included the following section which included language waving the facilities liability for health, safety, or personal property of a resident: Page 13: Indemnification "Bright Path Homes shall not be liable for any damage or injury to the resident, or any other person, or to any property, occurring on the premises, or any part thereof, or in common	0 970			

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0 970	Continued From page 37 areas thereof, and the resident agrees to hold Bright Path Homes harmless from any claims or damages unless caused solely by negligence of Bright Path Homes." On August 15, 2023, at 10:24 a.m., LALD-D stated they were unaware that the contract could not contain language for waiving the facility's liability. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970			
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of 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	01060			

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01060	Continued From page 38 provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for a resident's emergency relocation to the resident, legal representative, or designated representative, and failed to provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC) of the emergency relocation greater than four days, 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 a widespread scope (when problems are pervasive or represent a systemic	01060			

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01060	Continued From page 39 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 admitted to the licensee on February 27, 2023, and discharged on July 21, 2023. R1's progress notes dated April 20, 2023, through July 28, 2023, indicated R1 was transferred to the hospital on April 19, 2023, due to weakness and poor appetite. From the hospital, R1 transferred to a transitional care unit and expired while at the transitional care unit in July. R1's record lacked evidence the licensee provided the resident or resident's representative a written emergency relocation notice. The record also lacked evidence to indicate the licensee provided the notification to the OOLTC of the emergency relocation greater than four days as required. On August 15, 2023, at 10:58 a.m., licensed assisted living director (LALD)-D stated the licensee's understanding of the requirement was a notice was needed if the licensee initiated a transfer to a different facility and the licensee did not understand that it included hospitalizations. In addition, the LALD-D stated they had not initiated a notice for any hospitalizations or contacted OOLTC for any resident out of the facility for over four days in a hospital or transitional care unit. Clinical nurse supervisor (CNS)-C stated they were unaware of the requirement. The licensee's Discharge and Transfer of Residents policy dated August 1, 2021, read, " In the event of an emergency relocation, the facility will, as soon as possible, provide written notice of	01060			

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01060	Continued From page 40 Emergency Relocation to the following: a. The resident b. The resident's legal representative c. The resident's designated representative d. If the resident receives home and community-based services, the resident's case manager e. If the resident has been relocated and not returned to Bright Path Homes within four (4) days, the Office of Ombudsman for Long-Term Care." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060			
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	01290	On August 16, 2023, the immediacy of		

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01290	Continued From page 41 review, the licensee failed to ensure a background study was submitted and received in affiliation with the assisted living license for one of one employee (unlicensed personnel (ULP)-A). 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: ULP-A began employment with licensee on November 1, 2020, to provide direct cares and services to residents. ULP-A's employee record included a background study clearance dated November 2, 2020, affiliated to the licensee's former comprehensive license HFID #34407, which closed on January 23, 2022, and was no longer an active or accessible license through the Minnesota Department of Human Services NETStudy 2.0 (web-based system used to submit background study requests). ULP-A's record lacked evidence the licensee submitted a background study for ULP-A under the current assisted living license and affiliated to the current HFID number. On August 15, 2023, at 1:05 p.m., the surveyor requested ULP-B employee record. On August 15, 2023, at 1:13 p.m., the surveyor requested to see the licensee's current roster on NETStudy 2.0 from licensed assisted living	01290	correction order 1290 was removed, however non-compliance remained, and the scope and severity remained unchanged.		

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01290	Continued From page 42 director (LALD)-D. The surveyor observed ULP-A was not affiliated with the licensee's current HFID #37322. LALD-D stated the licensee did not conduct a new background study or affiliate previously employed staff with the new assisted living license when the licensee converted from comprehensive to assisted living licensure. LALD-D stated they did not conduct new background studies on previous employees however, they had conducted background studies on employees hired after the move to the new location. On August 15, 2023, at 2:11 p.m., the surveyor observed ULP-A administer medication to R2. At the time the medication was administered, there were no other staff members within eyesight of ULP-A. On August 15, 2023, at 3:16 p.m. through 3:18 p.m., the surveyor observed and compared the NETStudy 2.0 employee roster for the licensee with the licensee's internal employee roster. The surveyor observed seven out of nine unlicensed employees from the licensee's internal roster were not affiliated to the current HFID number. The licensee's registered nurse and licensed assisted living director were both licensed by health licensing boards after 2018, therefore, did not need to be affiliated with the licensee's NETStudy 2.0 roster. The licensee's Recruitment and Hiring policy, dated August 1, 2021, indicated NETStudy 2.0 or current version would be used to complete a background check and results of the background study would be maintained in the employee's personnel file. No further information was provided.	01290			

