Electronically Delivered

August 26, 2024

Licensee
24-Seven Home Care Inc
10774 Regent Avenue North
Brooklyn Park, MN 55443

RE: Project Number(s) SL36987015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 1, 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 . . ."

IMPOSITION OF FINES
In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in

§ 144G.20.

In accordance with Minn. Stat. § 144G.31, Subd. 4(a)(5), MDH may impose fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. MDH may impose a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. MDH also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this survey:

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

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

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

The correction order documentation should include the following:

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

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

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. to submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36987	A. BUILDING: _____ B. WING _____	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
24-SEVEN HOME CARE INC	10774 REGENT AVENUE NORTH BROOKLYN PARK, MN 55443

(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: SL36987015-0 On July 31, 2024, through, August 1, 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 five (5) resident(s); 5 receiving services under the provider's Assisted Living Facility 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 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 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 evaluators ' 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 July 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		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements:	0 680		

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0 680	Continued From page 2 (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation and record review, the licensee failed to have a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all staff, visitors, and residents receiving services under the license. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that	0 680		

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0 680	Continued From page 3 has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's EPP updated June 21, 2024, lacked evidence of a quarterly review of the missing resident plan. On August 1, 2024, at approximately 1:30 p.m., licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-B stated they were unaware the missing resident plan required a quarterly review. The licensee's 2.28 Missing Resident Policy dated August 1, 2021, indicated the policy would be reviewed annually and was authenticated as reviewed by LALD-A on May 24, 2024, and January 31, 2023. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 780 SS=D	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	0 780		

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0 780	Continued From page 4 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: Based on observation and interview, the licensee failed to provide interconnection of the smoke alarm in lower-level resident sleeping room 4 so that the actuation of the smoke alarm causes all alarms in the home to operate for proper notification. This has the potential to directly affect the resident in sleeping room 4. 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 August 1, 2024, from 8:45 a.m. to 10:15 a.m., survey staff toured the home with the licensed	0 780		

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0 780	Continued From page 5 assisted living director (LALD)-A. During the tour and upon testing of the smoke alarms, survey staff observed the smoke alarm on the lower-level resident sleeping room 4 failed to operate and sound as required when other smoke alarms in the home were actuated. The above deficient finding was verified by the LALD-A at the time of discovery during the home tour. The LALD-A stated that he would contact the alarm company to reset the system and make sure the smoke alarm inside room 4 was interconnected. On August 1, 2024, at approximately 11:00 a.m., the LALD-A understood and acknowledged the deficient finding and had no further questions. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment of the	0 800		

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0 800	Continued From page 6 facility in a continuous state of good repair and operation. This has the potential to directly affect the health, safety, and well-being of 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 of the residents). The findings include: On August 1, 2024, from 8:45 a.m. to 10:15 a.m., survey staff toured the home with the licensed assisted living director (LALD)-A. During the tour, survey staff observed the following: -The door on lower-level resident sleeping room 4 failed to latch positively when closed for resident locking privacy and fire/smoke protection during a fire emergency. The LALD-A stated they would fix it after they made several attempts to adjust the door hinge to have the door latch. -The lower-level bathroom toilet paper holder was broken and had missing pieces. -The abandoned shower inside the master bedroom (office) was not used for showering and the shower drain was not capped to prevent sewer gas from continuously entering the room and home's environment to protect the staff and residents from sewer gas. The finding was evident as both the shower head and handle were fully covered with crystalized copper sulfate and mineral deposits indicating the shower had not	0 800		

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0 800	Continued From page 7 been used for a long period. -The hallway near the door of the unoccupied room used for conference/meeting was damaged with an approximate 2-inch size penetration in the wall. The above deficient findings were verbally and/or visually verified by the LALD-A at the time of discovery during the home tour. On August 1, 2024, at approximately 11:00 a.m., during the exit interview, the LALD-A understood and acknowledged the deficient findings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation	0 810		

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0 810	Continued From page 8 plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to develop a fire safety and evacuation plan with the required contents and failed to provide required employee and resident training on fire safety and evacuation. 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On August 1, 2024, from 8:45 a.m. to 10:15 a.m.,	0 810		

