Electronically Delivered

October 26, 2023

Licensee
Residential Care Nine Mile Creek
7421 13th Avenue South
Richfield, MN 55423

RE: Project Number(s) SL37272015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on October 4, 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 . . ."

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by 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

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
	37272	A. BUILDING: _____ B. WING _____	10/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RESIDENTIAL CARE NINE MILE CRK	7421 13TH AVENUE SOUTH RICHFIELD, MN 55423

(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: SL37272015-0 On October 2, 2023, through October 4, 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 5 active residents receiving services under the Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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 included document titled, Food and Beverage Establishment Inspection Report dated October 3, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 650 SS=F	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	0 650		

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0 650	Continued From page 2 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 the registered nurse (RN) documented training and competencies for unlicensed personnel ((ULP)-A, ULP-B) who would provide medications for residents with unplanned time away from home when a licensed nurse was not available. 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 and ULP-B were hired on August 28, 2023, and July 21, 2023, respectively.	0 650		

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0 650	Continued From page 3 ULP-A and ULP-B's records lacked documentation of competency evaluations related to medication administration when a licensed nurse was not available to provide mediations for a resident with an unplanned time away from home. On October 2, 2023, at 12:30 p.m., RN-E stated they were responsible for medication training of ULPs. RN-E stated every staff member is trained on unplanned times away when a nurse is not available. RN-E stated there is a policy and staff are directed to follow the policy. On October 2, 2023, at 1:30 p.m., licensed assisted living director (LALD)-C stated all training and competency would be documented in each employee's respective records. On October 3, 2023, at 9:40 a.m., observed ULP-B provide oral and injectable medications to R2 in their room. ULP-B stated they were trained for medication administration and unplanned times away by RN-E when ULP-B was hired. The licensee's 7.10 Medication Management - Planned & Unplanned Time Away policy dated June 30, 2021, indicated staff would be trained and found competent with unplanned times away. Additionally, the licensee's 5.10 Training Records indicated all training and competencies would be documented and maintained in each employee's record. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		

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0 780	Continued From page 4	0 780		
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 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: The licensee failed to provide smoke alarms that are interconnected so that the actuation of one alarm causes all alarms in the dwelling unit 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	0 780		

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0 780	Continued From page 5 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 with the Licensed Assisted Living Director (LALD)-C on October 2, 2023, at approximately 12:00 p.m., it was observed that upon testing, the smoke alarms in the facility were not interconnected so that the actuation of one smoke alarm would cause all other alarms in the facility to actuate. It was also observed that a smoke alarm in the corridor on the main level did not work when it was tested. This deficient condition was visually verified by LALD-C accompanying the tour. TIME PERIOD FOR CORRECTION: Seven (7) 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	0 790		

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0 790	Continued From page 6 This MN Requirement is not met as evidenced by: The licensee failed to provide the required monthly maintenance on fire extinguishers. 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). Findings include: On October 2, 2023, at approximately 12:00 p.m., survey staff toured the facility with the Assisted Living Director (LALD)-C. During the facility tour, it was observed that portable fire extinguishers were tagged, showing the required annual service, but lacked records to show the required monthly visual inspections were performed or recorded for all portable fire extinguishers throughout the facility. This deficient condition was visually verified by LALD-C accompanying the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment	0 800		

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0 800	Continued From page 7 (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: The licensee failed to maintain the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On October 2, 2023, at approximately 12:00 p.m., survey staff toured the facility with Licensed Assisted Living Director (LALD)-C. During the facility tour, survey staff observed the following: In lower-level bedroom #3, it was observed that the egress window was obstructed by a plastic well cover that was installed lower than the window head. In the lower-level bathroom, it was observed that the cabinet over the bathroom sink was not	0 800		

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0 800	Continued From page 8 securely mounted and was falling apart from the wall. Near the front entrance, it was observed that the burnt used cigarettes were being disposed of without a proper disposal container, creating a possible fire hazard. During the facility tour, LALD-C visually verified these deficient findings at the time of discovery. 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 (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	0 810		

