DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

April 16, 2024

Licensee
Kind Heart Care Home, Inc.
1049 Glen Paul Court
Shoreview, MN 55126

RE: Project Number(s) SL35192015

Dear Licensee:

On April 11, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the February 7, 2024, survey were corrected. This follow-up survey verified that the facility is n substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Jessie Chenze

Jessie Chenze, Supervisor
State Evaluation Team
Email: Jessie Chenze
Telephone: 218-332-5175 Fax: 1-866-890-9290

PMB

Electronically Delivered

February 26, 2024

Licensee
Kind Heart Care Home, Inc.
1049 Glen Paul Court
Shoreview, MN 55126

RE: Project Number(s) SL35192015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on February 7, 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.

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 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services = $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,

Jessie Chenze

jessie chenze, Supervisor
State Evaluation Team
Email: jessie.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35192	A. BUILDING: _____ B. WING _____	02/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KIND HEART CARE HOME INC	1049 GLEN PAUL COURT SHOREVIEW, MN 55126

(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: SL35192015 On February 5, 2024, through February 7, 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 four residents; four receiving services under the Assisted Living license. An immediate correction order was identified on February 6, 2024, issued for SL35192015, tag identification 2310. On February 8, 2024, the immediacy of correction order 2310 was removed, however non-compliance remains at a scope and level of G.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35192	A. BUILDING: _____ B. WING _____	02/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KIND HEART CARE HOME INC	1049 GLEN PAUL COURT SHOREVIEW, MN 55126

(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
0 480	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 February 7, 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		
0 490 SS=F	144G.41 Subd 1 (13) (ii)-(vii) Minimum requirements (iv) upon the request of the resident, provide direct or reasonable assistance with arranging for	0 490		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35192	A. BUILDING: _____ B. WING _____	02/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KIND HEART CARE HOME INC	1049 GLEN PAUL COURT SHOREVIEW, MN 55126

(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
0 490	Continued From page 2 transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for providing this assistance; (v) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance; (vi) provide culturally sensitive programs; and (vii) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have daily programs of social and recreational activities based on individual and group interests, physical, mental, and psychosocial needs. This had the potential to affect all four residents of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On February 5, 2024, at 11:47 a.m., during	0 490		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35192	A. BUILDING: _____ B. WING _____	02/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KIND HEART CARE HOME INC	1049 GLEN PAUL COURT SHOREVIEW, MN 55126

(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
0 490	Continued From page 3 entrance conference, clinical nurse supervisor (CNS)-B stated there was no activity calendar or schedule posted or provided to the residents. CNS-B stated the residents were independent and the licensee did not provide daily planned activity program for the residents. CNS-B stated some of their residents worked, went to day programs, or attended school. Residents had an activity room with exercise equipment and a pool table and staff would take the residents shopping and on outings. On February 5, 2024, at 1:43 p.m., during the facility tour with licensed assisted living director (LALD)-A and CNS-B, the surveyor did not observe an activity calendar or daily activity posted in the facility. On February 6, 2024, at 3:45 p.m., unlicensed personnel (ULP)-G stated there was no activity calendar posted or provided to the residents. ULP-C stated the activity calendar was in the computer and would provide the surveyor a copy. On February 6, 2024, at 3:51 p.m., ULP-C provided the licensee's Daily Schedule which included: waking up, oral hygiene, getting dressed, medication administration, breakfast, morning coffee, morning exercise, morning shows, video games, room cleaning, lunch, games, lone time, guided exercise by staff, group video games, table games, group movie, and bedtime. On July 6, 2024, at 3:52 a.m., R1 stated he has never provided or observed an activity calendar posted with planned events. R1 stated sometimes staff would take them bowling, McDonalds or shopping but wished there were more things to do around the house.	0 490		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35192	A. BUILDING: _____ B. WING _____	02/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KIND HEART CARE HOME INC	1049 GLEN PAUL COURT SHOREVIEW, MN 55126

(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
0 490	Continued From page 4 During the survey from February 5, 2024, to February 7, 2024, the surveyor observed one activity interaction with ULP-C playing pool with R3. The residents either where in their rooms and occasionally one male resident would sit on the couch in the living room on his phone. On February 7, 2024, at 1:10 p.m., LALD-A stated the daily schedule was in the computer and was not provided or posted for the residents. LALD-A stated staff interact with the residents throughout the day and participate in activities at the request of the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 490		
0 495 SS=F	144G.41 Subd. 1 (14) Minimum Requirements (14) provide staff access to an on-call registered nurse 24 hours per day, seven days per week This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure a registered nurse (RN) was available on-call 24 hours a day, seven days per week. This had the potential to affect all four residents and staff of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when	0 495		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35192	A. BUILDING: _____ B. WING _____	02/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KIND HEART CARE HOME INC	1049 GLEN PAUL COURT SHOREVIEW, MN 55126

