DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

January 29, 2024

Licensee
His Services Home Care, LLC
2108 70th Avenue North
Brooklyn Center, MN 55430

RE: Project Number(s) SL35313015

Dear Licensee:

On January 19, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the October 23, 2023, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

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

PMB

Electronically Delivered

November 17, 2023

Licensee
His Services Home Care LLC
2108 70th Avenue North
Brooklyn Center, MN 55430

RE: Project Number(s) SL35313015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on October 23, 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
HRD 3A, 3rd Floor
P.O. Box 64900
625 Robert Street North
St. Paul, MN 55164

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,

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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35313	A. BUILDING: _____ B. WING _____	10/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIS SERVICES HOME CARE LLC	2108 70TH AVENUE NORTH BROOKLYN CENTER, MN 55430

(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: SL35313015-0 On October 23, 2023, through October 25, 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 3 active residents receiving services under the Assisted Living license. An immediate order for tag identification 1290 was issued on October 24, 2023 at 11:18 a.m. Immediacy of order 1290 was not removed prior to the time of exit.	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.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480		

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0 480	Continued From page 1 following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated October 23, 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		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the	0 580		

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0 580	Continued From page 2 quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to implement and maintain a quality management program (QMP) appropriate to the size of the facility and relevant to the type of services provided. This had the potential to affect all current 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: On October 23, 2023, at approximately 10:00 a.m. during the entrance conference, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated the licensee had not established nor implemented a quality management activity. LALD/CNS-C stated the licensee was aware of the requirement but had not instituted an activity at that time.	0 580		

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0 580	Continued From page 3 The licensee's Quality Improvement policy dated August 1, 2021, indicated the licensee had established a quality improvement program based on organization size and appropriate to the type of services provided. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 580		
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057.	0 650		

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0 650	Continued From page 4 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure documentation of training and competencies were maintained in the employee record for one of two unlicensed personnel ((ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-B was hired on September 15, 2023. ULP-B's record lacked documentation by a registered nurse of the required training and competencies related to Minnesota statute 144G.61 Subd. 2 (a) and (b). ULP-B's Nursing Assistant-Registered/Direct Support Staff Skills Performance Evaluation dated October 1, 2023, lacked documentation of training and competencies for bathing, hair care, toileting, dressing, transfers, ambulation, range of motion exercises, and positioning. On October 24, 2023, at 10:15 a.m., the licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated training had been provided to ULP-B by LALD/CNS-C but documentation of the training and competencies had not been maintained in ULP-B's record.	0 650		

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0 650	Continued From page 5 The licensee's policy titled "Staff Orientation and Education" dated August 1, 2021, indicated staff providing direct services will complete a competency evaluation as part of the orientation process and that licensee will maintain proof of orientation and education in the personnel file. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	0 800		

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0 800	Continued From page 6 or has potential to affect a large portion or all of the residents). Findings include: On a facility tour on October 23, 2023, at approximately 1:00 p.m. with licensed assisted living director/ clinical nurse supervisor (LALD/CNS)-C it was observed that a space heater in resident room #004 was plugged into a light duty extension cord. Portable heating appliances are required to be used according to the manufactures instructions and plugged directly into the wall outlet. It was also observed that a dead mouse was located in the light fixture on the ceiling in the basement living room. It is required to keep the facility free of rodents that contaminate the facility. These deficient conditions were visually verified by LALD/CNS-C accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) 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	0 810		

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0 810	Continued From page 7 (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to maintain the facility's fire safety and evacuation plan with required elements. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of	0 810		

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0 810	Continued From page 8 the residents). Findings include: A record review of available documentation and interview were conducted on October 24, 2023, at approximately 9:00 a.m. of documents provided by licensed assisted living director/ clinical nurse supervisor (LALD/CNS)-C on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. It was observed that numbers identifying resident rooms were not included on the fire evacuation floor plan or the resident room doors. Room numbers identifying resident rooms are required to be installed on the resident room doors and the evacuation floor plan for accurate and effective direction of evacuation during a fire or similar emergency. Record review of the available documentation indicated that the licensee did not include fire protection procedures necessary for residents in the event of a fire or similar emergency for this specific facility. Record review of the available documentation indicated the licensee did not have unique and unusual needs for individual resident movement or evacuation during a fire or similar emergency available with the fire safety and evacuation plan. Individual unique and unusual needs of each resident for evacuation during a fire or similar emergency is required to be available with the fire safety and evacuation plan in order to help communicate evacuation needs to staff and emergency personnel. Record review of the available documentation	0 810		