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0 810	Continued From page 9 survey staff toured the home with the licensed assisted living director (LALD)-A. During the tour, survey staff observed incorrect signage installed above the garage door as an approved exit. Survey staff explained to the LALD-A that the garage is considered a hazardous area and poses an unsafe exit route, and in addition, when there is a power failure, the garage overhead door will not open for the residents to exit. The LALD-A verified the finding at the time of discovery the LALD-A stated they would remove the signage above the garage. On August 1, 2024, at approximately 10:45 a.m., document and record review and interview with the LALD-A on the home's fire safety and evacuation plan, and related training policies, procedures, and records indicated the following: -The licensee failed to have the home's fire safety and evacuation plan readily available on site. Survey staff requested for the plan before the home tour at approximately 8:40 a.m., the LALD-A stated that the plan was on its way to the home. At approximately, 9:00 a.m., the administrative assistant-C arrived on site with the plan in a binder format. -Document review of the home's fire safety and evacuation floor plan indicated the floor plan incorrectly labeled the garage as an approved exit route. In addition, the floor plan was not updated with correct uses of the bedrooms in the home and did not correctly label the upstairs master bedroom for use as an office. -Document review indicated the licensee lacked an accurate fire safety and evacuation plan and failed to include site-specific employee actions to take in the event of a fire or similar emergency in	0 810		

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0 810	Continued From page 10 the home. The home's fire safety plan available for review was from a third-party provider and only included external fire procedures and failed to include the internal fire procedures for the home. The LALD-A attempted to find the required documentation but was unable to locate the internal fire procedures. Survey staff also commented that the plan must be updated to the home's site-specific conditions. -Document review indicated the licensee's fire safety and evacuation plan did not include the identification of unique or unusual resident needs for movement or evacuation under procedures for resident movement, evacuation, or relocation during a fire or similar emergency. -Document review indicated that the licensee failed to include specific fire protection procedures for residents who are capable of self-evacuation on the proper actions to be taken in case of a fire or similar emergency. During the interview, the LALD-A stated they had developed the procedure, but the LALD-A was unable to provide documentation for review. -Record review indicated the licensee failed to provide evacuation training to residents at least once per year. The LALD-A was unable to provide records or logs to show any training offered to residents on the fire safety and evacuation plan.\ -Record review indicated the licensee failed to provide training to employees on the fire safety and evacuation plan upon hire and at least twice per year. Survey staff noted that there were training materials in the binder but no records available. The LALD-A was adamant that they performed the training but the LALD-A was unable to provide records or logs showing any	0 810		

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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
0 810	Continued From page 11 training provided to employees on the fire safety and evacuation plan. The above deficient findings were verbally verified by the LALD-A during the interview. On August 1, 2024, at approximately 11:00 a.m., during the exit interview, survey staff explained the above deficient findings to the LALD-A and stated that any additional records relating to employee and resident training on fire safety and evacuation, and information relating to the resident fire protection procedures will be honored if received by today at 4:00 p.m. (August 1, 2024). The LALD-A acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 820 SS=H	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction.	0 820		

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	36987	A. BUILDING: _____ B. WING _____	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
24-SEVEN HOME CARE INC	10774 REGENT AVENUE NORTH BROOKLYN PARK, MN 55443

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0 820	Continued From page 12 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure physical facility elements did not constitute a distinct hazard to life. The licensee had unsafe use of double-keyed deadbolt hardware on the egress side of the occupied resident sleeping room 2 and laundry room doors and in addition, had screws installed on the egress window of resident room 2 preventing the window from safe egress out of the room promptly during an emergency. This had the potential to affect resident in the sleeping room 2 and staff because timely evacuation would not be possible in the event of a fire or other life-threatening emergencies. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On August 1, 2024, from 8:45 a.m. to 10:15 a.m., survey staff toured the home with the licensed assisted living director (LALD)-A. During the tour survey staff observed the following: -The LALD-A attempted to open the window in occupied resident sleeping room 2 on the upper-level floor and the LALD-A was not able to open the window fully but to an approximate	0 820		

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0 820	Continued From page 13 maximum height of 4 inches. Survey staff and the LALD-A observed two screws installed on the side of the wood window frame preventing the window from being opened more than 4 inches in height. Survey staff explained to LALD-A screws prevent the window from being readily operable for immediate use for safe egress during an emergency. LALD-A verified the finding and immediately located their tools to remove the screws. -The occupied upper-level resident sleeping room 2 door had a double-keyed deadbolt hardware that required a key to lock and unlock the door from inside of the room. Survey staff asked the LALD-A about the double-keyed deadbolt hardware and why it was necessary. The LALD-A stated that the double-keyed deadbolt hardware was not needed and that they just forgot about this sleeping room having a double-keyed deadbolt. Survey staff also explained that the double deadbolt lock on the door of the resident sleeping room 2 requiring a key would cause delay and impediment in proper exiting of the room during a fire or similar emergency and violate state codes. -The laundry room door had double-keyed deadbolt hardware that required a key to lock and unlock the doors from inside of the room. The LALD-A was not aware of the double-keyed deadbolt hardware on this door. On August 1, 2024, at approximately, 10:10 a.m., survey staff observed the clinical nurse supervisor-B placed a phone call to a contractor. At 10:30 a.m., survey staff observed a contractor arrive on site and start the repair of the room 2 door and the laundry room door. At about 10:50 a.m., the contractor replaced the deadbolt on the	0 820		