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01290	Continued From page 43	01290			
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.	01500			

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01500	Continued From page 44 (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on 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, unlicensed personnel ULP-A). 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).	01500			

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01500	Continued From page 45 The findings include: ULP-A ULP-A was hired on November 1, 2020, to provide direct services to the residents. ULP-A's employee record contained no training records for the years 2022 or 2023. CNS-C CNS-C was hired as a on June 10, 2022, to provide supervision and oversight to unlicensed personnel and to provide direct services to residents. CNS-C's employee record contained no hours of annual training. On August 16, 2023, at 10:10 a.m., CNS-C and licensed assisted living director (LALD)-D verified CNS-C and ULP-A's records lacked eight hours of annual training. LALD-D stated annual trainings were completed through EduCare (a training software). In addition, LALD-D stated they had assigned annual training to ULP-A however, ULP-A did not complete it. The licensee's Plan for Orientation, Initial Education and Annual / Continuing Education procedure dated April 30, 2022, indicated all staff that perform direct services must complete at least eight hours of annual training for each 12 month of employment that could be obtained from the licensee or other sources like EduCare. In addition, annual training must include the following: - reporting of maltreatment of vulnerable adults; - review of assisted living bill of rights; - review of infection control techniques used in	01500			

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01500	Continued From page 46 the home; - problem solving, challenging behaviors, communicating with resident with dementia, Alzheimer's disease, or related disorder (Meets 144G.64 A2b); - review of facility's policies and procedures relating to provision of assisted living services (and how to implement those policies); and - the principal of person-centered planning and service delivery. 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	01530			

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01530	Continued From page 47 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 supervisors of direct-care staff received at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date for one of one employee (clinical nurse supervisor (CNS)-C). In addition, the licensee failed to have at least two hours of training on topics related to dementia care for each 12 months of employment for two of two employees (unlicensed personnel (ULP)-A, 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 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: CNS-C CNS-C was hired as a full-time employee on June 10, 2022, to provide supervision and oversite to unlicensed personnel and to provide direct services to residents. CNS-C's employee record included 2.5 hours of	01530			

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01530	Continued From page 48 dementia care training completed on June 13, 2022. CNS-C's employee record lacked eight hours of initial dementia care training within the first 120 hours of employment and lacked at least two hours of training on topics related to dementia care for each 12 months of employment. ULP-A ULP-A was hired on November 1, 2020, to provide direct services to the residents. ULP-A's employee record contained no hours of dementia care training in the years 2022 and 2023. ULP-A's record lacked at least two hours of training on topics related to dementia for each 12 months of employment. On August 16, 2023, at 10:10 a.m., licensed assisted living director (LALD)-D and CNS-C stated dementia care training was provided by EduCare (a training software). LALD-D and CNS-C stated dementia care training had not been completed for CNS-C and ULP-A. LALD-D stated initial and annual training was assigned to CNS-C and annual training to ULP-A however, it was not completed. The licensee's Plan for Orientation, Initial Education and Annual /Continuing Education procedure dated April 30, 2022, indicated supervisors of direct-care employees were required to have at least eight hours of initial training in the topics specified within 120 working hours of employment start date. In addition, all direct care employees would receive at least two hours of training on topics related to dementia care for each 12 months of employment. No further information was provided.	01530			

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01530	Continued From page 49	01530			
01620 SS=F	TIME PERIOD FOR CORRECTION: Twenty-one (21) days 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) conducted ongoing resident monitoring and reassessment to include all areas required on the uniform assessment tool for two of two residents	01620			

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01620	Continued From page 50 (R2, R3). In addition, the licensee failed to ensure the registered nurse (RN) re-assessed residents after a change of condition to investigate causative factors, evaluate interventions, and to implement new interventions for one of one resident (R2) with falls. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: UNIFORM ASSESSMENT TOOL R2 R2 admitted to licensee on November 2, 2022, and began receiving assisted living services. R2's diagnoses included chronic pain, anxiety, and substance abuse. R2's unsigned service plan dated November 2, 2022, indicated R2 received 24/7 home health aide services per care plan which included assistance with dressing, grooming, showers, nail care, toileting as needed (PRN), wheelchair assistance, standby assistance for ambulation, assistance in the community, meals, medication administration, weekly blood pressure, behavior management, housekeeping, and laundry. On August 15, 2023, at 2:03 p.m., the surveyor observed ULP-A administer oral medications to	01620			

