Electronically Delivered

September 24, 2024

Licensee
Jabez Customized Living Services
1417 Brookdale Drive
Brooklyn Park, MN 55444

RE: Project Number(s) SL34432015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 27, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

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

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

If you have any questions, please contact me.

Sincerely,

Renee L. Anderson

Renee Anderson, Supervisor
State Evaluation Team
Email: renee.anderson@state.mn.us
Telephone: 651-201-5871 Fax: 1-866-890-9290

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34432	A. BUILDING: _____ B. WING _____	08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JABEZ CUSTOMIZED LIVING SERVI	1417 BROOKDALE DRIVE BROOKLYN PARK, MN 55444

(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 In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been 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: SL34432015-0 On August 26, 2024, through August 27, 2024, the Minnesota Department of Health conducted an initial survey at the above provider, and the following correction orders are issued. At the time of the survey, there were four (4) residents, all of whom received services under the provider's Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control	0 660		

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0 660	Continued From page 1 (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included TB symptom screening and baseline testing for one of two employees (unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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:	0 660		

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0 660	Continued From page 2 The facility TB risk assessment dated February 1, 2024, indicated the facility was a low risk setting for TB transmission. ULP-B was hired July 3, 2024, and provided direct cares for residents of the facility on July 13, 2024. On August 27, 2024, at 8:29 a.m., surveyor observed unlicensed personnel (ULP)-B assist R1 with medication administration. ULP-B's employee record included a TB history and symptom screening form completed, July 19, 2024, which was 16 days after hire date and a QuantiFERON TB-Gold blood test obtained on July 19, 2024, and reported as negative on July 24, 2024, which was 21 days after hire date. On August 27, 2024, at 10:15 a.m., licensed assisted living director (LALD)-A stated ULP-B's employee record lacked a TB symptom screen and TB testing at time of hire. LALD-A further stated, ULP-B started working on the floor on July 13, 2024, and it had been an oversite on her part that the above information was not completed at time of hire. The Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013 noted training was required at the time of hire and included: pathogenesis, signs symptoms, and the licensee's infection control plan. In addition, baseline screening for all health care workers (HCW) included a history and symptom screen and testing for the presence of TB infection. The regulations noted a blood test should include the date of the test. According to the regulations, if a HCW had documentation for latent TB, that documentation could be substituted for	0 660		

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0 660	Continued From page 3 documentation of a previous positive TST or blood test. The licensee's Infection Control policy, dated June 2021, indicated on page 13, titled "Staff TB Screening and Risk Assessment" that licensee would test and screen all staff whose essential job functions required them to work in the same air space as assisted living residents, prior to the staff being exposed to residents. Furthermore, new staff would be screened for active TB using the baseline TB screening tool and would include a TB risk assessment and a two-step Mantoux (skin test), with results documented on the baseline TB screening tool for health care workers or an approved blood test. Moreover, no staff would be permitted to work where the work involved sharing the air space with assisted living residents until TB screen was negative and the results of the first step Mantoux was negative, or an approved blood test result was negative. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently;	0 680		

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0 680	Continued From page 4 (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 interview and record review, the licensee failed to have a written emergency preparedness (EP) plan with all the required content. 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 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 26, 2024, at 10:45 a.m., the EP plan was reviewed and found to be lacking the following requirements:	0 680		

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0 680	Continued From page 5 - Policy and procedure to address role of facility under a waiver declared by the Secretary in accordance with section 1135 of the Act; - Policy and procedure with arrangement agreements with other facilities/providers to receive residents in the event of limitations/cessation of operations to maintain the continuity of services to residents; - Must conduct exercises to test the EP plan at least twice per year, including unannounced staff drills using the EP plan; - Must participate in an annual full-scale exercise that is community based OR conduct an annual, individual, facility-based functional exercise OR if the facility experiences an actual emergency requiring activation of plan, facility is exempt from engaging in its next required full-scale exercise; - Conduct an additional annual exercise that may include: a second full-scale exercise that is community-based or an individual, facility based functional exercise OR mock disaster drill OR table-top exercise; and - Analyze the facility's response to and maintain documentation of all drills, tabletop exercises and emergency events & revise plan as needed. On August 26, 2024, at 11:13 a.m., licensed assisted living director (LALD)-A stated the licensee's EP plan was missing all of the above required content. LALD-A further stated EP documents had been located in bits and pieces, and she was aware all the EP plan information needed to be pulled together; therefore, she and unlicensed personnel (ULP)-B had been working on revising the EP binder. The licensee's undated Emergency Management policy indicated, licensee would have an identified plan in place to ensure the safety and well-being of residents and employees during periods of an	0 680		

