Electronically Delivered

December 14, 2023

Licensee
Sabainah Healthcare Inc
914 38th Street
Anoka, MN 55303

RE: Project Number(s) SL34158015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on December 1, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

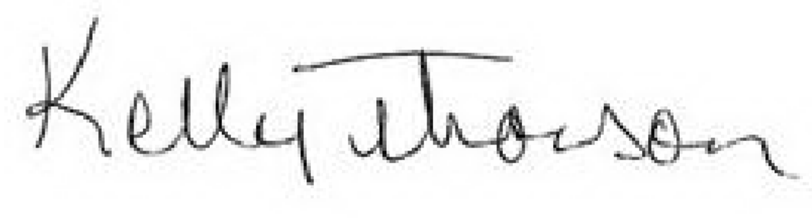
Please address your cover letter for reconsideration requests to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

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

If you have any questions, please contact me.

Sincerely,



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
	34158	A. BUILDING: _____ B. WING _____	12/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SABAINAH HEALTHCARE INC	914 38TH STREET ANOKA, MN 55303

(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: SL34158015-0 On November 27, 2023, through November 28, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were four active residents whom were receiving services under the Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Licensing 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 November 27, 2023, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 810 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:	0 810		

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0 810	Continued From page 2 (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 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 and provide required training and drills. This had the potential to directly affect all residents, staff, and visitors.	0 810		

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0 810	Continued From page 3 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 November 28, 2023, licensed assisted living director (LALD)-B 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 August 1, 2021, failed to include the following: The numbers of each resident sleeping room on the FSEP evacuation floor plan. During an interview on November 28, 2023, at 9:30 a.m., LALD-B stated the evacuation floor plan provided was old and had not been updated with the required numbers identifying the resident rooms. TRAINING Record review indicated the licensee failed to provide training to employees on the FSEP upon hire and at least twice per year thereafter as evident by not retaining and providing documentation of the required employee training. During an interview on November 28, 2023, at 9:30 a.m., LALD-B stated the training had been completed but had not been documented and	0 810		

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0 810	Continued From page 4 retained. 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 drill records that include drill date documentation of February 1, 2023, at 8:30 p.m., May 1, 2023, at 11:00 a.m., August 10, 2023, at 9:00 p.m., and November 4, 2023, at 12:00 p.m. During an interview on November 28, 2023, at 9:30 a.m., LALD-B stated it was misunderstood the drills were required every other month and not every third month. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01290 SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits.	01290		

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01290	Continued From page 5 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a background study was submitted and received in affiliation with the assisted living license for one of two employees (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, 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 November 27, 2023, at 10:30 a.m., during the entrance conference, clinical nursing supervisor (CNS)-A stated two ULP's worked the day shift in the facility from 7:00 a.m. to 7:00 p.m. and one ULP from 7:00 p.m. to 7:00 a.m. ULP-C began employment with licensee on April 30, 2019, to provide direct cares and services to residents. ULP-C's employee record included a background study clearance dated May 9, 2019, affiliated to the licensee's former comprehensive license health facility identification (HFID) #33611. ULP-C's record lacked evidence the licensee submitted a background study for ULP-C under the current assisted living license and affiliated to the current HFID number. On November 28, 2023, at 11:00 a.m., the	01290		

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01290	Continued From page 6 surveyor observed ULP-C administer R2's morning medications and conduct a blood glucose (sugar) check. On November 28, 2023, at 11:40 a.m., the surveyor requested to see the licensee's current roster on NETStudy 2.0 from licensed assisted living director (LALD)-B. LALD-B stated she was unable to access the NETStudy roster and had requested assistance. A short time later LALD-B stated they were unable to access the information, however, none of the requested background studies would be affiliated with the current assisted living license. LALD-B stated the only employees affiliated with the current assisted living license were the last two ULP's hired in August 2023. On November 28, 2023, at 11:50 a.m., LALD-B stated they conducted a background study on all employees prior to finding the current building and had submitted earlier background checks under the previous address. The licensee's Recruitment and Hiring policy dated March 18, 2020, indicated background checks would be conducted and the result would be obtained before a potential team member may begin employment or engagement with licensee. No further information was provided. TIME PERIOD FOR CORRECTION: TWO DAYS (2)	01290		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must	01620		

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01620	Continued From page 7 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 observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive reassessment to include an assessment of current smoking status for two of two residents (R1, 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 a widespread scope (when problems are pervasive or represent a systemic	01620		

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01620	Continued From page 8 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 R1's diagnoses included post-traumatic stress syndrome (PTSD), polysubstance abuse and major depressive disorder. R1's service plan dated May 6, 2023, indicated the resident received services to include medication administration, assistance with dressing, grooming, meals, vital signs, behavior management, housekeeping and laundry. R1's Assessment dated October 29, 2023, indicated R1 had poor initiative with self-care, outbursts of anger, impulsive and ready to fight for no reason, used derogative words with or without triggers, disliked confrontation and could be fearful when upset. The assessment indicated R1 smoked cigarettes and had no interest in smoking cessation programs. R1's assessment did not address the safety, risks and management of R1's cigarettes or lighter usage. On November 27, 2023, at 3:45 p.m., the surveyor observed R1 exit the building to smoke. On November 27, 2023, at 3:50 p.m., unlicensed personnel (ULP)-C stated R1 smoked between two to three times a day and smokes three to four each smoking session. ULP-C stated R1 admitted to the licensee as a smoker. R4 R4's diagnoses included paranoid schizophrenia, major depressive disorder and cannibas disorders.	01620		

