Electronically Delivered

February 26, 2024

Licensee
3mb Health Services LLC
1702 13th Avenue West
Shakopee, MN 55379

RE: Project Number(s) SL39663015

Dear Licensee:

This is your **official notice** that you have been **granted your assisted living facility license.** Your license effective and expiration dates remain the same as on your provisional license. Your updated status will be listed on the license certificate at renewal and **this letter serves as proof** in the meantime. If you have not received a letter from us with information regarding renewing your license within 60 days prior to your expiration date, please contact us at (651) 201-5273 or by email at Health.assistedliving@state.mn.us.

The Minnesota Department of Health completed an initial survey on January 31, 2024, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

The Department of Health 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. The Department of Health documents state correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Home Care 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 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
Per 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 residents/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

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

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

To submit a reconsideration request, please visit:
https://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.

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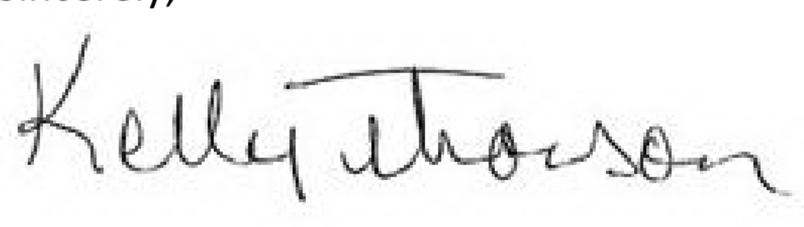
If you have any questions, please contact me.

Sincerely,



Kelly Thorson, Supervisor
State Evaluation Team
Email: kelly.thorson@state.mn.us
Telephone: 320-223-7336 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
	39663	A. BUILDING: _____ B. WING _____	01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
3MB HEALTH SERVICES LLC	1702 13TH AVENUE WEST SHAKOPEE, MN 55379

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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: SL39663015 On January 29, 2024, through January 31, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were three residents; all 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 document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated January 31, 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		
0 630 SS=D	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;	0 630		

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0 630	Continued From page 2 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 ensure an individual abuse prevention plan (IAPP) was developed to include the required content for one of two residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1 was admitted on August 25, 2023. R1's diagnoses included congestive heart failure, obstructive sleep apnea, and benign prostatic hyperplasia. R1's record lacked an individual abuse prevention plan which reviewed the resident's risk of abusing other vulnerable adults. On January 30, 2024, at 10:00 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the IAPP for R1 does not contain the risk to abuse others and must have been missed when adding the information to the assessment.	0 630		

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0 630	Continued From page 3 The licensee's undated Abuse Prevention Plan policy indicated all residents admitted to the facility will be assessed for their susceptibility to abuse by other individuals, including other vulnerable adults and their risk of abusing other vulnerable adults. The facility will develop a statement of the specific measures that will be taken to minimize the risk of abuse to that person and other vulnerable adults. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not	0 680		

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0 680	Continued From page 4 received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to develop an all-hazards risk assessment emergency preparedness program and plan to include Appendix Z required elements. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: The licensee's undated emergency preparedness plan (EPP), lacked the required content: - a process for emergency preparedness (EP) collaboration with state and local EP officials/organizations; - the development of policies/procedures to address: - procedures for tracking staff and residents; - evacuation plan; - the medical record documentation system to preserve resident information; - use of volunteers; and - roles under a wavier declared by secretary.	0 680		

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0 680	Continued From page 5 - a communication plan that included: - names and contact information for staff, entities providing services, resident physicians, other facilities, and volunteers; - contact information for federal, state, tribal, local EP staff, state licensing and certification agency, or the ombudsman for long term care; - primary and alternative means for communicating with facility staff, or federal, state, regional and local emergency management agencies; - methods for sharing medical documentation for residents under the facility's care, as necessary, with other health care providers to maintain continuity of care; - means to provide information about the facility's occupancy, needs, and its ability to provide assistance to the authority having jurisdiction, the incident command center, or a designee; - method for sharing information from the emergency plan with residents and their families/representatives; and - a quarterly review of missing resident policy. On January 30, 2024, at 1:45 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A agreed their emergency preparedness plan was missing some of the required content. LALD/CNS-A stated they had hired someone to create the emergency plan for them, so they thought it contained all the information needed. The licensee's undated Communication Plan for Emergency Preparedness policy, indicated as part of the facility's overall emergency disaster plan, the facility will establish and maintain a communication plan that complies with Federal, State, and local laws.	0 680		