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0 810	Continued From page 9 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: The licensee failed to develop a fire safety and evacuation plan with the required elements; failed to provide a maintained fire safety and evacuation plan that showed the location and number of resident rooms; failed to provide a maintained fire safety and evacuation plan that contains employee actions to be taken in the event of a fire or similar emergency; fire protection procedures necessary for residents, and procedures necessary for resident movement, evacuation, or relocation during a fire or similar emergency with identification of unique or unusual resident needs for the movement or evacuation; failed to provide training to residents capable of assisting in their own evacuation; failed to provide training to residents capable of assisting in their own evacuation and failed to conduct required evacuation drills as required. 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	0 810		

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0 810	Continued From page 10 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: Record reviews were conducted on October 4, 2023, at approximately 9:30 a.m. with the Licensed Assisted Living Director (LALD)-C on the fire safety and evacuation plan, fire safety and evacuation training for the facility, and fire safety and evacuation drills for the facility. An interview and review of the available documentation indicated that the licensee did not maintain the fire safety and evacuation plan for the facility. Review of the available documentation and the staff training document provided by LALD-C contained the following discrepancies: - The policy states that all should be evacuated to safest exit or behind the nearest set of smoke compartment doors away from fire/smoke. This facility is a residential home and does not contain any sort of smoke compartments or smoke compartment doors to contain fire and smoke. - The policy states that when the fire alarm is triggered all fire doors on magnetic holders will automatically close to contain smoke and fire. The facility does not have any doors that are on magnetic door holders or that are rated for smoke and fire. The facility also does not have a fire alarm system that supports the use of magnetic door holders. - The policy states that the system was wired directly to the fire station. The facility did not have a fire alarm system that supported the direct connection to the fire station. On the facility tour with the Assisted Living Director (LALD)-C on October 2, 2023, at	0 810		

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0 810	Continued From page 11 approximately 12:00 p.m., with the Assisted Living Director (LALD)-C, it was observed that the fire safety and evacuation plan did not show the number of resident rooms. Record review of the available documentation indicated that the plan did not have employee actions to be taken in the event of a fire or similar emergency. The facility plan did include some provisions for employee action but did not include the facility-specific employee actions to be taken in the event of a fire or similar emergency. During the interview, LALD-C stated that the policy was a basic policy from a third-party provider and had yet to be edited or updated to fit the facility. He verified that the fire safety and evacuation plan for the facility lacked these provisions. 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. During the interview, LALD-C verified that the fire safety and evacuation plan for the facility lacked these provisions. Record review of the available documentation indicated that the fire safety and evacuation plan did not include the facility-specific 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 the relocation of residents but did not specify how to move or evacuate residents or identify the unique and unusual needs of the residents. During the interview, LALD-C verified that the fire safety and evacuation plan for the facility lacked these provisions.	0 810		

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0 810	Continued From page 12 Record review of the available documentation indicated that the licensee did not conduct evacuation drills twice per year per shift as required by statute. Review of the provided documented drills indicated that the fire drills had been conducted every other month but failed to provide drills for the night shift. LALD-C verified that there were no further drills conducted besides those that were provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
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	0 950		

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	37272	A. BUILDING: _____ B. WING _____	10/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RESIDENTIAL CARE NINE MILE CRK	7421 13TH AVENUE SOUTH RICHFIELD, MN 55423

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0 950	Continued From page 13 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. 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 and identification of the designated representative for all residents who signed an assisted living contract. 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 October 2, 2023, at 10:00 a.m. during the entrance conference, licensed assisted living director (LALD)-C provided licensee's blank contract and stated the contract is used for all residents who signed an assisted living contract. The licensee's undated Assisted Living Lease Agreement lacked a document separate from the contract with the verbatim notice and lacked a page or space for the residents to identify a designated representative or a space to decline	0 950		

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0 950	Continued From page 14 to name one. On October 2, 2023, at 11:15 a.m., LALD-C stated the licensee was not aware of the designated representative requirement for the licensee's contract. LALD-C stated the licensee would use a sample document from licensee's policy and procedures. The licensee's 1.08 Designated Representative policy dated June 30, 2021, indicated the licensee would provide the required verbatim notice and space for the resident to identify or decline to name a designated representative. 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 of a resident. This had the potential to	0 970		