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01620	Continued From page 51 R2. R2's 90-day reassessment titled Nurse Reassessment Visit dated April 26, 2023, and July 26, 2023, lacked areas required on the uniform assessment tool including a full physical and cognitive assessment. R3 R3 admitted to the licensee on January 1, 2022, and began receiving assisted living services. R3's diagnoses included schizophrenia (a mental disorder characterized by delusions, hallucinations, disorganized thoughts, speech, and behavior), illicit drug abuse, depression, and alcoholism. R3's service plan dated June 6, 2022, indicated R3 received 24/7 home health aide service per care plan which included assistance with picking out clothing, encourage oral care, encourage bathing, meals, and medication administration. R3's 90-day reassessment titled Nurse Reassessment Visit dated June 13, 2023, lacked areas required on the uniform assessment tool including a full physical and cognitive assessment. On August 16, 2023, at 10:40 a.m., clinical nurse supervisor (CNS)-C and licensed assisted living director (LALD)-D verified the document Nurse Reassessment lacked the content listed above. CNS-C and LALD-D stated the licensee did not update the ongoing assessment form when they converted to an assisted living licensure. The Comprehensive Nursing Assessment policy dated August 1, 2021, indicated the RN would	01620			

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01620	Continued From page 52 conduct a comprehensive assessment for all residents admitted to the licensee to determine the services required and to develop and individualized care plan for staff to implement. The assessment would address the resident's physical, mental, and cognitive needs. FALLS R2's Home Health Aide Care Plan updated on July 7, 2023, indicated R2 required standby assist with mobility and had a history of falls. R2's Nurse Reassessment Visit dated April 26, 2023, indicated R2 fell two times since last visit while using a walker and refused emergency room visits. R2's Nurse Reassessment Visit dated July 26, 2023, indicated R2 fell since last visit when they bent over to pick something up off the floor. R2's progress note dated June 16, 2023, read, "staff asked the client to used [sic] the wheelchair client refused client filled [sic] staff asked the client if the client was okay she salid [sic] she is ok staff want [sic] to called 911 client saild [sic] no." R2's incident report dated June 16, 2023, indicated there was an incident that occurred to R2. The report lacked a full description of the event, and action to be taken. R2's incident report dated August 7, 2023, indicated R2 hit staff with their walker and fell to the ground. The incident report indicated the action taken was call the police. R2's incident report dated August 15, 2023,	01620			

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01620	Continued From page 53 indicated R2 had a near fall. The incident report lacked documentation for an action taken. On August 18, 2023, at 1:20 p.m., clinical nurse supervisor (CNS)-C stated when a fall occurred at the facility the ULP would complete vital signs and call the nurse or 911 based on the severity of the fall. The ULP would create an incident report and a progress note. The nurse would review the incident report on what occurred and depending on the severity of the fall they would document a follow up note. The surveyor inquired if the nurse would always write a follow up note related to the fall. CNS-C stated no. In addition, CNS-C stated R2 fell frequently. On August 18, 2023, at 1:25 p.m., CNS-C confirmed the incident report and note indicated R2 had a fall on June 16, 2022. The surveyor inquired if the CNS-C re-assessed residents after a fall to investigate causative factors, evaluate interventions, and to implement new interventions. CNS-C stated they placed basic fall interventions into place for R2 like stand by assist with ambulation and they were attempting to get R2 a hospital bed. In addition, CNS-C stated they did not investigate reasons for falls or create new interventions as they were unfamiliar with this process. The licensee's Adverse Events policy dated August 1, 2021, indicated the licensee investigates all adverse events, incidents, accidents, variances or unusual occurrences that involve resident care and develops a plan of correction to prevent the same or similar event from occurring again. No further information provided.	01620			