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01620	Continued From page 9 R4's service plan dated May 6, 2023, indicated the resident received services to include medication administration, assistance with dressing, grooming, meals, monthly vital signs, behavior management, housekeeping and laundry. R4's Assessment dated September 7, 2023, indicated R4 had poor initiative with self-care, hallucinated, experienced delusions, had very poor reasoning ability, would laugh to self with outbursts of laughter, would mumble with incomprehensible sentences, would at times cheek and spit out his medications. The assessment indicated R4 smoked cigarettes, marijuana and had no interest in smoking cessation programs. R4's assessment did not address the safety, risks and management of R4's cigarettes or lighter usage. On November 28, 2023, at 11:15 a.m., the surveyor observed R4 exit his room and request a cigarette from licensed assisted living director (LALD)-B. LALD-B attained a pack of cigarettes and a lighter from a locked cabinet in the main living area and exited to the deck with R4. On November 28, 2023, at 11:45 a.m., the surveyor reviewed R1 and R4's assessments with LALD-B. LALD-B confirmed the assessments contained a single sentence R1 and R4 were smokers, however, lacked assessment of the safety, risks and/or abilities of R1 and R4 to manage cigarettes or lighters. Additionally, LALD-B stated all assessments were the same and would have the same single sentence to indicate if the resident was a smoker or not and no further information.	01620		

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01620	Continued From page 10 The licensee's Comprehensive Nursing Assessment policy dated August 1, 2021, indicated the registered nurse (RN) would conduct a comprehensive assessment with lifestyle choices to include smoking and safety factors. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		

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

Type: Full
Date: *11/27/23*
Time: 12:46:44
Report: 1021231389

Food and Beverage Establishment Inspection Report

Location:
Sabainah Healthcare Inc
914 38th Street
Anoka, MN55303
Anoka County, 02

Establishment Info:
ID #: 0037860
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 9543197890
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.

6-300 Physical Facility Numbers and Capacities

6-301.12 ***** Priority 2 *****

MN Rule 4626.1445 Provide and maintain a supply of individual disposable towels, a continuous towel system, a heated-air hand drying device, or an approved ambient air temperature hand drying device at each handwashing sink or group of adjacent handwashing sinks.

NO PAPER TOWELS AT THE KITCHEN HANDWASHING SINK. STAFF PROVIDED A ROLL OF PAPER TOWELS DURING INSPECTION. CORRECTED ON-SITE. MAINTAIN A SUPPLY OF PAPER TOWELS AT THE HANDWASHING SINK DURING ALL HOURS OF OPERATION.

Comply By: 11/27/23

2-100 Supervision

2-102.12DMN

MN Rule 4626.0033D Post the certified food protection manager certificate.

THE CERTIFIED FOOD PROTECTION MANAGER (CFPM) CERTIFICATE WAS NOT POSTED. STAFF FOUND A COPY OF THE CFPM IN THE OFFICE AND THEY WILL POST IT IN THE KITCHEN. COMPLY WITH RULE ABOVE.

Comply By: 11/27/23

3-300C Protection from Contamination: equipment/utensils, consumers

3-304.14B

MN Rule 4626.0285B Wiping cloths used for wiping counters and other equipment surfaces must be held in an approved sanitizing solution and laundered daily.

A COUPLE OF WET WIPING CLOTHS FOUND STORED ON THE COUNTERTOP BY THE KITCHEN TWO COMPARTMENT SINK. STAFF PLACED WET WIPING CLOTHS INSIDE THE SANI BUCKET DURING INSPECTION. CORRECTED ON-SITE. COMPLY WITH RULE ABOVE.

Type: Full
Date: *11/27/23*
Time: 12:46:44
Report: 1021231389
Sabainah Healthcare Inc

Food and Beverage Establishment Inspection Report

Comply By: 11/27/23

Surface and Equipment Sanitizers

Quaternary Ammonia: = 400PPM at Degrees Fahrenheit
Location: SANI BUCKET, KITCHEN
Violation Issued: No

Food and Equipment Temperatures

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

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

Process/Item: Ambient Temperature
Temperature: 39 Degrees Fahrenheit - Location: CRITERION REFRIGERATOR
Violation Issued: No

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

ALL FINDINGS ON THIS REPORT WERE DISCUSSED WITH HOME HEALTH AID, GRACE ONSONGO AND HEALTH REGULATION DIVISION NURSE EVALUATOR, KATHERINE BARNHARDT.

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

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

THE KITCHEN HAS RESIDENTIAL EQUIPMENT, VINYL FLOORING, LAMINATE COUNTERTOPS, POPCORN CEILING AND PAINTED DRYWALL. PHYSICAL FACILITY ITEMS WILL BE MONITORED AT FUTURE INSPECTIONS.

Type: Full
Date: *11/27/23*
Time: 12:46:44
Report: 1021231389
Sabainah Healthcare Inc

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1021231389 of 11/27/23.

Certified Food Protection Manager: CHRISTIANA TENIOLA

Certification Number: FM107379 Expires: 07/08/24

Inspection report reviewed with person in charge and emailed.

Signed: _____
GRACE ONSONGO
HOME HEALTH AID

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