(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
0 495	Continued From page 5 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 February 5, 2024, at 11:47 a.m., during entrance conference, clinical nurse supervisor (CNS)-B stated she was the only licensed staff employed by the licensee and had a part-time position. CNS-B stated she was onsite at least one time a week and had no dedicated set days or hours. CNS-B stated she work another job part-time and the other job had a flex schedule. CNS-B stated she was on call for the licensee 24 hours a day, 7 days per week and was available by phone or text. CNS-B stated when she was working her other job, she would check her phone on her breaks and return any calls or texts at that time. CNS-B stated if for some reason staff were unable to reach her, staff would call licensed assisted living director (LALD)-A and if it was an emergency, staff were instructed to call 911 then notify her. CNS-B informed the surveyor, CNS-B had to be on the floor at her other job by 3:30 p.m. that day, and worked at her other job again the next day from 9:00 a.m. to 5:00 p.m., and would be available for any questions by phone. On February 5, 2024, at 1:43 p.m., during the facility tour, CNS-B's telephone number was observed posted in the office. On February 6, 2024, at 8:28 a.m., unlicensed personnel (ULP)-C stated when CNS-B was called she usually called or text back within 30 minutes. ULP-C stated there had been a couple of times when he had not heard back from CNS-B and had to call LALD-A. ULP-C was unable to recall the reason why CNS-B needed to	0 495		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35192	A. BUILDING: _____ B. WING _____	02/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KIND HEART CARE HOME INC	1049 GLEN PAUL COURT SHOREVIEW, MN 55126

(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
0 495	Continued From page 6 be called. On February 6, 2024, at 3:08 p.m., LALD-A stated CNS-B had another part-time job; however, was available to staff 24 hours/day, 7 days/week. LALD-A stated he was in the process of hiring another RN for when CNS-B was unavailable. On February 6, 2024, at 11:33 a.m., the surveyor called CNS-B by phone and CNS-B answered the call and was available to answer a few questions from the surveyor. On February 7, 2024, at 7:00 a.m., ULP-F stated he worked from 10:00 p.m. to 7:00 a.m. ULP-F stated he could not recall any particular incident where he had to call CNS-B after hours. ULP-F stated he called LALD-A more frequently usually giving resident updates. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 495		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents;	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35192	A. BUILDING: _____ B. WING _____	02/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KIND HEART CARE HOME INC	1049 GLEN PAUL COURT SHOREVIEW, MN 55126

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 680	Continued From page 7 (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 develop a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all residents, staff, and visitors of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's undated Emergency Preparedness Manual did not include the following: -documentation of an annual review of the licensee's EPP; -a hazard vulnerability assessment;	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35192	A. BUILDING: _____ B. WING _____	02/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KIND HEART CARE HOME INC	1049 GLEN PAUL COURT SHOREVIEW, MN 55126

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 680	Continued From page 8 -a quarterly review of the missing resident policy; and -emergency prep testing requirements. On February 7, 2024, at 1:10 p.m., licensed assisted living director (LALD)-A stated he was unable to find the licensee's Hazard Vulnerability Assessment, and the Hazard Vulnerability Assessment in the EPP binder was a template and had not been completed. LALD-A stated he was unaware the Missing Resident policy needed to be reviewed every quarter. LALD-A was unable to provide documentation to support the licensee participated in an annual full-scale exercise or tabletop emergency exercises or documentation the licensee analyzed the facility's response. The licensee's undated Emergency Preparedness Plan indicated the licensee would participate in one full-scale exercise that was either community based with the participating state and local agencies and some regional entities such as health care coalitions, or if a community-based exercise was not accessible, an individual, facility based. The licensee would conduct an additional exercise that may include a table-top exercise that uses clinically based relevant emergency scenarios to challenge an emergency plan. The licensee's CMS State Operations Manual Appendix Z; MN Rules 4659.0100 dated August 1, 2021, indicted the licensee would have an identified plan in place to assure the safety and well-being of residents and staff during periods of emergency of disaster that disrupts services. The licensee's Missing Resident policy dated August 1, 2021, indicated the missing resident	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35192	A. BUILDING: _____ B. WING _____	02/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KIND HEART CARE HOME INC	1049 GLEN PAUL COURT SHOREVIEW, MN 55126

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 680	Continued From page 9 procedure would be reviewed by the Director and Clinical Nurse Supervisor at least quarterly. Changes to the plan would be documented. Per Assisted Living Facilities: Minnesota Rules Chapter 4659, 4659.0110, Subp. 4. Review missing resident plan. The assisted living director and clinical nurse supervisor must review the missing person plan at least quarterly and document any changes to the plan. Per Assisted Living Facilities: Minnesota Rules Chapter 4695, 4659.0100, sections A and B, assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.73, or successor requirements. This part references documents, specifications, methods, and standards in "State Operations Manual Appendix Z - Emergency Preparedness for All Providers and Certified Supplier Types: Interpretive Guidance," which is incorporated by reference. No further information was provided. TIME PERIOD 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	0 780		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35192	A. BUILDING: _____ B. WING _____	02/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KIND HEART CARE HOME INC	1049 GLEN PAUL COURT SHOREVIEW, MN 55126