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01620	Continued From page 54	01620			
	TIME PERIOD FOR CORRECTION: Seven (7) days				
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plan included a signature or other authentication by the resident or resident's designated representative to document agreement on the services to be provided for one of two residents (R2).	01640			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01640	Continued From page 55 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: R2 admitted to licensee on November 2, 2022, and began receiving assisted living services. R2's diagnoses included chronic pain, anxiety, and substance abuse. R2's unsigned service plan dated November 2, 2022, indicated R2 received 24/7 home health aide services per care plan which included assistance with dressing, grooming, showers, nail care, toileting as needed (PRN), wheelchair assistance, standby assistance for ambulation, assistance in the community, meals, medication administration, weekly blood pressure, behavior management, housekeeping, and laundry. R2's service plan lacked a signature or other authentication by the resident or resident's designated representative to document agreement on services to be provided. On August 14, 2023, at 10:18 a.m., licensed assisted living director (LALD)-D stated R2 refused to sign the service plan and the licensee had attempted to contact the guardian for signature however, the guardian of R2 changed multiple times. The surveyor inquired if they documented the attempts to obtain a signature for the service plan. LALD-D stated no.	01640			

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01640	Continued From page 56 The licensee's Service Plan policy dated August 1, 2021, read, "Beginning with the date assisted living services are first provided, a service plan is developed for the resident based on an agreement with the resident / responsible party and on the assessed needs identified in the comprehensive assessment." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640			
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency;	01650			

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01650	Continued From page 57 and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plan included the required content for one of one resident (R3). 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: R3 admitted to the licensee on January 1, 2022, and began receiving assisted living services. R3's diagnoses included schizophrenia (a mental disorder characterized by delusions, hallucinations, disorganized thoughts, speech, and behavior), illicit drug abuse, depression, and alcoholism. R3's service plan dated June 6, 2022, indicated R3 received 24/7 home health aide service per care plan which included assistance with picking out clothing, encourage oral care, encourage bathing, meals, and medication administration. R3's service plan lacked the following:	01650			

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01650	Continued From page 58 -frequency of each service, according to the resident's assessment and /or preference. On August 15, 2023, at 10:09 a.m., licensed assisted living director (LALD)-D stated they were unaware the frequency of service was required in the service plan. LALD-D stated the same service plan template was used by all residents and was provided to the licensee by a consultant. In addition, LALD-D stated there was not enough space on the template to write all of the content required. The licensee's Service Plan policy dated August 1, 2021, indicated the service plan would include frequency of each service, according to the resident's current review or assessment and resident preferences. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650			
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based	01730			

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01730	Continued From page 59 on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and maintain a current individualized medication management record for each resident to include all required content for one of one resident (R2). 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	01730			

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01730	Continued From page 60 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: R2 admitted to licensee on November 2, 2022, and began receiving assisted living services. R2's unsigned service plan dated November 2, 2022, indicated R2 received 24/7 home health aide services per care plan which included assistance with dressing, grooming, showers, nail care, toileting as needed (PRN), wheelchair assistance, standby assistance for ambulation, assistance in the community, meals, medication administration, weekly blood pressure, behavior management, housekeeping, and laundry. On August 15, 2023, at 2:03p.m., the surveyor observed ULP-A administer oral medications to R2. R2's Home Health Aide Care Plan dated November 2, 2022, indicated R2 received administration with medications per medication profile /prn medications. R2's Resident Evaluation dated November 2, 2022, indicated R2 received assistance with medication set up, medication administration, coordination of medications, and resident education. In addition, R2's medications were stored in a locked cabinet. R2's Medication Administration Record (MAR) dated August 1, 2023, through August 31, 2023,	01730			

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01730	Continued From page 61 included Sarna original lotion, apply to affected area topically every six hours as needed (PRN) for stenosis of cervical spine, diclofenac 1 percent (%) gel apply 2 grams (g) to affected area three times per day PRN for pain, and lidocare pad 4 percent apply three patches to skin once per day as needed for stenosis of the cervical spine, leave on for 12 hours and remove for at least 12 hours. The orders listed above lacked specific instructions for administration. R2's unsigned service plan, Home Health Aide Care Plan, and Resident Evaluation dated November 2, 2022, and MAR dated August 1, 2023, through August 31, 2023, included parts of the individualized medication management plan however, lacked the following required content: - specific written instruction for resident medication administration; - person responsible for monitoring medication supplies and refills; and - procedures for staff to notify a registered nurse (RN) when problems arose. On August 15, 2023, at 10:33 a.m., clinical nurse supervisor (CNS)-C stated the medication listed above are to be applied to R2's joints when needed however, R2 has not used the medications. In addition, CNS-C stated specific instructions for medications should be listed on the MAR. On August 15, 2023, at 10:55 a.m., the surveyor inquired where the licensee documented procedures for staff to notify a RN when problems arose with medication management. CNS-C stated they verbally educate staff on when to alert the RN if problem arose with medication management however, they had nothing in writing in any of their resident's chart to cover the	01730		