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0 810	Continued From page 9 indicated that employees have not received training on the fire safety and evacuation plan for this facility. Training of employees is required at hire and twice per year thereafter on the facility fire safety and evacuation plan and procedures of this facility. Facility fire safety and evacuation plan employee training is required to be completed and documented separately from drills. Record review of the available documentation indicated that the facility did not offer specific training based on the facility fire safety and evacuation plan to the residents. Resident training based on the facility fire safety and evacuation plan is required to be offered to the residents at least annually. All deficiencies were verified by LALD/CNS-C during the interview. 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 10 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide facilities that were not 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). Findings include: On a facility tour on October 23, 2023, at approximately 1:00 p.m. with licensed assisted living director/ clinical nurse supervisor (LALD/CNS)-C, it was observed that compliant emergency escape and rescue openings were not provided in resident sleeping rooms #001, #002 and #004. Occupied Resident Rooms Resident sleeping room #001 emergency escape and rescue clear window opening measurements are 35 inches wide, 17 inches in height and 595 square inches in openable area. The window was measured with LALD/CNS-C, and survey staff present. The window did not meet the minimum requirements for clear opening height and minimum clear opening area.	0 820	This immediate correction order identified on October 23, 2023, has had the immediacy lifted as of October 24, 2023, by assigning a fire watch for the facility. This was confirmed by the licensee via email and approved by evaluation supervisor.	

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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
0 820	Continued From page 11 Resident sleeping room #004 emergency escape and rescue clear window opening measurements are 15 inches wide, 43 1/2 inches in height and 652 square inches in openable area. The window was measured with LALD/CNS-C and survey staff present. The window did not meet the minimum requirements for clear opening width. Unoccupied Room Resident sleeping room #002 emergency escape and rescue clear window opening measurements are 35 inches wide, 17 inches in height and 595 square inches in openable area. The window was measured with LALD/CNS-C, and survey staff present. The window did not meet the minimum requirements for clear opening height and minimum clear opening area. It was explained to LALD/CNS-C that at least one compliant emergency escape and rescue opening is required within each resident sleeping room. Existing emergency escape and rescue openings are required to meet a minimum clear opening area of 648 square inches and have a minimum dimension of 20 inches in height and a minimum dimension of 20 inches in width. And have a windowsill height from the floor to the clear opening of not more than 48 inches. It was also observed that a metal bucket with sand in it was used as a dispenser for discarding smoking materials at the rear of the facility. Dispensers for discarded smoking materials are required to be listed for the intended use and used according to the manufacturer's instructions. These deficient conditions were visually verified	0 820		

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	35313	A. BUILDING: _____ B. WING _____	10/23/2023

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0 820	Continued From page 12 by LALD/CNS-C accompanying on the tour. Survey staff explained that an immediate correction order was issued for the above findings. TIME PERIOD FOR CORRECTION: Immediate.	0 820		
0 950 SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative.	0 950		

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0 950	Continued From page 13 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract included the designation of representative statutory language notice for one of one resident (R1). 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: R1 was admitted on February 23, 2023. R1's Assisted Living Contract authenticated prior to admission was dated February 13, 2023, and lacked the verbatim designated representative notice, a location to identify a designated representative, or a space for the resident to initial if they wished to decline to name one. On October 24, 2023, at 2:00 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated the licensee was not aware of the required notice and areas to identify or decline a designated representative in the contract. LALD/CNS stated the licensee had purchased the contract template in 2021 but the licensee had not reviewed the contract template for changes since originally purchasing the template. LALD/CNS stated the contract template was used for all residents who resided at the	0 950		

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0 950	Continued From page 14 facility and no contract would have the required content for designated representatives. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 950		
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: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety, or personal property for one of one resident (R1). 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:	0 970		

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0 970	Continued From page 15 R1 was admitted on February 23, 2023. R1's Assisted Living Contract authenticated prior to admission was dated February 13, 2023. Under the section Miscellaneous Provisions 1. Insurance Liability and Release read, "the resident agrees that [licensee] will not be liable to the resident for any personal injury or property damage." On October 24, 2023, at 2:00 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated the licensee was not aware a liability waiver could not be included in the assisted living contract. LALD/CNS stated the licensee had purchased the contract template in 2021 but the licensee had not reviewed the contract template for changes since originally purchasing the template. LALD/CNS stated the contract template was used for all residents who resided at the facility and each contract signed by a resident would include the liability waiver. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01290 SS=F	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	01290		

