DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

AMENDED

Electronically Delivered

April 25, 2024

Licensee
HealthPoint HWS @ 93rd
351 93rd Avenue Ne
Blaine, MN 55434

RE: Project Number(s) SL34173016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 11, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

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

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

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

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

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If you have any questions, please contact me.

Sincerely,

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

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	34173	A. BUILDING: _____ B. WING _____	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTHPOINT HWS @ 93RD	351 93RD AVENUE NE BLAINE, MN 55434

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0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL#34173016 On April 8, 2024, through April 11, 2024, 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; 3 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 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated April 9, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and	0 510		

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0 510	Continued From page 2 nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program that complies with accepted health care, medical and nursing standards for infection control. The deficient practice had the potential to affect residents, employees, 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On April 8, 2024, at approximately 11:15 a.m., unlicensed personnel (ULP)-C failed to perform hand hygiene prior to R2's medication administration. On April 8, 2024, at approximately 11:25 a.m., ULP-C acknowledged not washing hands prior to	0 510		

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0 510	Continued From page 3 R2's medication administration and did not answer why when asked by surveyor. On April 8, 2024, at approximately 11:30 a.m., assisted living director in residency/clinical nursing supervisor (ALDIR/CNS)-A stated all staff should be performing hand hygiene prior to medication administration on residents. The licensee's undated 8.09 Infection Control policy indicated staff would perform hand hygiene prior to caring for residents with medication administration. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
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 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	0 580		

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0 580	Continued From page 4 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On April 8, 2024, at approximately 10:20 a.m., during the entrance conference, assisted living director in residency/clinical nurse supervisor (ALDIR/CNS)-A stated the licensee was not aware of the QMP requirement and one had not been developed or implemented. ALDIR/CNS-A stated the licensee provided ongoing improvement as areas were identified, but no meeting minutes, tracking, or specific improvement projects would be documented. The licensee's 2.31 undated Quality Management Project policy indicated a QMP would be implemented, and documentation would be provided upon request. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 580		

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0 630	Continued From page 5	0 630		
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop an individual abuse prevention plan (IAPP) with the required content for one resident (R2). This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client'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 clients). The findings include: R2 was admitted on October 31, 2022. R2's IAPP dated April 8, 2024, indicated R3 was at risk to be abused and did not include: - the resident's susceptibility to abuse by another	0 630		

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0 630	Continued From page 6 individual, including other vulnerable adults; and - statements of specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. On April 8, 2024, at 2:30 p.m., registered nurse (RN)-B confirmed R2's IAPP did not address the above noted areas of risk or include statements of specific measures to be taken to minimize risks. RN-B stated was not aware of the required contents of the IAPP and the IAPP was completed based on the questions shown in the electronic health record (RTasks). The licensee's undated 2.44 Vulnerable Adult Maltreatment - Prevention & Reporting policy indicated the licensee developed individualized vulnerable adult abuse prevention plans to identify risks and develop measures to minimize maltreatment based on identified information. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
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	0 650		

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0 650	Continued From page 7 evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document a completed TB baseline screening at time of hire for one of one employee (unlicensed personnel (ULP)-C. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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-C was hired on January 9, 2023. ULP-C's employee record lacked documentation of a completed TB baseline screening at time of ULP-C's hire. On April 8, 2024, at 12:10 p.m., assisted living director in residency/clinical nurse supervisor	0 650		

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0 650	Continued From page 8 (ALDIR/CNS)-A stated ULP-C received TB baseline screening at time of hire but has no record of a completed TB screening for ULP-C at time of hire. The licensee's undated 8.16 Tuberculosis Screening policy indicated baseline screening was completed at time of hire for all direct care providers and testing results will be kept in each employee medical file. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and the CDC guidelines, indicated a TB infection control program should include a facility TB risk assessment. The guidelines also indicated an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by	0 660		