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0 680	Continued From page 6 Per Assisted Living Facilities: Minnesota Rules Chapter 4659, 4659.0110, Subp. 4. Review missing resident plan. The assisted living director and clinical nurse supervisor must review the missing person plan at least quarterly and document any changes to the plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
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 proper actions to take in the event of a fire to include movement, evacuation, or relocation. The	0 810		

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0 810	Continued From page 7 training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop the fire safety and evacuation plan with required content, make the plan readily available, provide required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On January 30, 2024, at 2:30 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A, provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee FSEP dated December 25, 2024,	0 810		

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0 810	Continued From page 8 failed to include the following: The location and number of resident sleeping rooms was not identified on the FSEP floor plan posted in the facility. The FSEP floor plan is required to include the location and number of resident rooms in order to be used by occupants for navigation and communication in the event of a fire or similar emergency. The FSEP did not identify specific fire protection actions for residents evident by not providing written procedures for residents in the event of a fire or similar emergency in the FSEP. During an interview on January 30, 2024, at 2:45 p.m., LALD/CNS-A, stated the resident sleeping room numbers were not included on the FSEP floor plan and the resident procedures required during a fire or similar emergency were not included in writing in the FSEP. TRAINING Record review indicated the licensee failed to provided evacuation training to residents at least once per year as evident by not providing documentation the training was offered to the residents. Record review indicated the licensee failed to provide training to employees on the FSEP upon hire and/or at least twice per year as evident by not providing documentation the employees received FSEP training for the facility. During an interview on January 30, 2024, at 2:50 p.m., LALD/CNS-A, stated the documentation for training of employees and offering of training for residents was not available.	0 810		

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0 810	Continued From page 9 DRILLS Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month as evident by providing documentation drills were completed July 31, 2023, for night shift, July 31, 2023, for a.m. shift and September 13, 2023, for a.m. shift, no other drill documentation was provided. During an interview on January 30, 2024, at 2:55 p.m., LALD/CNS-A, stated all available documentation for drills for the past year were provided which includes 2 in July and 1 in September. 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	0 950		

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0 950	Continued From page 10 Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to offer the resident the opportunity to identify a designated representative in writing with the required statutory language for 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: R1 began receiving assisted living services from the licensee on August 25, 2023. R1's Resident Contract for Assisted Living was signed on August 25, 2023.	0 950		

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0 950	Continued From page 11 R1's Resident Contract for Assisted Living did not include an area to designate a representative and lacked the verbatim "right to designate a representative for certain purposes" notice. On January 29, 2024, at 2:15 p.m., licensed assisted living director/ clinical nurse supervisor (LALD/CNS)-A stated the designated representative was missing due to not being aware of the requirement. The licensee's undated Assisted Living Contracts policy read, "Clients have the right to designate a representative before they sign a contract. The facility must offer the resident the opportunity to identify a representative in writing on the contract and must provide the following notice on a document separate from the contract: a. Right to designate a representative for certain purposes: "You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact") or health care power of attorney ("health care agent"), if applicable. b. The contract must contain a page or space for the name and contact information of the Designated Representative and a box the resident must initial if they decline to name a representative. The resident has the right to add, remove, or change the name and contact information of the Designated Representative at any time." No further information provided.	0 950		

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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
0 950	Continued From page 12 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 950		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to ensure medication administration was documented accurately for one of one resident (R1) who received medication management. 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).	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39663	A. BUILDING: _____ B. WING _____	01/31/2024