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01290	Continued From page 16 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 review, the licensee failed to ensure current employee records contained all the required content to include a current background study (BGS) clearance letter for one of two 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). The findings include: ULP-A was hired on November 30, 2019, under the licensee's previously held 144A comprehensive home care license with health facility identification number (HFID) 34154. ULP-A's Background Study Notice dated December 2, 2019, was associated with licensee's closed 34154 license and included the correct spelling of ULP-A's first name as indicated on ULP-A's driver's license (DL) and social security number (SSN) card.	01290		

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01290	Continued From page 17 On August 1, 2021, the licensee converted from the 144A comprehensive home care license with HFID 35154 to the 144G assisted living facility license with HFID 35313, which the licensee actively operated under. When the licensee converted their license and received their new HFID, the licensee would need to complete or associate all current employees with the new HFID in the Department of Human Services (DHS) NetStudy 2.0 (background clearance website) to have a current BGS for each employee. ULP-A's Background Study Notice dated November 3, 2021, was associated with licensee's current 35313 license, however ULP-A's first name was misspelled compared to ULP-A's driver's license and social security card. ULP-A's employee record lacked a completed and affiliated BGS associated with ULP-A's correctly spelled name. On October 24, 2023, at 9:10 a.m., ULP-A was working with R1 and provided R1 with their morning medications. ULP-A stated they were not sure why their name was misspelled on their most recent background study, but the previous background study included their correct name. The DHS NetStudy screenshot dated October 24, 2023, at 8:54 a.m., indicated there were two results with the same middle name, last name, and birthdate, however, only one result included ULP-A's SSN. The DHS NetStudy screenshot dated October 24, 2023, at 8:54 a.m., indicated ULP-A's account with SSN associated included multiple current	01290		

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01290	Continued From page 18 locations where ULP-A had been affiliated with no restrictions and a separation date from the licensee's previous HFID 34154. The licensee's current HFID 35313 was not included in the current affiliations for ULP-A. The DHS NetStudy screenshot dated October 24, 2023, at 8:55 a.m., indicated ULP-A's account with the incorrect first name, was affiliated with licensee's current HFID 35313 and was affiliated on November 2, 2021. The DHS NetStudy screenshot dated October 24, 2023, at 9:31 a.m., indicated ULP-A's BGS was completed under the incorrect name and under the COVID-19 study exceptions which had expired as no fingerprints were associated with the BGS and the study exceptions had expired. On October 24, 2023, at 10:15, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated they were not sure how a new name was created for ULP-A. LALD/CNS-C stated they had entered the information into NetStudy, but did not notice the switching of the last letter of the first name which created confusion in the affiliation and the fingerprinting. LALD/CNS-C stated they would need to log into NetStudy and affiliate the correct account with the SSN for ULP-A to the licensee's current HFID 35313. The licensee's Recruitment and Hiring policy dated August 1, 2019, indicated all employees would have a BGS as required by the DHS establish procedure and results of the BGS clearance for each employee would be maintained in the employee file. No further information provided.	01290		

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01290	Continued From page 19 TIME PERIOD FOR CORRECTION: Immediate Immediacy of order 1290 was not removed prior to the time of exit.	01290		
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a registered nurse (RN) conducted 30-day supervision of delegated tasks to an unlicensed staff as required	01440		

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01440	Continued From page 20 for one of two 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). The findings include: ULP-A was hired November 30, 2019, under licensee's closed comprehensive home care license. ULP-A's Home Health Aide Medication Competency Evaluation dated November 30, 2019, indicated ULP-A was trained and found competent for the delegated task of medication administration. On October 24, 2023, at 9:10 a.m., observed ULP-A provide medication administration to R1. ULP-A stated they had been trained by licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C when they were originally hired and performed medication administration each shift for the duration of employment with the licensee. On October 24, 2023, at 10:15 a.m., LALD/CNS-C stated ULP-A was trained when they were hired, but LALD/CNS-C stated a 30-day supervision was not completed and no documentation would be present in ULP-A's record. LALD/CNS-C stated the licensee was not aware of the 30-day supervision requirement and	01440		