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0 970	Continued From page 15 affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On October 2, 2023, at 10:00 a.m. during the entrance conference, licensed assisted living director (LALD)-C provided the licensee's blank undated contract and stated the contract is used for all residents who signed an assisted living contract. - On page eight (8) of the contract under section 20. Personal Property it read, "You agree the Landlord (licensee) is not responsible for any loss or damage to your personal property." - On page ten (10) of the contract under section 26. Liability it read, "Landlord is not liable to the Tenant (resident) ... for any injury, death or property damage." On October 2, 2023, at 11:15 a.m., LALD-C stated the licensee was not aware of the waiver of liability prohibition requirement for the licensee's contract. LALD-C stated the licensee would edit the contract to remove liability waiver. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		

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01370	Continued From page 16	01370		
01370 SS=F	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and	01370		

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01370	Continued From page 17 (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competencies were completed and documented for two of two unlicensed personnel ((ULP)-A, 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, 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 and ULP-B were hired on August 28, 2023, and July 21, 2023, respectively. ULP-A and ULP-B's record lacked documentation the registered nurse (RN) trained and completed competency evaluations as required for all statutorily required areas. ULP-A's My Transcript dated September 18, 2023, at 8:40 a.m., indicated ULP-A had completed the licensee's assigned trainings. The required content and RN evaluations were not indicated as completed and were not documented in ULP-A's transcript. ULP-B's My Transcript dated September 18, 2023, at 8:37 a.m., indicated ULP-B had	01370		

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01370	Continued From page 18 completed the licensee's assigned trainings. The required content and RN evaluations were not indicated as completed and were not documented in ULP-B's transcript. On October 2, 2023, at 12:30 p.m., licensed assisted living director (LALD)-C stated the licensee had not completed training in all the required areas and the licensee had not required the RN to complete competencies in the required areas. LALD-C stated no employee records would have the required training and competencies documented. The licensee's 5.02 Competency Training Evaluations policy dated June 30, 2021, correctly indicated the required areas of training and competencies to be completed by all employees who provided services. The policy indicated the training and competencies would be documented and maintained in each employee's respected training record. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01380 SS=F	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to	01380		

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01380	Continued From page 19 appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competencies were completed and documented for two of two unlicensed personnel ((ULP)-A, 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, 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 and ULP-B were hired on August 28, 2023, and July 21, 2023, respectively. ULP-A and ULP-B's record lacked documentation the registered nurse (RN) trained and completed competency evaluations as required for all statutorily required areas. ULP-A's My Transcript dated September 18, 2023, at 8:40 a.m., indicated ULP-A had	01380		

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01380	Continued From page 20 completed the licensee's assigned trainings. The required content and RN evaluations were not indicated as completed and were not documented in ULP-A's transcript. ULP-B's My Transcript dated September 18, 2023, at 8:37 a.m., indicated ULP-B had completed the licensee's assigned trainings. The required content and RN evaluations were not indicated as completed and were not documented in ULP-B's transcript. On October 2, 2023, at 12:30 p.m., licensed assisted living director (LALD)-C stated the licensee had not completed training in all the required areas and the licensee had not required the RN to complete competencies in the required areas. LALD-C stated no employee records would have the required training and competencies documented. The licensee's 5.02 Competency Training Evaluations policy dated June 30, 2021, correctly indicated the required areas of training and competencies to be completed by all employees who provided services. The policy indicated the training and competencies would be documented and maintained in each employee's respected training record. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or	01440		

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01440	Continued From page 21 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 supervision was completed within 30 calendar days of beginning to provide delegated tasks for two of two unlicensed personnel ((ULP)-A, 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 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).	01440		