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0 660	Continued From page 9 the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention and control program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) when the licensee failed to complete a facility TB risk assessment. 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 April 8, 2024, at approximately 10:30 a.m. during the entrance conference, assisted living director in residency/clinical nurse supervisor (ALDIR/CNS)-A acknowledged the licensee had not completed a facility TB risk assessment.	0 660		

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0 660	Continued From page 10 ALDIR/CNS-A stated the licensee was not aware of the facility TB risk assessment and one was not completed. The licensee's undated 8.16 Tuberculosis Screening policy indicated a facility TB risk assessment would be completed annually. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and the CDC guidelines, indicated a TB infection control program should include a facility TB risk assessment. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and	0 680		

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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
0 680	Continued From page 11 disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have a written emergency preparedness plan with all the required content and failed to post an emergency preparedness plan prominently. This had the potential to impact all residents, staff, and visitors to the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 April 8, 2024, at approximately 10:45 a.m. during a tour of the facility, the surveyor did not observe any signage or information regarding the licensee's emergency preparedness plan posted in a prominent location. On April 8, 2024, at approximately 11:00 a.m., the surveyor requested the licensee's emergency preparedness plan. Assisted living director in	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34173	A. BUILDING: _____ B. WING _____	04/11/2024

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0 680	Continued From page 12 residency/clinical nurse supervisor (ALDIR/CNS)-A stated an emergency preparedness plan for the licensee had not been created and was not aware of all the requirements of Appendix Z. The licensee's undated 9.01 Emergency Preparedness Plan - Appendix Z Compliance policy indicated the licensee would create and post an emergency preparedness plan with all required content related to Appendix Z. No additional information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
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	01370		

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01370	Continued From page 13 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 (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 competencies were completed and documented for one of one employee (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-C had a hire date of January 9, 2023.	01370		

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01370	Continued From page 14 ULP-C's training record lacked evidence the registered nurse (RN) completed competencies for: -documentation requirements for all services provided; -reports of changes in the resident's condition to the supervisor designated by the facility; -basic infection control, including blood-borne pathogens; -maintenance of a clean and safe environment; -appropriate and safe techniques in personal hygiene and grooming, including hair care and bathing, care of teeth, gums, and oral prosthetic devices, care, and use of hearing aids; and dressing and assisting with toileting; -training on the prevention of falls; -standby assistance techniques and how to perform them; -medication, exercise, and treatment reminders; -basic nutrition, meal preparation, food safety, and assistance with eating; -preparation of modified diets as ordered by a licensed health professional; -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; -awareness of confidentiality and privacy; -understanding appropriate boundaries between staff and residents and the resident's family; -procedures to use in handling various emergency situations; and -awareness of commonly used health technology equipment and assistive devices. On April 8, 2024, at 1:30 p.m., RN-B stated ULP-C had record of competencies on delegated nursing tasks, but competencies in the these required 15 areas were not completed and the missing training would not have been provided to	01370		

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01370	Continued From page 15 any ULPs already working for licensee. RN-B also stated was not aware of all these competencies needed to be completed. The licensee's undated 5.02 Competency Training Evaluations policy indicated all ULPs would have all required competency training conducted and documented in each respected ULP's employee record. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
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 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	01470		

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01470	Continued From page 16 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 that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure orientation with all the required content was completed for one of one employee (unlicensed personnel (ULP)-C).	01470		

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01470	Continued From page 17 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-C had a hire date of January 9, 2023. ULP-C's employee record lacked documentation of a completed orientation to assisted living regulations to include all the required content below: -Overview of Assisted Living statutes; -Review of provider's policies and procedures; -Handling emergencies and using emergency services; -Reporting maltreatment of vulnerable adults or minors; -Assisted Living bill of rights; and -Handing of resident complaints, reporting of complaints, where to report. -Consumer advocacy services -Review of types of Assisted Living services the employee will provide and provider's scope of license; -Principles of person-centered planning/service delivery; -Orientation to each specific resident and services provided; and -Dementia training required for all direct care staff. On March 8, 2024, at approximately 10:20 a.m., during the entrance conference, assisted living director in residency/clinical nurse supervisor	01470		