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01440	Continued From page 21 documentation related to a 30-day supervision visit was not developed by the licensee. The licensee's Supervision: Unlicensed Staff policy dated August 1, 2021, indicated direct supervision within 30-days would be completed by the RN and evidence of the supervision would be maintained in the employee record. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		
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	01620		

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01620	Continued From page 22 facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN) completed a comprehensive reassessment to include all required content identified per Minnesota Administrative Rule 4659.0150 Uniform Assessment Tool 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 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 was admitted on February 23, 2023. R1's Service Plan dated February 15, 2023, and reviewed last on August 9, 2023, indicated R1 received the services for medication management, behavior monitoring, assistance with meals, and home health aide services. R1's Nurse Reassessment Visit dated February 28, May 29, and August 29, 2023, were each a two-page assessment and each lacked portions of the required content identified on the uniform assessment tool. The assessments indicated specific physical assessments to be completed and marked with a checkmark next to, "NC,"	01620		

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01620	Continued From page 23 which is an abbreviation for, "No Change." The assessments failed to be developed and address the required content per Minnesota Administrative Rule 4659.0140 Subp. 2. B. (3). On October 24, 2023, at 2:00 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated the licensee was not aware of the requirements of Minnesota Administrative Rule 4659.0150 Uniform Assessment Tool. LALD/CNS-C stated the licensee used the licensee's policy to identify areas to be included in the development of the licensee's assessment and was not aware of the required areas identified in the Minnesota Administrative Rule to be included in each assessment. The licensee's Comprehensive Nursing Assessment policy dated August 1, 2021, indicated a comprehensive assessment to address the resident's physical, mental and cognitive needs would be completed, however the policy failed to identify all areas to be assessed as required per Minnesota Administrative Rule 4659.0150 Uniform Assessment Tool. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01620		

Minnesota Department of Health
Food, Pools, & Lodging Services
P.O. Box 64975
Saint Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *10/23/23*
Time: 14:45:48
Report: 1021231330

Food and Beverage Establishment Inspection Report

Location:
His Services Home Care Llc
2108 70th Avenue North
Brooklyn Center, MN55430
Hennepin County, 27

Establishment Info:
ID #: 0039362
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 7635664661
ID #:

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

The following orders were issued during this inspection.

2-200 Employee Health

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

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

NO EMPLOYEE ILLNESS LOG ON-SITE. DISCUSSED EMPLOYEE ILLNESS POLICY AND RECORDING WITH OWNER. AN MDH EMPLOYEE ILLNESS LOG SENT WITH REPORT.

Comply By: 10/24/23

4-700 Sanitizing Equipment and Utensils

4-702.11 ***** Priority 1 *****

MN Rule 4626.0900 Sanitize utensils and food contact surfaces of equipment before use, after cleaning.

ESTABLISHMENT WAS ONLY WASHING AND RINSING THE DISHES AND UTENSILS IN THE KITCHEN TWO COMPARTMENT SINK. THE DISH MACHINE WORKS BUT WAS TURNED OFF AND PER CONVERSATION WITH OWNER, IT WAS NOT BEING USED AT THE MOMENT. SEE COMMENTS.

Comply By: 10/23/23

7-200 Toxic Supplies and Applications

7-204.11 ***** Priority 1 *****

MN Rule 4626.1620 Discontinue using chemical sanitizers, including chemical sanitizing solutions generated on site and other chemical antimicrobials on food-contact surfaces that do not meet the requirements specified in 40 CFR part 180, section 180.940, or part 180, subpart E, section 180.2020.

THE BLEACH FOUND ON-SITE IS LEMON SCENTED. THE LABEL DOES NOT MENTION THAT IT CAN BE USED FOR FOOD CONTACT SURFACES. DISCUSSED WITH OWNER THE APPROVED

SANITIZING SOLUTIONS AND FACT SHEET WAS SENT WITH REPORT. OWNER WILL GET APPROVED SANITIZER.

Comply By: 10/24/23

3-500C Microbial Control: date marking

3-501.17B ***** Priority 2 *****

MN Rule 4626.0400B Mark the refrigerated, ready-to-eat, TCS food prepared and packaged in a processing plant and opened 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. The date must not exceed the manufacturer's use-by-date.