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0 680	Continued From page 6 emergency or a disaster that disrupts facility services, and would implement the emergency management policy as soon as the facility became aware of the existence of an emergency. Licensee's policy indicated, all administrative emergency or disaster activities would be documented by the assisted living director and/or the administrator, and all resident related activities would be documented in the resident record. No further information was provided. TIME FOR CORRECTION: Twenty-one (21) days	0 680		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing	0 780		

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0 780	Continued From page 7 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 smoke alarms that are interconnected so that the actuation of one alarm causes all alarms in the dwelling unit to actuate. 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 the potential to affect a large portion or all of the residents). The findings include: During facility tour on August 27, 2024, from 9:50 a.m. through 10:10 a.m., with licensed assisted living director (LALD)-A, the surveyor observed that the smoke alarms located inside resident sleeping rooms 1, 2, 3 and 4 were not interconnected so activation of one alarm activates all alarms throughout the facility. All dwelling units required to have multiple smoke alarms are required to have interconnected alarms so activation of one alarm activates all alarms within the dwelling unit. During the tour the smoke alarms were tested by LALD-A. LALD-A verified the smoke alarms were	0 780		

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0 780	Continued From page 8 not interconnected and stated that they understood the requirement. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
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 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	0 810		

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0 810	Continued From page 9 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 the required content and failed to conduct the required training. 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: During facility tour on August 27, 2024, from 9:50 a.m. through 10:10 a.m., with licensed assisted living director (LALD)-A, the surveyor observed that the fire evacuation map posted on the main floor did not show the location and number of resident sleeping rooms. The evacuation map posted in the basement showed the floor plan and evacuation routes for the main floor. On August 27, 2024, at 10:12 a.m., LALD-A provided documentation on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN	0 810		

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0 810	Continued From page 10 The licensee's FSEP, titled "Emergency Response, Reporting and Review Policy", undated, lacked the following: The FSEP did not include an evacuation map with a floor plan accurate to the building layout that showed the location and number of resident sleeping rooms. The FSEP included standard resident evacuation procedures but lacked specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. During an interview on August 27, 2024, at 10:33 a.m., LALD-A stated that they would update the evacuation maps posted in the facility and include a map of each floor in the FSEP. LALD-A stated they understood the areas of the FSEP that were incomplete and would work to bring them into compliance. TRAINING Record review indicated the licensee failed to provide evacuation training based on the fire safety and evacuation plan to residents, at least once per year as evident by not providing documentation of training offered or training scheduled for a future date. Record review indicated the licensee failed to	0 810		

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0 810	Continued From page 11 provide evacuation training based on the fire safety and evacuation plan to employees, at hire and twice per year as evident by not providing documentation of training offered or training scheduled for a future date. During an interview on August 27, 2024, at 10:33 a.m., LALD-A stated that they would email training records to the surveyor. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 970 SS=F	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 facility's liability for health, safety, or personal property of a resident. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a	0 970		

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0 970	Continued From page 12 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 was admitted to licensee on December 22, 2023, and signed an Assisted Living Contract upon admission. R1's contract, dated December 22, 2023, included the following language: - Section 23 "Indemnification", indicated the resident would, "indemnify and hold harmless, landlord, its employees and agents from and against any and all claims, actions, damages, and liability and expense in connection with loss of life, personal injury or damage to property, arising from or out of the use by tenant of the rented premises or any other part of the landlord's property, or caused wholly or in part by an act or omission of tenant or tenant's guests or agents." - Section 25 "Liability", indicated, "landlord is not liable to tenant or tenant's guests for any injury, death or property damage occurring in the room or on the landlord's premises unless such injury, death or property damage occurs as the result of an equipment malfunction or hazardous conditions within the building not caused by the tenant or tenant's guests. Landlord may be liable to tenant for its own negligent acts or those of its employees or agents, unless, caused by one of the aforementioned accepted reasons. Tenant agrees to hold landlord harmless from any and all claims for injuries, property damage or any other loss resulting from an accident or other occurrence in the room or on landlord's premises."	0 970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34432	A. BUILDING: _____ B. WING _____	08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JABEZ CUSTOMIZED LIVING SERVI	1417 BROOKDALE DRIVE BROOKLYN PARK, MN 55444

(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
0 970	Continued From page 13 On August 27, 2024, at 11:25 a.m., licensed assisted living director (LALD)-A stated, the contract R1 signed was used by the licensee for all residents who received services and included the waiver of liability. LALD-A stated the licensee was not aware the statutes did not allow a liability waiver. LALD-A stated they would remove the waiver from all residents' records and have them sign an addendum to the contract. The licensee's undated Assisted Living Contracts policy indicated, the licensee's contract would not include a waiver of liability for the health, safety, or personal property of a resident, or any provision that the licensee knows or would know to be deceptive, unlawful, or unenforceable under state of federal law. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications with time sensitive dates were labeled with a date opened after first use, for one of one resident	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34432	A. BUILDING: _____ B. WING _____	08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JABEZ CUSTOMIZED LIVING SERVI	1417 BROOKDALE DRIVE BROOKLYN PARK, MN 55444