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01470	Continued From page 18 (ALDIR/CNS)-A stated that registered nurse (RN)-B was identified as the RN who was responsible for all clinical requirements for the licensee. On April 8, 2024, at 1:30 p.m., RN-B stated ULP-C did not complete the required training and RN-B was unaware of all the required orientation content. RN-B also stated would ensure all the required training would be assigned to all employees during orientation. The licensee's 4.18 Employee General Orientation policy dated August 1, 2021, indicated the required orientation content would be provided to the licensee's new employees. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing	01500		

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01500	Continued From page 19 techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication	01500		

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01500	Continued From page 20 access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an employee received at least eight hours of annual training for each 12 months of employment for one of one employee (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-C had a hire date of January 9, 2023. ULP-C's training record lacked evidence of the eight hours annual training requirement to include all the required content below: -Infection control techniques; and -Dementia Training: Met two (2) hours annually. On April 8, 2024, at 1:30 p.m., registered nurse (RN)-B stated ULP-C did not complete all the required annual training and was unaware of all the required annual training content. RN-B also stated would ensure all the required annual training for employees would be completed. The licensee's 4.18 Employee General Orientation policy dated August 1, 2021, indicated the required trainings would be completed annually.	01500		

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01500	Continued From page 21 No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident monitoring and	01620		

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01620	Continued From page 22 reassessment no more than 90 days after the previous assessment 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 the residents). The findings include: R2 was admitted on October 31, 2022. R2's 90-day Assessment was completed on November 21, 2023, with the next assessment due within 90 days or by February 19, 2024. R2's record included a subsequent 90-day assessment on April 8, 2024, which is 49 days past due. On April 8, 2024, at 2:45 p.m., registered nurse (RN)-B acknowledged R2's 90-day assessment was due by February 19, 2024, and was not performed. RN-B stated weekly assessments were performed on residents but not documented. The licensee's undated 6.01 Assessments, Reviews & Monitoring policy indicated licensee would complete ongoing resident assessment not to exceed 90 calendar days from the resident's last date of the assessment. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		

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01880 SS=D	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 maintain a temperature log to ensure appropriate storage of refrigerated medications for one of three residents (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On April 8, 2024, at approximately 10:55 a.m., during a tour of the facility, the surveyor observed a locked medication refrigerator inside the living room with a temperature log that lacked twelve temperature tracking dates (3,4,5,6,8,9,10,11,12,13,14, and 27) for the month of March 2024. The medications Humalog Kwik Pen Insulin 100 unit/milliliter (ml) (inject 3 units subcutaneously three times a day before meals for type 2 diabetes mellitus) and Lantus Solostar U-100 Insulin 100 unit/ml (inject 3 units subcutaneously before bedtime for type 2	01880		

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01880	Continued From page 24 diabetes mellitus) was observed stored in the refrigerator. Manufacturer storage directions for Lantus Solostar U-100 Insulin 100 units/ml dated August 2022, indicated protect from light, store in the refrigerator at 36°F [degrees Fahrenheit] to 46°F, and do not freeze. Manufacturer storage directions for Humalog Kwik Pen Insulin 100 units/ml dated July 2023, indicated protect from light, store in the refrigerator at 36°F to 46°F, and do not freeze. On April 8, 2024, at 12:10 p.m., assisted living director in residency/clinical nurse supervisor (ALDIR/CNS)-A acknowledged the licensee's medication refrigerator that stored R4's medications lacked temperature tracking for twelve days in March 2024, and was unsure why. The licensee's undated 7.11 Medication Storage policy indicated medications requiring refrigeration will be stored consistent with manufacturer's recommendations. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		

Minnesota Department of Health
Division of Environmental Health, FPLS
PO Box 64975
Saint Paul, 55164-0975
651-201-4500

Type: Full
Date: *04/09/24*
Time: 11:02:22
Report: 1023241081

Food and Beverage Establishment Inspection Report

Location:
Healthpoint Hws @ 93rd
351 93rd Avenue Ne
Blaine, MN55434
Anoka County, 02

Establishment Info:
ID #: 0039061
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6122728118
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.