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0 820	Continued From page 14 resident room 2 door and the laundry door with a standard doorknob set. On August 1, 2024, at approximately 11:00 a.m., during the exit interview, survey staff explained to the LALD-A that even though the corrections to the above deficient conditions have been made, a distinct hazard order tag was issued for the above findings. The LALD-A stated he understood and acknowledged the deficient findings and had no further questions. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 820		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety, or personal property for two of two residents (R1, R2). This practice resulted in a level one violation (a violation that has no potential to cause more than	0 970		

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0 970	Continued From page 15 a minimal impact on the client 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 the potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted on December 16, 2020, under the licensee's former comprehensive license and began receiving assisted living services on August 1, 2021. R1's [licensee] Assisted Living Agreement signed July 29, 2021, read under Miscellaneous Provisions L. Hold Harmless (p. 15), "You agree to hold harmless [licensee], its owners, management, all of their officers, trustees, staff, and personnel from any and all claims arising from an injury or illness incurred through natural or normal causes during his life at [licensee]." R2 R2 was admitted on May 5, 2021, under the licensee's former comprehensive license and began receiving assisted living services on August 1, 2021. R2's [licensee] Assisted Living Agreement signed July 30, 2021, read under Miscellaneous Provisions L. Hold Harmless (p. 15), "You agree to hold harmless [licensee], its owners, management, all of their officers, trustees, staff, and personnel from any and all claims arising from an injury or illness incurred through natural or normal causes during his life at [licensee]." On August 1, 2024, at approximately 1:30 p.m.,	0 970		

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0 970	Continued From page 16 licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-B stated they thought all language waiving the licensee's liability had been removed from their contracts and R1 and R2 had signed an older version of the contract. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01530 SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two	01530		

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01530	Continued From page 17 hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received the required initial eight (8) hours of dementia care training for two of two employees (unlicensed personnel (ULP)-D, ULP-E). 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-D ULP-D was hired on September 1, 2023, and began providing assisted living services. ULP-D's My Transcript dated July 31, 2024, indicated ULP-D had completed five (5) hours of dementia care training between August 26, 2023, and August 27, 2023. An additional four (4) hours of dementia care training had been completed by ULP-D on May 2, 2024. ULP-D's Weekly Timecard Report dated September 1, 2023, through August 1, 2024, indicated ULP-D had exceeded 160 working hours on November 22, 2023, and had not completed the required 8 hours of dementia care training at that time.	01530		

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01530	Continued From page 18 ULP-E ULP-E was hired on May 13, 2022, and began providing assisted living services. ULP-E's undated My Transcript indicated ULP-E had completed 5 hours of dementia care training on May 2, 2022. An additional five and three quarters (5.75) hours of dementia care training was completed on September 14, 2022, through September 15, 2022. ULP-E's Weekly Timecard Report dated January 1, 2019, through August 1, 2024, indicated ULP-E had exceeded 160 working hours on June 9, 2022, and had not completed the required 8 hours of dementia training at that time. On July 31, 2024, at approximately 2:30 p.m., administrative assistant (ADM)-C stated they were responsible for assigning dementia care training hours at the time of hire and were not aware of the 8-hour requirement. ADM-C stated they assigned 5 hours of training to all employees at the time of hire and all employee records would be deficient in initial dementia care training hours. The licensee's 5.03 Dementia Training policy dated August 1, 2021, indicated direct care employees would complete 8 hours of initial training on dementia care within 160 hours of the employment start date. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to	01640		

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01640	Continued From page 19 (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plan included a signature or other authentication by the resident or resident's designated representative to document agreement on the services to be provided for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when	01640		