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01730	Continued From page 62 content. The licensee's Assessment of Medications dated August 1, 2021, indicated based on the results of the medication assessment, the RN would document an individualized medication management plan, including the following elements: - description of medication management services to be provided; - description of medication storage based on resident need, preference, risk of diversion and per manufacturer's direction; - documentation procedures; - procedures for verification that medications are administered as prescribed; - procedures for monitoring medication use to prevent complications or adverse reactions; - identification of person(s) responsible for monitoring medication supplies and ensuring refills are ordered in a timely manner; - identification of medication management tasks delegated to unlicensed staff; and - procedures for notifying the registered nurse or licensed health profession regarding problems arising with medication management services. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730			
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who	01760			

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01760	Continued From page 63 administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered per providers order for one of one resident (R2). 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: R2 admitted to licensee on November 2, 2022, and began receiving assisted living services. R2's diagnoses included chronic pain, anxiety, and substance abuse. R2's unsigned service plan dated November 2, 2022, indicated R2 received 24/7 home health aide services per care plan which included assistance with dressing, grooming, showers, nail	01760			

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01760	Continued From page 64 care, toileting as needed (PRN), wheelchair assistance, standby assistance for ambulation, assistance in the community, meals, medication administration, weekly blood pressure, behavior management, housekeeping, and laundry. R2's Medication Administration Record (MAR) dated August 1, 2023, through August 31, 2023, included Enulose 10 grams (g) / 15 milliliter (ml) take 45ml by mouth twice per day. On August 15, 2023, at 9:51 a.m., R2 requested Enulose from ULP-A. The surveyor observed ULP-A obtain the medication and a graduated medication cup from a secured file cabinet, take the medication into the bathroom, pour 30 ml of Enulose into the graduated medication cup, then attempt to administer the medication to R2. R2 stated "why does no one ever listen to me, it is supposed to be one and a half cup full." ULP-A stated it was the correct dose and administered the medication to R2. The surveyor did not observe use of the MAR throughout the medication administration. After exiting the bathroom, the surveyor inquired how ULP-A knew they administered the correct dose of medication. ULP-A stated, "It will match the book." The surveyor inquired if they did not look at the MAR how would they know if a medication had a dosage change. ULP-A stated if there were a change to the medication they would know from report. The surveyor observed ULP-A place medication back into the file cabinet and tend to other tasks without documenting medication administration on the MAR. On August 15, 2023, at 10:38 a.m., clinical nurse supervisor (CNS)-C stated ULPs were trained to use the MAR when administering medication by counting medications in the planner and	01760			

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01760	Continued From page 65 comparing it to the MAR. CNS-C stated for PRN medication or medication not in the planner, the ULP needed to compare the MAR to the medication for the right resident, date, time, and dose and after the medication was given they were instructed to sign the MAR. In addition, CNS-C stated they update ULP when there are changes to medications. The licensee's Medication Documentation policy dated August 1, 2021, indicated each medication administered by the licensee's staff would be documented on accurately and legibly. In addition, documentation of medication administration would be completed promptly. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the	01910			

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01910	Continued From page 66 medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide documentation in the resident's record regarding the disposition of medication to include medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition for one of one discharged 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 discharged from the licensee on July 21, 2023, after R1 expired at a transitional care unit. R1's Discharge Summary dated July 21, 2023, indicated R1 received 24 hour assisted living customized care and read, "Disposition of Medications (if applicable) None." R1's medication administration record (MAR) dated May 1, 2023, through May 31, 2023,	01910			