4-300 Equipment Numbers and Capacities

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

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

OPERATOR STATED NO THERMOMETER AVAILABLE. ACQUIRE AND USE THIS DEVICE TO ENSURE SAFE FOOD TEMPERATURES.

Comply By: 04/09/24

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.

OPERATOR STATED NO IRREVERSIBLE DEVICE AVAILABLE. ACQUIRE AND USE THIS DEVICE TO ENSURE PATHOGEN DESTRUCTION.

Comply By: 04/09/24

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.

OPERATOR STATED NO TEST STRIPS AVAILABLE. ACQUIRE AND USE TO ENSURE PATHOGEN DESTRUCTION.

Comply By: 04/09/24

Type: Full
Date: *04/09/24*
Time: 11:02:22
Report: 1023241081
Healthpoint Hws @ 93rd

Food and Beverage Establishment Inspection Report

2-100 Supervision

2-102.12AMN

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

TO GET A CFPM YOU MUST TAKE EIGHT HOUR MANAGER CLASS, PASS TEST, AND MAIL APPLICATION IN TO MDH. YOU CAN SIGN UP FOR FOOD MANAGER COURSES AND FIND AN APPLICATION HERE:
https://fmctraining.web.health.state.mn.us/search/index.cfm

Comply By: 04/09/24

4-500 Equipment Maintenance and Operation

4-501.11AB

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

MICROWAVE HANDLE BROKEN AND INTERIOR DAMAGED. REPAIR/REPLACE MICROWAVE.

Comply By: 04/09/24

Surface and Equipment Sanitizers

Hot Water: = at Degrees Fahrenheit
Location: DISH WASHER
Violation Issued: No

Quaternary Ammonia: = at Degrees Fahrenheit
Location:
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Hold/BRATS
Temperature: 41 Degrees Fahrenheit - Location: REACH IN COOLER
Violation Issued: No

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

THIS INSPECTION WAS CONDUCTED IN CONJUNCTION WITH MDH HEALTH REGULATORY DIVISION (HRD) SURVEY. INSPECTION CONDUCTED IN PRESENCE OF THE PERSON IN CHARGE.

THIS FACILITY DOES NOT HAVE ALL COMMERCIAL GRADE ANSI EQUIPMENT. ALL FOOD MUST BE SERVED THE SAME DAY IT IS PREPARED, AND LEFTOVERS CAN NEVER BE SAVED. FOOD SERVICE IS PROVIDED BY FACILITY STAFF.

FOOD SERVICE AREA FLOORS, WALLS, CEILINGS, COUNTERTOPS, AND FINISH MATERIALS MUST BE NON-ABSORBANT, SMOOTH, DURABLE, AND EASILY CLEANABLE. CEILINGS CANNOT HAVE POPCORN TEXTURE. CABINETS CANNOT HAVE HOLLOW BASES. EXPOSED WOOD IS NOT APPROVED FOR FOOD SERVICE AREAS. WOOD IS NOT AN APPROVED FOOD CONTACT SURFACE.

Type: Full
Date: *04/09/24*
Time: 11:02:22
Report: 1023241081
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THESE TOPICS WERE DISCUSSED WITH THE PERSON IN CHARGE:
- EMPLOYEE ILLNESS EXCLUSION
- HAND WASHING PROCEDURE
- NO BARE HAND CONTACT WITH RTE FOOD
- VOMIT CLEAN UP PROCEDURE
- FULLY COOKING FOOD FOR HIGH RISK POPULATIONS
- ANSI 184 DISH WASHER REQUIRED

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 1023241081 of 04/09/24.

Certified Food Protection Manager: HAMZA ISMAIL

Certification Number: SERVESAF Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed: _____
GAMADE BUTTA
PERSON IN CHARGE

Signed: Gregory T Nelson
Gregory T. Nelson
Public Health Sanitarian
Freeman Building
651-201-4259
greg.nelson@state.mn.us