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3MB HEALTH SERVICES LLC	1702 13TH AVENUE WEST SHAKOPEE, MN 55379

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01760	Continued From page 13 The findings include: R1 began receiving assisted living services from the licensee on August 25, 2023. R1's diagnoses included congestive heart failure, obstructive sleep apnea, and benign prostatic hyperplasia. R1's Service Plan dated August 31, 2023, indicated R1 received services for medication management, treatment management, continuous positive airway pressure (CPAP) therapy, activities of daily living (ADL) assistance for dressing, grooming, bathing, and transferring, housekeeping, and laundry. R1's electronic medical administration record (EMAR) dated January 1, 2024, through January 31, 2024, included: -Jardiance (diabetes) 10 milligrams (mg) one tablet by mouth once daily -Sennosides docusate sodium (constipation) 8.6 - 50mg give two tabs by mouth twice daily -pantoprazole sodium (acid reflux) 40 mg one tab by mouth once before meals -aspirin (heart health) 81 mg one tablet by mouth once daily -duloxetine hydrochloride (depression) 60 mg one capsule by mouth once daily -furosemide (heart failure fluid retention) 20 mg one tablet by mouth once daily -metoprolol succinate (heart disease) 50 mg one tablet by mouth once daily -tamsulosin hydrochloride (benign prostatic hyperplasia) 0.4 mg one capsule by mouth once daily -atorvastatin (cholesterol) 40 mg one tablet by mouth at bedtime	01760		

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01760	Continued From page 14 -trazadone hydrochloride (sleep) 50 mg one tablet by mouth at bedtime -Trulicity 1.5 mg/0.5 milliliter (ml) inject 1.5 mg subcutaneous once weekly -quetiapine 50 mg one tablet by mouth at bedtime R1's prescriber's order dated September 18, 2023, included all the above medications. R1's EMAR dated January 1, 2024, through January 31, 2024, included boxes beside each medication for each day of the month, the box included the initials of the staff member that administered the medication or had a red circle that indicated the medication was declined. R1's January EMAR documentation included empty boxes for several medications on January 7, 13, 14, and 21. On January 30, 2024, at 1:45 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated they expected the staff to document each day for all medications listed on the EMAR and the staff must have missed documentation for these medications on the days that were blank. The licensee's undated, Documentation of Medication Administration policy indicated each medication administered by the assisted living facility staff will be documented in the resident's record. The documentation will include the signature and title of the person who administered the medication. Documentation will include the medication name, dosage, date and time administered, and method and route of administration. Staff will document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39663	A. BUILDING: _____ B. WING _____	01/31/2024

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01760	Continued From page 15 resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must 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	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 16 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 develop and implement a treatment or therapy management plan to include all required content for one of two residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 began receiving assisted living services from the licensee on August 25, 2023. R1's Service Plan dated August 31, 2023, indicated R1 received services for medication management, treatment management, continuous positive airway pressure (CPAP) therapy, activities of daily living (ADL) assistance for dressing, grooming, bathing, and transferring, housekeeping, and laundry. On January 30, 2024, at 12:00 p.m., during an interview with R1, the surveyor observed a CPAP machine on R1's nightstand. R1's signed provider orders dated September 18,	01940		

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01940	Continued From page 17 2023, included CPAP on PM shift at bedtime off in the AM. Wash in the morning after taking it off and air dry. R1's Individualized Treatment and Therapy Plan dated January 30, 2024, lacked information related to the CPAP. R1's treatment administration record (TAR) dated January 1, 2024, through January 31, 2024, included provider order, CPAP AM and PM. R1's individualized treatment management plan lacked the following required content: - procedures to notify a registered nurse (RN) or other licensed health professional when problems arose with treatment or therapies; and -any resident-specific requirements related 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. On January30, 2024, at 1:45 p.m., licensed assisted living director/ clinical nurse supervisor (LALD/CNS)-A stated they agreed the treatment and therapy plan was missing some of the required components and missed them when entering the treatment. The licensee's undated Treatment and Therapy Management Plan policy indicated when the resident has been assessed and orders for treatments and therapies are obtained, an individualized treatment/therapy plan and management record will be developed. The plan will include the following: -A written statement of the treatment or therapy that will be provided;	01940		