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01640	Continued From page 20 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: R1 R1 admitted to licensee on December 16, 2020, under the licensee's former comprehensive license and began receiving assisted living services on August 1, 2021. R1's signed Service Plan (Waiver) - Addendum to Contract dated July 30, 2021, indicated R1's services included assistance with dressing and grooming, medication administration, vital signs monitoring, and behavior management. The document was authenticated by R1's representative and lacked authentication by licensee. R1's unsigned Service Plan - Waiver dated August 1, 2024, indicated the following services had been added to R1's service plan: -assistance walking two times per day; -bedmaking daily; -declutter room daily; -exercise offered to YMCA daily; -linen change daily; -manage agitation behavior three times daily; -manage anxiety behavior three times daily; -manage paranoia three times daily; -medication administration two times per day; -medication setup monthly; -record blood glucose four times daily; -safety check three times daily; -supervision of blood glucose check monthly; and -supervision of skin care monthly. R2	01640		

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01640	Continued From page 21 R2 admitted to licensee on May 5, 2021, under the licensee's former comprehensive license and began receiving assisted living services on August 1, 2021. R2's signed Service Plan (Waiver) - Addendum to Contract dated July 30, 2021, indicated R2's services included dressing and grooming assistance, behavior management, medication administration, and monitoring of vital signs. R2's unsigned Service Plan -Waiver dated August 1, 2024, indicated the following services had been added to R2's service plan: -assistance walking two times daily; -declutter room daily; -escort and mobility assistance three times daily; -manage depression three times daily; -manage orientation issues and behavior three times daily; -manage self-injurious and suicidal behavior three times daily; -medication administration two times daily; -medication setup monthly; -monitoring smoking two times daily; -skin care two times daily; -socialization activities and outings two times daily; and -supervision of skin care monthly. R1 and R2's service plans lacked a signature or other authentication by the resident or resident's designated representative and licensee indicating agreement on services to be provided when revisions occurred. On August 1, 2024, at approximately 1:30 p.m., licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-B stated they were unaware a signature was required with	01640		

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01640	Continued From page 22 changes to the service plan. The licensee's 6.08 Service Plan policy dated August 1, 2021, indicated the service plan and any revisions would include a signature or other authentication by [licensee] and by the resident, or resident's representative, documenting agreement on the services to be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		

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

Type: Full
Date: *07/31/24*
Time: 12:00:00
Report: 1005241169

Food and Beverage Establishment Inspection Report

Location:
24-Seven Home Care Inc
10774 Regent Avenue North
Brooklyn Park, MN55443
Hennepin County, 27

Establishment Info:
ID #: 0037986
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6128862828
ID #:

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

The following orders were issued during this inspection.

3-500B 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.

FOODS IN THE KITCHEN REFRIGERATOR WERE ABOVE 41 DEGREES F. FRIDGE WAS ADJUSTED TO A COLDER SETTING. MONITOR TEMPERATURES TO ENSURE THEY COME TO 41dF OR BELOW.

Comply By: 07/31/24

Surface and Equipment Sanitizers

Utensil Surface Temp.: = at 160+ Degrees Fahrenheit
Location: DISHWASHER
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Hold/BUTTER
Temperature: 45 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: Yes

Process/Item: Cold Hold/AMBIENT
Temperature: 45 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: Yes

Type: Full
Date: *07/31/24*
Time: 12:00:00
Report: 1005241169
24-Seven Home Care Inc

Food and Beverage Establishment Inspection Report

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

INSPECTION COMPLETED WITH FOOD MANAGER AND REVIEWED WITH HRD NURSING EVALUATOR, MICHELLE WINTERS.

INSPECTOR LEFT THERMOLABELS ON SITE AND AFTER INSPECTION OPERATOR SENT INSPECTOR A PICTURE OF THE TEMPERATURE STRIP THEY RAN THROUGH THEIR DISHWASHER, WHICH SHOWED IT PROVIDED A UTENSIL SURFACE TEMPERATURE OF 160+ DEGREES F.

DISCUSSED DATE MARKING, GLOVE USE, COOKING TEMPERATURES, CROSS-CONTAMINATION, AND EMPLOYEE ILLNESS.

KITCHEN IS RESIDENTIAL AND FOOD IS PREPARED FOR SAME DAY SERVICE.

FLOORING IS WOOD AND CABINETS ARE WOOD WITH HOLLOW BASE. ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT SUCH A TIME THEY ARE FOUND TO BE A CONCERN OR RISK OF CONTAMINATION, THEY WILL BE ORDERED TO BE REPLACED AND BROUGHT UP TO CODE.

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 1005241169 of 07/31/24.

Certified Food Protection Manager OVIE AVWENAGHAGHA

Certification Number: FM107172 Expires: 08/01/24

Inspection report reviewed with person in charge and emailed.

Signed: _____
OVIE AVWENAGHAGHA

Signed: _____
Jessica Davis
Public Health Sanitarian III
651-201-3961
jessica.davis@state.mn.us