(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
01890	Continued From page 14 (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's Individualized Medication Management Plan dated December 22, 2023, indicated R1 received services including medication management, medication setup as needed, and medication administration. R1's Medication Administration Record dated August 2024, indicated R1 received 6 units of Victoza® (medication used along with diet and exercise to lower blood sugar), via injection pen, under the skin, in the morning, and 27 units of Lantus® SoloStar® insulin (medication used to control high blood sugar levels), via injection pen, under the skin, in the evening. On August 27, 2024, at 8:29 a.m., surveyor observed unlicensed personnel (ULP)-B assist R1 with medication administration. ULP-B gathered supplies, donned gloves, and dialed up 6 units of Victoza® medication. ULP-B handed the pen to R1 for self-administration, and R1 self-administered the Victoza® medication. R1 handed the used pen to ULP-B, who discarded the needle, and put the pen back into R1's medication container. ULP-B removed gloves, and washed her hands.	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34432	A. BUILDING: _____ B. WING _____	08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JABEZ CUSTOMIZED LIVING SERVI	1417 BROOKDALE DRIVE BROOKLYN PARK, MN 55444

(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
01890	Continued From page 15 On August 27, 2024, at 8:31 a.m., surveyor observed the medication in R1's container with ULP-B. Observation revealed opened Victoza® and Lantus® SoloStar® pens both lacked the date the medications had been opened. On August 27, 2024, at 8:35 a.m., licensed assisted living director (LALD)-A stated her expectation was, once a new medication requiring a date opened had been opened, it would be the responsibility of the staff member opening the new medication for the first time, to ensure the medication label had an open date on it. The manufacturer's instructions for use of Victoza® pen, 1.2 milligram (mg)|1.8 mg injection, dated July 2023, directed the pen be discarded 30-days after opening, even if some medication had been left in the pen. The manufacturer's instructions for use of Lantus® SoloStar® pen, 100 Units/milliliter (mL) injection, dated November 2023, directed the pen be discarded 28-days after opening, even if some medication had been left in the pen. The licensee's Insulin Storage Process dated December 2023, indicated, licensee would store insulin as directed so that it remained usable by those who needed it. Furthermore, Insulin products contained in vials or cartridges supplied by the manufacturers (opened or unopened) would be left unrefrigerated at a temperature between 59°F and 86°F for up to 28 days and continue to work. No further information was provided.	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01890	Continued From page 16 TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

Minnesota Department of Health

625 North Robert Street
Saint Paul, MN
651-201-5000

Type: Full
Date: *08/26/24*
Time: 16:30:00
Report: 8087241198

Food and Beverage Establishment Inspection Report

Location:
Jabez Customized Living Servi
1417 Brookdale Drive
Brooklyn Park, MN55444
Hennepin County, 27

Establishment Info:
ID #: 0038306
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7637104084
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.

No NEW orders were issued during this inspection.

Food and Equipment Temperatures

Process/Item: Ambient Air
Temperature: 0 Degrees Fahrenheit - Location: STAND-UP FREEZER
Violation Issued: No

Process/Item: Ambient Air
Temperature: 38 Degrees Fahrenheit - Location: STAND-UP REFRIGERATOR
Violation Issued: No

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

Process/Item: Cold Holding: CHEESE
Temperature: 40 Degrees Fahrenheit - Location: STAND-UP REFRIGERATOR
Violation Issued: No

Process/Item: Cold Holding: DELI MEAT
Temperature: 39 Degrees Fahrenheit - Location: STAND-UP REFRIGERATOR
Violation Issued: No

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

THIS WAS AN ANNOUNCED AND SCHEDULED FULL INSPECTION.

INSPECTION CONDUCTED IN THE PRESENCE OF NURSE EVALUATOR RHONDA MAKELA.

FLOORS ARE LINOLEUM, CABINETS ARE HARDWOOD, COUNTERTOPS ARE LAMINATE AND CEILING IS TEXTURED BUT APPEARS TO BE DURABLE. 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.

DESIGNATED HAND WASHING SINK IN THE KITCHEN IN 2-BIN, STAINLESS STEEL RESIDENTIAL KITCHEN SINK.

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 8087241198 of 08/26/24.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed:_____

PANDORA WHITE
DIRECTOR

Signed:_____

John Boettcher
Public Health Sanitarian 3
St. Paul, MN / Freeman
651-201-5076
john.boettcher@state.mn.us