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01910	Continued From page 67 indicated while at the facility R1 received alendronate 70 milligrams (mg), levothyroxine 88 micrograms (mcg), sertraline 200 mg, azathioprine 50 mg, olopatadine 0.1 percent (%) ophthalmic solution, azelastine 0.1 % nasal spray, chlorhexidine 0.12% oral solution, ipratropium 0.06 % nasal spray as needed (PRN), baclofen 10 mg PRN, clonazepam 0.25 mg PRN, meclizine 50 mg PRN, Artificial tears eye drops, Xiidra 5 % ophthalmic solution, and ropinirole 1.5 mg. R1's record lacked a medication disposition to include the medication's name, strength, prescription number as applicable, quantity, date of disposition, and names of staff and other individuals involved in the disposition. On August 14, 2023, at 2:26 p.m., clinical nurse supervisor (CNS)-C stated they had not destroyed R1's medications however, they have a form to complete when they do. The surveyor inquired how long the licensee waits to destroy medication. CNS-C stated they destroyed the medication as soon as they could however, medications were normally destroyed within the first three days of discharge. The Disposition and Disposal of Medications policy dated August 1, 2021, indicated medications for a resident who is deceased or that have been discontinued or expired may be provided for disposal. In addition, the licensee upon disposition, would document the following information in the clinical record: -Name, strength and prescription number of medication, as applicable; -quantity; -method of disposition or to whom the medications were given;	01910			

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01910	Continued From page 68 -date of disposition; -name(s)/signature(s) of staff or other individuals involved in disposition; and -if applicable, to whom the medications were given. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910			

Type: Full
Date: 08/14/23
Time: 12:00:00
Report: 1025231186

Food and Beverage Establishment Inspection Report

Page 1

Location:

Bright Path Homes Llc
6600 Central Avenue Ne
Fridley, MN55432
Anoka County, 02

Establishment Info:

ID #: 0037947
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 9526586176
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.

3-200B Food Characteristics:Receiving: temperature, condition

3-202.15 **** Priority 2 ****

MN Rule 4626.0190 Food packages must be in good condition and must protect the food from adulteration and potential contaminants.

Provide storage containers for open food product (e.g. opened sugar packages) to protect from pests and contamination.

Comply By: 08/18/23

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.

Mark the date of opened TCS foods in the refrigerator.

Comply By: 08/14/23

4-300 Equipment Numbers and Capacities

4-301.12A **** Priority 2 ****

MN Rule 4626.0680A Provide a 3 compartment sink with integrally attached drainboards at each end for manually washing, rinsing and sanitizing equipment and utensils.

Provide a 3 compartment sink for the establishment, or a dishwasher rated for the sanitizing of utensils in a residential setting.

Provide 3 basins for W/R/S in the meantime.

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4-300 Equipment Numbers and Capacities

4-302.12B **** Priority 2 ****

MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.

Provide a food thermometer as indicated above for the kitchens where cooking and food preparation is taking place.

Comply By: 08/18/23

4-300 Equipment Numbers and Capacities

4-302.14 **** Priority 2 ****

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

Provide a test kit for the sanitizer to be used for sanitizing equipment and utensils.

Comply By: 08/18/23

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

Food course certificate posted on wall - obtain and post a CFPM certificate.

Comply By: 09/14/23

4-200 Equipment Design and Construction

4-201.11

MN Rule 4626.0505 Replace equipment or utensils that are not durable or do not retain their characteristic qualities under normal use conditions.

Discontinue use and replace any non-stick pans and utensils which have become scratched or damaged. Do not replace items with non-stick if metal or scouring items are used, or users aren't familiar with the maintenance of non-stick surfaces.

Comply By: 08/18/23

4-200 Equipment Design and Construction

4-202.17

MN Rule 4626.0545 Remove kick plates that are not designed to be easily removed for cleaning and inspection.

Provide cabinetry in the kitchens without hollow enclosed bases. Expose underneath the cabinetry to clean and treat for pests, see additional comments.

Comply By: 08/14/23

4-500 Equipment Maintenance and Operation

4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

Replace/repair the light in the #3 refrigerator, the light is not currently working.

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4-600 Cleaning Equipment and Utensils

4-601.11C

MN Rule 4626.0840C Clean non-food contact surfaces of equipment and maintain free of accumulations of dust, dirt, food residue, and other debris.

Clean walls, cabinetry fronts, cabinet interiors, and behind and beneath ranges and refrigerator.

Comply By: 08/18/23

5-200A Plumbing: approved materials/design

5-201.11B

MN Rule 4626.1040B Maintain the plumbing system in good repair.

Sink plumbing in basement #2 kitchen is leaking; repair the plumbing.

Accordion plastic connection used in kitchen #3, ensure plumbing is maintained per MN 4717

Comply By: 08/16/23

6-100 Physical Facility Construction Materials

6-101.11A1

MN Rule 4626.1325A1 Provide smooth, durable, and easily cleanable floor, wall and ceiling surfaces.

Wood cabinetry worn, no longer easily cleanable, chipped/broken in corners, missing knobs, sagging hinges.