AN OPEN GALLON OF MILK AND OPEN CONTAINER OF SLICED HAM IN THE WHIRLPOOL REFRIGERATOR WERE FOUND WITHOUT A DATE MARK. PER CONVERSATION WITH OWNER, THEY WERE OPENED A COUPLE OF DAYS AGO. DISCUSSED DATE MARKING AND STAFF WILL DATE MARK TCS FOOD ITEMS.

Comply By: 10/23/23

4-300 Equipment Numbers and Capacities

4-302.13B ***** Priority 2 *****

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

ESTABLISHMENT DOES NOT HAVE A MEASURING DEVICE THAT INDICATES THE FINAL UTENSIL SURFACE TEMPERATURE IN DISH MACHINE. PROVIDE. THERMOLABELS LEFT ON-SITE.

Comply By: 10/30/23

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.

NO TEST KIT ON-SITE TO MEASURE THE CONCENTRATION OF CHLORINE. PROVIDE AS DESCRIBED IN RULE ABOVE.

Comply By: 10/30/23

4-600 Cleaning Equipment and Utensils

4-601.11A ***** Priority 2 *****

MN Rule 4626.0840A Equipment food-contact surfaces and utensils must be clean to sight and touch.

THE FOOD THERMOMETER PROBE FOUND WITH DRIED FOOD DEBRIS. FOOD THERMOMETER PROBE WAS CLEANED AND SANITIZED WITH AN ALCOHOL SWAB DURING INSPECTION. DISCUSSED CLEANING AND SANITIZING THE FOOD THERMOMETER PROBE AFTER EACH USE. CORRECTED ON-SITE.

Comply By: 10/23/23

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.112

MN Rule 4626.1570 Remove dead or trapped birds, insects, rodents, and other pests from the premises.

10/24/23 - HRD STAFF FOUND A DEAD MOUSE ON A CLEAR SHIELD LIGHT FIXTURE IN THE BASEMENT'S CEILING. REMOVE DEAD MOUSE. PROVIDE CONTROL OF RODENTS AND OTHER PESTS BY ROUTINELY INSPECTING THE ESTABLISHMENT AND ELIMINATING ANY HARBORAGE CONDITIONS.

Comply By: 10/24/23

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: MILK - WHIRLPOOL REFRIGERATOR
Violation Issued: No

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: SLICED HAM - WHIRLPOOL REFRIGERATOR
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	3	4	1

ALL FINDINGS ON THIS REPORT WERE DISCUSSED WITH OWNER/LALD, SYLVESTER ONAIWU AND HEALTH REGULATION DIVISION NURSE EVALUATOR, BRANDON MUELLER.

THIS FACILITY IS A RESIDENTIAL HOME AND THEY CURRENTLY HAVE 3 CLIENTS AND THE FACILITY CAN HAVE UP TO 4 CLIENTS.

PER CONVERSATION WITH SYLVESTER, FOOD IS MADE FOR SAME DAY SERVICE. NO LEFTOVERS ARE KEPT.

CONTINUATION OF MN Rule 4626.0900:
DISCUSSED WITH OWNER THAT ALL DISHES AND UTENSILS NEED TO BE WASHED, RINSED AND SANITIZED AFTER EACH USE. SINCE ESTABLISHMENT DOES NOT HAVE A THREE COMPARTMENT SINK ON-SITE, THEY NEED TO USE THE DISH MACHINE. OWNER WILL TURN ON DISH MACHINE AND THEY WILL USE IT.

DISH MACHINE ON-SITE DOES MEET THE RESIDENTIAL ANSI/NSF 184 STANDARD.

THE KITCHEN HAS RESIDENTIAL EQUIPMENT, VINYL FLOORING, LAMINATE COUNTERTOPS, WOOD CABINETS AND POPCORN CEILING. EQUIPMENT AND PHYSICAL FACILITIES WILL BE MONITORED AT FUTURE INSPECTIONS.

Type: Full
Date: *10/23/23*
Time: 14:45:48
Report: 1021231330
His Services Home Care Llc

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1021231330 of 10/23/23.

Certified Food Protection Manager: SYLVESTER A. ONAIWU

Certification Number: FM17992 Expires: 09/08/24

Inspection report reviewed with person in charge and emailed.

Signed: _____
SYLVESTER ONAIWU
LALD

Signed: _____
Melissa Ramos
Environmental Health Specialist
Metro District Office
651-201-4495
Melissa.Ramos@state.mn.us