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01940	Continued From page 18 -Documentation of specific instructions that relate to providing the treatment or therapy administration; -Identification of treatment or therapy tasks that will be delegated to unlicensed personnel; -Procedures for notifying a registered nurse or other licensed health professional if problems arise with the treatment or therapy services; -Any resident-specific requirements that relate to documentation of treatments and therapy, and direction on where tasks are to be documented; -Frequency of supervision of personnel providing the delegated treatment or therapy services; -Verification by the registered nurse that services are administered as prescribed and monitoring of treatment or therapy to prevent complications or adverse reactions; -The treatment or therapy plan will be updated when there are changes; and -The Facility may provide Care Plans and other supportive documents to communicate the plan to caregivers by referencing them on the individualized plan. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		

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

Type: Full
Date: *01/29/24*
Time: 13:00:00
Report: 8041241013

Food and Beverage Establishment Inspection Report

Location:
3MB Health Services LLC
1702 13th Avenue W
Shakopee, MN55379
Scott County, 70

Establishment Info:
ID #: 0042376
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/24

Operator:

Phone #:
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.

4-700 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.

AFTER TESTING, DISHWASHER IS NOT REACHING THE 160 DEG F TEMPERATURE REQUIRED TO SANITIZE DISHES. USE ALTERNATE MEASURES TO SANITIZE UNTIL DISHWASHER IS REPAIRED. FACT SHEET SENT WITH REPORT.

Comply By: 01/29/24

3-500C Microbial Control: date marking

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

MN Rule 4626.0400B Mark the refrigerated, ready-to-eat, TCS food prepared and packaged in a processing plant and opened and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded. The date must not exceed the manufacturer's use-by-date.

MILK AND TURKEY DELI MEAT OPENED MORE THAN 24 HOURS AGO NOT DATE MARKED. DATE MARKING REQUIREMENTS REVIEWED DURING INSPECTION. FACT SHEET PROVIDED.

Comply By: 01/29/24

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.

FOOD THERMOMETER COULD NOT BE FOUND.

Comply By: 02/05/24

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.

NO IRREVERSIBLE REGISTERING TEMPERATURE INDICATOR TO MEASURE THE UTENSIL SURFACE TEMPERATURE IN THE DISH MACHINE ON SITE. THERMAL LABEL PROVIDED DURING INSPECTION.

Comply By: 02/05/24

2-100 Supervision

2-102.12AMN

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

FACILITY DOES NOT HAVE A CERTIFIED FOOD PROTECTION MANAGER. STAFF ARE SCHEDULED TO TAKE A FOOD SAFETY CLASS NEXT MONTH. CFPM APPLICATION SENT WITH REPORT.

Comply By: 03/29/24

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: upstairs GE refrigerator: milk
Violation Issued: No

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: upstairs GE refrigerator: deli meat
Violation Issued: No

Process/Item: Cold Holding
Temperature: 36 Degrees Fahrenheit - Location: lower level kenmore refrigerator: salisbury steak meal
Violation Issued: No

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

Inspection was completed with the Director, Barbara Onwona-Appiah. Sarabeth Remker was the lead Health Regulation Division Nurse Evaluator. Facility had three residents on site at time of inspection. Meals are prepared on site by staff.

This establishment has a residential kitchen. Food must be prepared for same day service only. The kitchen has wood cabinets with a hollow base, a laminate countertop and wood flooring. All found to be in good condition.

A two basin sink is located in the kitchen with one basin designated for handwashing. Establishment has an LG under counter dish machine with a high temp. option but after testing is not reaching 160F rinse requirement for sanitizing dishes.

Discussed the following:
-Employee illness policy and logging requirements
-Handwashing
-Glove-use and bare hand contact

-Food storage and preventing cross contamination
-Date marking
-Vomit clean up procedures
-Restrictions concerning serving a highly susceptible population

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 8041241013 of 01/29/24.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed:_____

Barbara Onwona-Appiah
Director

Signed: Sarah Conboy

Sarah Conboy
Public Health San. Supervisor
651-201-3984
sarah.conboy@state.mn.us