Repair cabinetry in kitchen and provide a smooth, durable, and easily cleanable finish for the cabinetry. Provide smooth and cleanable knobs.

Comply By: 09/14/23

6-300 Physical Facility Numbers and Capacities

6-303.11C

MN Rule 4626.1470C Provide at least 50 foot candles (540 LUX) of light intensity for areas where food employees are working with utensils and equipment where safety is a factor.

Light in the downstairs kitchen did not turn on during inspection. Repair the downstairs kitchen light.

Comply By: 08/18/23

6-300 Physical Facility Numbers and Capacities

6-305.11B

MN Rule 4626.1480B Provide lockers or other suitable facilities for the orderly storage of employees' clothing and other possessions.

Provide a container or other means of separating staff items from resident items in the refrigerator and freezers.

Comply By: 08/18/23

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.111ABD

MN Rule 4626.1565ABD Provide control of insects, rodents, and other pests by routinely inspecting incoming food and supply shipments; routinely inspecting the premises for evidence of pests; and eliminating harborage conditions.

Observation strip in basement kitchen contained German cockroaches. Provide control for pests and

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clean/insect areas to address harborage conditions.

Comply By: 08/14/23

Total Orders	In This Report	Priority 1	Priority 2	Priority 3
		0	5	10

Send follow-up information to casey.kipping@state.mn.us by 9/14/23

Facility has 3 kitchen spaces, each with sink, range, freezer/refrigerator

Reported no chest freezers or other food storage areas

Orders apply for all 3 kitchens, unless otherwise specified

Kitchen #1 upstairs

Pickles (non TCS) 40 deg F

Smoke detector "chirping" – test and service

Kitchen #2 basement

Bacon 49 deg F

Evidence of pests – clean the kitchen and adjacent areas thoroughly and repair plumbing and treat for pests

Hot air blowing from vent in ceiling in front of the wall-unit A/C

Kitchen #3 upstairs 6600 unit

Bologna 40 deg F

*Kitchen 3 is used by a resident who reportedly prepares their own food and maintains the kitchen themselves.

For independent residents, ensure food and ingredients are from approved sources and staff are checking for and removing expired items.

PESTS

Evidence of German cockroaches in downstairs kitchen (the sticky boxes aren't a treatment or to catch insects, they are for observation to gauge pest activity). Provide pest control for the facility, protecting food, utensils, and contact surfaces during treatment. Clean thoroughly to eliminate food and water and harborage conditions (clean up sprouting potatoes from cabinets and fix the leak on the sink).

The counters are also hollow enclosed bases – the underside of the cabinets will need to be exposed for cleaning and treatment.

Hollow enclosed bases are not permitted in licensed food establishments for reason of pest control and cleaning (4626.0545)– the suggestion is usually to fill the existing base with concrete or another solid non-porous material, however the cabinets are in poor shape (worn wood, they look as though they may be original to the building) and it would probably be more efficient (cost and otherwise) to upgrade the kitchen with more durable cabinetry and provide either an enclosed base or 6" stainless legs.

SINK USAGE

Kitchens have 2 compartment sinks

Signage provided to designate handwashing vs warewashing

Provide 2 compartments of sufficient size for warewashing (e.g. 2 bus tubs) so the warewashing sink can be used to wash, and then two compartments for rinsing and sanitizing.

Sanitizer: (e.g. chlorine bleach (non-scented, labeled for Sanitizing Food Contact Surfaces) at 50-100 PPM; provide a test kit for chemical sanitizing)

Provide an appropriate test kit

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Facility does not have a food preparation sink.

Provide a hand-pump supply of soap at the handwashing sinks (more convenient than using the dishwashing bottle of soap)

COUNTERTOPS AND FOOD CONTACT SURFACES

Facility has laminate countertops

Provide a smooth, non-porous food contact surface (e.g. cutting board) that can be easily washed, rinsed, and sanitized for food preparation

Soap and water can be used to clean non-food contact surfaces. By provided a cutting board or other non-porous food contact surface, the countertops can be kept clean but without the use of chemicals which may damage the finish. Do not use wood as a food contact surface.

EQUIPMENT

MN 4626.0506 includes alternate equipment and finish requirements for adult care facilities which serve TCS foods for same-day service only:

MN 4626.0506 G. A food establishment that is an adult care center, child care center, or boarding establishment does not need to comply with item A [certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program for food service equipment] if approved by the regulatory authority and the food establishment:

- (1) serves only non-TCS food; or
- (2) prepares TCS foods only for same-day service.