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01440	Continued From page 22 The findings include: ULP-A and ULP-B were hired on August 28, 2023, and July 21, 2023, respectively. ULP-A and ULP-B's records lacked documentation the registered nurse (RN) completed a 30-day supervision after the ULPs began providing the delegated service. ULP-A's Skill Competency dated August 30, 2023, related to medications administration was signed as completed by clinical nurse supervisor (CNS)-D. ULP-A's record lacked documentation of a 30-day supervision for a delegated task by a RN. ULP-B's Skill Competency dated July 22, 2023, related to medications administration was signed as completed by CNS-D. ULP-B's record lacked documentation of a 30-day supervision for the delegated task by a RN. ULP-B's Skill Competency dated July 24, 2023, related to blood glucose testing was signed as completed by CNS-D. ULP-B's record lacked documentation of a 30-day supervision for the delegated task by a RN. On October 2, 2023, at 12:30 p.m., RN-E stated they worked with CNS-D to train staff for medication administration. RN-E stated they had not completed a 30-day supervision with the staff that were trained for medication administration. On October 2, 2023, at 12:45 p.m., licensed assisted living director (LALD)-C stated CNS-D and RN-E were responsible for training and 30-day supervision for all delegated tasks. LALD-C stated the licensee had not documented	01440		

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01440	Continued From page 23 any 30-day supervision for any ULPs with delegated tasks. On October 3, 2023, at 8:40 a.m., surveyor observed ULP-B perform the delegated task of blood glucose testing on R2. ULP-B obtained R2's blood glucose and recorded the results in R2's record. On October 3, 2023, at 9:40 a.m., surveyor observed ULP-B provide the delegated task of medication administration with oral and injectable medications to R2. ULP-B obtained ordered medications, provided them to R2, and documented they were completed. The licensee's 6.17 Supervision of Staff - Delegated Services policy dated June 30, 2021, indicated direct supervision of staff who performed delegated task must be provided within 30 calendar days. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the	01470		

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01470	Continued From page 24 maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology	01470		

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01470	Continued From page 25 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 two of two unlicensed personnel ((ULP)-A, ULP-B) received orientation to the assisted living facility licensing requirements and regulations. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-A and ULP-B were hired on August 28, 2023, and July 21, 2023, respectively. ULP-A and ULP-B's records lacked evidence they were orientated to principles of person-centered planning and service delivery. ULP-A's My Transcript dated September 18, 2023, at 8:40 a.m., lacked evidence ULP-A had completed person-centered orientation. ULP-B's My Transcript dated September 18, 2023, at 8:37 a.m., lacked evidence ULP-A had completed person-centered orientation.	01470		

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RESIDENTIAL CARE NINE MILE CRK	7421 13TH AVENUE SOUTH RICHFIELD, MN 55423

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01470	Continued From page 26 On October 2, 2023, at 1:30 p.m., licensed assisted living director (LALD)-C stated the licensee used an electronic training program and all completed employee training would be documented in the program. LALD-C stated the licensee believed the training program automatically assigned all the required trainings. LALD-C signed into the training system and noted the person-centered training class was not assigned and would have to be assigned for each employee. The licensee's 5.01 Orientation of Staff and Supervisors & Content policy dated June 30, 2021, indicated each staff would be orientated to principles of person-centered planning and service delivery and evidence of the completion of the orientation would be maintained in each employee's training record. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
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;	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37272	A. BUILDING: _____ B. WING _____	10/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RESIDENTIAL CARE NINE MILE CRK	7421 13TH AVENUE SOUTH RICHFIELD, MN 55423

(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
01730	Continued From page 27 (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: Based on interview and record review, the licensee failed to develop an individualized medication management record with the 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 28 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 was admitted on October 8, 2020, with diagnoses which included schizoaffective disorder and Diabetes Meletus II. R2's Assisted Living License Resource Manual - 6.09 dated September 28, 2023, was identified by licensed assisted living director (LALD)-C as R2's current service plan. R2's service plan indicated R2 received the service of medication administration. R2's Medication Assessment for Safety in Self Administration dated September 28, 2023, indicated R2 preferred the licensee manage their medications. R2's current individualized medication management record lacked description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with manufacturer's directions. On October 3, 2023, at 1:45 p.m. LALD-C and clinical nurse supervisor (CNS)-D stated the medication management record for each resident would not include identification of the description of storage of medications. The licensee's 7.03 Medications Management Individualized Plan policy dated June 30, 2023, indicated a description of storage of medication	01730		

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01730	Continued From page 29 and specific instructions related to administration of medications would be included each resident's individualized medications management record. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01730		
01820 SS=F	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure written or electronically recorded prescriptions were obtained 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2 was admitted on October 8, 2020, with diagnoses which included schizoaffective disorder and Diabetes Meletus II.	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01820	Continued From page 30 R2's Assisted Living License Resource Manual - 6.09 dated September 28, 2023, was identified by licensed assisted living director (LALD)-C as R2's current service plan. R2's service plan indicated R2 received the service of medication administration. R2's Medication Assessment for Safety in Self Administration dated September 28, 2023, indicated R2 preferred the licensee manage their medications. R2's untitled document from Bluestone Physician Services dated October 10, 2022, was identified by clinical nurse supervisor (CNS)-D as the most current signed provider orders. The orders included the following medications not included or different from the medications managed by the licensee: - amlodipine 10 milligram (mg) tablet QD (once daily); and - metoprolol tartrate 100 mg tablet, take 2 tablets twice daily. R2's Medication Administration Record (MAR) dated October 2023, included the following medications the licensee administered to R2 and did not have an active prescription for or were different from the above signed orders: - amlodipine 5 mg tablet once daily; - carvedilol tablet 25 mg tablet twice daily; - chlorthalidone 25 mg tablet take 0.5 tablet (12.5 mg) daily; - melatonin 3 mg tablet at bedtime; - olanzapine 5 mg tablet at bedtime; and - omeprazole 20 mg capsule once daily. On October 3, 2023, at 1:45 p.m., CNS-D stated the licensee believed the pharmacy would have all signed prescriptions for all medications R2 and	01820		

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01820	Continued From page 31 other residents receiving medication management were prescribed but the licensee did not have a copy of the current signed orders for the surveyor to review. CNS-D stated they would email a copy of the current orders once they arrived from the pharmacy. On October 3, 2023, at 2:00 p.m., CNS-D provided R2's Physician's Order Report signed by R2's provider on October 3, 2023. CNS-D obtained current orders on the same day surveyor requested signed orders as the licensee did not have signed prescriptions as required for all medications managed by the licensee. The licensee's 7.20 Medications & Treatment Orders policy dated June 30, 2023, indicated licensee would have current, written prescriber's orders in each resident's record for all medications provided to each resident. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were stored securely for one of one resident (R2)	01880		

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01880	Continued From page 32 with medication management services. 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: R2 was admitted on October 8, 2020, with diagnoses which included schizoaffective disorder and Diabetes Meletus II. R2's Assisted Living License Resource Manual - 6.09 dated September 28, 2023, was identified by licensed assisted living director (LALD)-C as R2's current service plan. R2's service plan indicated R2 received the service of medication administration. R2's Medication Assessment for Safety in Self Administration dated September 28, 2023, indicated R2 preferred the licensee manage their medications. On October 2, 2023, at approximately 10:00 a.m. during the entrance conference, LALD-C stated the licensee manages medications for all residents. LALD-C stated all medications are secured in a closet which one staff member has a key for during each shift. LALD-C stated no medications would be accessible by residents. On October 3, 2023, at 10:30 a.m., surveyor noted a small white refrigerator in the corner of	01880		

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01880	Continued From page 33 the common living area on the main level of the facility. On the front of the refrigerator a sign read, "Medications Only." The refrigerator was not secured, and no security device was noted on it. The surveyor opened the refrigerator and inside were medications for R2 including a Novolog Flex Pen (insulin) box with two (2) unused insulin pens and a Lantus (insulin) box with four (4) unused insulin pens. Over the course of the survey from October 2, 2023, to October 4, 2023, the surveyor observed residents used the common area with the unsecured refrigerator with no staff present in the area. Residents would have access to the unsecured medications in the refrigerator. On October 3, 2023, at 1:45 p.m., clinical nurse supervisor (CNS)-D and LALD-C stated the medications in the refrigerator should be secured. LALD-C stated it was something the licensee was thinking about when the medications were placed in the refrigerator. CNS-D stated once surveyor pointed out the unsecured medications licensee recognized the need to secure the medications. LALD-D stated refrigerator would need a security device installed immediately to secure medications. The licensee's 7.11 Mediation Storage policy dated June 30, 2021, read, "medications will be kept securely locked," when licensee managed medications for residents. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		