Discontinue any service of TCS food for multiple day service (e.g. cooling and reservice of leftovers of prepared and cooked TCS food), or upgrade finishes and equipment in the kitchen

CFPM

For information, please search "MDH CFPM"

GENERAL COMMENTS

Discussed employee health and hygiene, illness exclusion

Food cook and holding temperatures, cross-contamination,

Highly susceptible populations - no service or raw or undercooked animal food

Provide a food thermometer with a thin-probe (e.g. a digital thermometer with the thin tip)

Date marking TCS foods (when packages are opened or food is prepared, date mark and discard after 7 days)

Chemical label, use, and storage

Discussed food source, recalls, and refusing food which has signs of tampering or temperature abuse
Information on food recalls available "MDA Food Recall"

<https://www.mda.state.mn.us/food-feed/food-recalls-consumer-advisories-minnesota>

ADDITIONAL INFORMATION

"MDH Highly Susceptible Population"

<https://www.health.state.mn.us/communities/environment/food/docs/fs/highsuspopfs.pdf>

"MDH TCS Foods"

<https://www.health.state.mn.us/communities/environment/food/docs/fs/tcsfoodfs.pdf>

"MDH Sanitizing"

<https://www.health.state.mn.us/communities/environment/food/docs/fs/cleansanfs.pdf>

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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 1025231186 of 08/14/23.

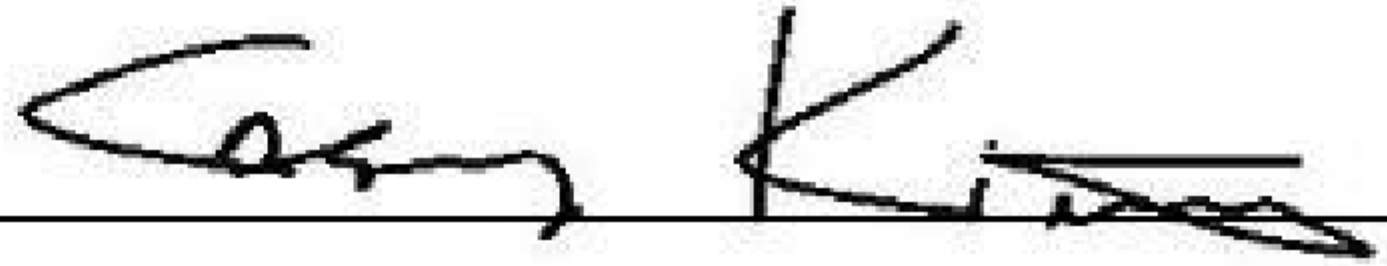
Certified Food Protection Manager: _____

Certification Number: _____ Expires: ____ / ____ / ____

Inspection report reviewed with person in charge and emailed.

Signed: _____

Establishment Representative

Signed:  _____

Casey Kipping
Public Health Sanitarian III
Freeman Building St Paul
651-201-4513
casey.kipping@state.mn.us

Report #: 1025231186

DEPARTMENT OF HEALTH

Minnesota Department of Health

Division of Environmental Health, FPLS

P.O. Box 64975

St. Paul, MN 55164-0975

No. of RF/PHI Categories Out

3

Date

08/14/23

No. of Repeat RF/PHI Categories Out

0

Time In

12:00:00

Legal Authority MN Rules Chapter 4626

Time Out

Bright Path Homes Llc

Address

6600 Central Avenue Ne

City/State

Fridley, MN

Zip Code

55432

Telephone

9526586176

License/Permit #

0037947

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 proceeedures 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

X

Thermometers provided & accurate

Food Identification

37

Food properly labeled; original container

Prevention of Food Contamination

38

X

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

Compliance Status

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

X

Food & non-food contact surfaces cleanable, properly designed, constructed, & used

48

X

Warewashing facilities: installed, maintained, & used; test strips

49

X

Non-food contact surfaces clean

Physical Facilities

50

Hot & cold water available; adequate pressure

51

X

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

X

Physical facilities installed, maintained, & clean

56

X

Adequate ventilation & lighting; designated areas used

57

Compliance with MCIAA

58

Compliance with licensing & plan review

Food Recalls:

Person in Charge (Signature)

Date:

08/14/23

Inspector (Signature)