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01940	Continued From page 34	01940		
01940 SS=F	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a service plan included all required content for one of one resident (R2) with treatment services.	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01940	Continued From page 35 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2 was admitted on October 8, 2020, with diagnoses which included schizoaffective disorder and Diabetes Meletus II. R2's Assisted Living License Resource Manual - 6.09 dated September 28, 2023, was identified by licensed assisted living director (LALD)-C as R2's current service plan. R2's service plan included an empty checkmark box next to, "Treatments/Therapies." The service plan lacked identification R2 received a treatment or therapy service. R2's Individualized Treatment or Therapy Management Plan form signed by clinical nurse supervisor (CNS)-D on September 28, 2023, indicated R2 received the treatment of blood glucose monitoring. On October 2, 2023, at approximately 10:00 a.m. during the entrance conference, LALD-C stated all service plans are maintained and updated by the registered nurse (RN) or CNS-D. On October 3, 2023, at 8:40 a.m., surveyor observed ULP-B perform the delegated task of blood glucose testing on R2. ULP-B obtained R2's blood glucose and recorded the results in	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01940	Continued From page 36 R2's record. On October 3, 2023, at 1:45 p.m., CNS-D stated they were responsible for updates to each resident's service plan based on the RN's assessment. CNS-D stated R2's service plan should identify R2 received treatment services for blood glucose monitoring. CNS-D stated the service plan would need to be updated and authenticated with all services the licensee provided to R2. The licensee's 7.05 Treatment & Therapy Management Plan policy dated June 30, 2021, indicated treatment and therapy services would be included in the service plan for each resident who required the service. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01940		

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

Type: Full
Date: *10/03/23*
Time: 11:30:44
Report: 1029231254

Food and Beverage Establishment Inspection Report

Location:

Residential Care Nine Mile Crk
7421 13th Avenue South
Richfield, MN55423
Hennepin County, 27

Establishment Info:

ID #: 0038791
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 6129782238
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 at the specific request of the regulatory authority.

No employee illness log. Instructed representative to maintain employee illness log to document foodborne illness. Illness log emailed to establishment following the inspection.

Comply By: 10/03/23

3-500B Microbial Control: hot and cold holding

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

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

TCS items in refrigerator measured in the danger zone. Items discarded and refrigerator adjusted by representative. Representative was instructed to not put TCS foods into the refrigerator until safe temperatures are verified.

Comply By: 10/03/23

4-500 Equipment Maintenance and Operation

4-501.114A ***** Priority 1 *****

MN Rule 4626.0805A Use the approved sanitizer according to the rule and the EPA approved manufacturer's label.

Establishment uses sanitizer spray for kitchen counters and surfaces without an identifiable EPA registration number. Instructed representative to verify product is EPA registered for food contact surfaces or obtain EPA approved sanitizer.

Comply By: 10/03/23

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 washing and rinsing in sink but not sanitizing prior to air drying. Establishment has dishwasher with sanitize setting. Instructed representative to use chemical sanitizer or sanitize setting on dishwasher.

Comply By: 10/03/23

2-100 Supervision

2-102.11ABCQ ***** Priority 2 *****

MN Rule 4626.0030ABCQ The person in charge must be able to demonstrate their knowledge to the inspector of the following factors associated with employee health and the transmission of foodborne disease: symptoms of illness frequently associated with foodborne diseases; food worker illness reporting requirements; and medical conditions requiring exclusion of an employee from work or the restriction of their work duties.

The person in charge was unable to provide a demonstration on knowledge regarding foodborne illness. Instructed representative to ensure that during at least one establishment representative with food safety knowledge is present.

Comply By: 10/03/23

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.

TCS ready to eat items identified without datemarking. Instructed representative to provide date markings on the items that require it. Datemaking information emailed to establishment following the inspection.

Comply By: 10/03/23

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.

No min/max thermometer or temperature stickers to test high water temperature in dishwasher. Instructed representative to provide a way to test high water temperature in dishwasher.

Comply By: 10/13/23

2-100 Supervision

2-102.12AMN

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

No CFPM. Instructed representative to employ a CFPM. CFPM attainment information emailed to representative following the inspection.

Comply By: 10/13/23

4-100 Equipment Construction Materials

4-101.19

MN Rule 4626.0495 Remove non-food-contact surfaces of equipment that are exposed to splash, spillage, or other food soiling, or that require frequent cleaning, that are not constructed of a corrosion-resistant, non-absorbent, and smooth material.

Wood utensil holder used in drying rack. Instructed representative to discontinue. Wood holding removed during inspection.

Comply By: 10/03/23

4-900 Protecting Clean Items

4-901.11

MN Rule 4626.0935 Allow equipment and utensils to air-dry after cleaning and sanitizing; only use cloths that are clean and dry for polishing utensils that have been air dried.

Representative observed drying plates with paper towels after washing. Corrected during inspection. Instructed representative to sanitize by chemical or heat then let air dry.

Comply By: 10/03/23

6-300 Physical Facility Numbers and Capacities

6-301.14A

MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands

No handwashing reminder sign at handwashing sink. Instructed operator to post sign or poster.

Comply By: 10/03/23

Food and Equipment Temperatures

Process/Item: sliced turkey
Temperature: 43 Degrees Fahrenheit - Location: refrigerator
Violation Issued: Yes

Process/Item: sliced turkey
Temperature: 44 Degrees Fahrenheit - Location: refrigerator
Violation Issued: Yes

Process/Item: sliced cheese
Temperature: 48 Degrees Fahrenheit - Location: refrigerator
Violation Issued: Yes

Process/Item: milk
Temperature: 44 Degrees Fahrenheit - Location: refrigerator (2-3 days)
Violation Issued: Yes

Process/Item: milk
Temperature: 45 Degrees Fahrenheit - Location: refrigerator (2-3 days)
Violation Issued: Yes

Process/Item: milk
Temperature: 45 Degrees Fahrenheit - Location: refrigerator (2-3 days)
Violation Issued: Yes

Process/Item: mozzarella
Temperature: 50 Degrees Fahrenheit - Location: refrigerator
Violation Issued: Yes

Process/Item: bratwurst
Temperature: 45 Degrees Fahrenheit - Location: refrigerator
Violation Issued: Yes

Process/Item: shell eggs
Temperature: 47 Degrees Fahrenheit - Location: refrigerator
Violation Issued: Yes

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

Conducted inspection with Sadik Abdi, LALD, and other food service associates. All identified issues were discussed with Sadik throughout the inspection. Topics discussed with Sadik included employee illness reporting and exclusion procedures, vomit/fecal matter cleanup, highly susceptible populations, sanitizing, date marking effectively, common contagious foodborne illness pathogens (e.g., salmonella, shigella, Shiga toxin-producing E. coli, hepatitis A virus, and norovirus), hygienic practices (e.g., handwashing), and general food safety practices (e.g., holding temperatures at or below 41°F and 135°F or above for TCS foods).

The kitchen was non-commercial in nature and had tile flooring, laminate counter tops, tile backsplash, wood/composite wood cabinetry and drawers with laminate coverings, and a painted ceiling with minor texture. The kitchen was in great condition and clean to sight and touch.

Inspection findings conveyed to Brandon W. Mueller, BSN, RN, PHN, Nurse Evaluator-Health Regulation Division.

Type: Full
Date: *10/03/23*
Time: 11:30:44
Report: 1029231254
Residential Care Nine Mile Crk

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 1029231254 of 10/03/23.

Certified Food Protection Manager: Vacant (Mohamedamin Abdi)

Certification Number: NA Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed: _____
Sakik Abdi
LALD

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

Report #: 1029231254

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

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

No. of RF/PHI Categories Out	7	**Date**	10/03/23
No. of Repeat RF/PHI Categories Out	0	**Time In**	11:30:44
Legal Authority MN Rules Chapter 4626		**Time Out**	

Residential Care Nine Mile Crk	**Address** 7421 13th Avenue South	**City/State** Richfield, MN	**Zip Code** 55423	**Telephone** 6129782238
License/Permit # 0038791	**Permit Holder**	**Purpose of Inspection** Full	**Est Type**	**Risk Category**

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

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

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

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

GOOD RETAIL PRACTICES

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

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

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

			COS	R
		Proper Use of Utensils		
43		In-use utensils: properly stored		
44	X	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		Non-food contact surfaces clean		
		Physical Facilities		
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) **Date:** 10/03/23

Inspector (Signature) Trevor L McClimint