(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
0 780	Continued From page 10 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 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 a smoke alarm in a resident's sleeping room. The licensee also failed to provide smoke alarms that are interconnected throughout the facility so that actuation of one alarm will cause all alarms in the dwelling to actuate. This deficient condition had the ability to affect all staff and 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, 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).	0 780		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35192	A. BUILDING: _____ B. WING _____	02/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KIND HEART CARE HOME INC	1049 GLEN PAUL COURT SHOREVIEW, MN 55126

(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
0 780	Continued From page 11 Findings include: On a facility tour on February 05, 2023, at approximately 1:43 p.m. with licensed assisted living director (LALD)-A, it was observed that resident room #4 did not have a smoke alarm installed. It was also observed that the smoke alarms throughout the facility were not interconnected so that actuation of one alarm will cause all alarms in the dwelling to actuate. This was discovered when the LALD-A tested the smoke alarms. LALD-A verbally confirmed survey staff observations during the facility tour. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) 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	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35192	A. BUILDING: _____ B. WING _____	02/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KIND HEART CARE HOME INC	1049 GLEN PAUL COURT SHOREVIEW, MN 55126

(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 12 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 an attempt to collect records for review, the licensee failed to provide a fire safety and evacuation plan. Also, failed to provide the required documentation for employee and resident training and drills for the 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, 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). Findings include:	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35192	A. BUILDING: _____ B. WING _____	02/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KIND HEART CARE HOME INC	1049 GLEN PAUL COURT SHOREVIEW, MN 55126

(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 13 An attempt was made on February 6, 2024, via email at 10:09 a.m. and another attempt via phone call on February 7, 2024, at 11:35 a.m. by staff to obtain the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for this facility. Licensed assisted living director (LALD)-A did not respond to the email or the phone call. No information was provided during the time of the survey. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
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 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 one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a	0 970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35192	A. BUILDING: _____ B. WING _____	02/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KIND HEART CARE HOME INC	1049 GLEN PAUL COURT SHOREVIEW, MN 55126

(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 14 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: The licensee's Assisted Living contract for R1, signed August 1, 2021, contained the following language waiving the facility's liability for health, safety, or personal property of a resident: Miscellaneous Provisions 1. Insurance Liability and Release. The resident shall maintain at all times his or her own health, personal property, liability, automobile (if applicable), and other insurance coverage and shall provide evidence of same by copies of binders or policies provided to [facility name] upon request. The resident acknowledges that [facility name] is not an insurer of the resident's person or property. The resident agrees that [facility name] will not be liable to the resident for any personal injury or property damage (including, without limitation, damage to, or loss or theft of, automobiles or personal property of resident) suffered by the resident or the resident's agents, guests or invitees, unless and to the extent that the injury or damage is caused by the negligence of [facility name] or its employees or agents. The resident hereby releases [facility name] from liability for any personal injury or property damage suffered by the resident or the resident's agents, guests or invitees, unless caused by the negligence of [facility name] or its employees or agents. On February 7, 2024, at 1:10 p.m., licensed assisted living director (LALD)-A stated the licensee provided the same assisted living	0 970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35192	A. BUILDING: _____ B. WING _____	02/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KIND HEART CARE HOME INC	1049 GLEN PAUL COURT SHOREVIEW, MN 55126

(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 15 contract to all residents and confirmed the above liability clause was in all residents Assisted Living Contracts. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		
01710 SS=D	144G.71 Subd. 3 Individualized medication monitoring and reas The assisted living facility must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. 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 for self-administration of medications for one of one resident (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:	01710		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35192	A. BUILDING: _____ B. WING _____	02/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KIND HEART CARE HOME INC	1049 GLEN PAUL COURT SHOREVIEW, MN 55126

(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
01710	Continued From page 16 R1's diagnoses included anxiety, schizophrenia-affective disorder, bipolar, type two diabetes, and sleep apnea. R1's Service Plan dated November 8, 2023, indicated R1 received medication administration. R1's prescriber's orders dated November 2, 2023, included: -Ventolin 90 micrograms (mcg) inhale one to two puffs every four hours while awake for shortness of breath; -Symbicort 160 mcg inhale two puffs by mouth two times a day; and -nicotine patch 14 milligrams (mg) (used to help quit smoking) apply one patch to clean, dry, hairless skin. R1's comprehensive assessments dated August 1, 2023, and November 9, 2023, indicted staff administered R1's medications as ordered by providers and medication self-administration was not applicable. R1's February 2024 Medication Administration Record (MAR) indicated to apply one nicotine patch to clean, dry, hairless skin once daily and remove old patch before applying new patch. Symbicort inhaler 160/4.6 mcg inhale two puffs by mouth twice daily then rinse mouth after every use; and Ventolin inhaler 90 mcg inhale one to two puffs by mouth every four hours while awake. R1's MAR did not indicate R1 was able to self-administer inhalers or apply own nicotine patch. On February 7, 2024, at 7:33 a.m., the surveyor observed R1 open a nicotine patch and hand R1 the patch to apply. R1 removed the film from the	01710		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35192	A. BUILDING: _____ B. WING _____	02/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KIND HEART CARE HOME INC	1049 GLEN PAUL COURT SHOREVIEW, MN 55126

(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
01710	Continued From page 17 back of the new patch and applied the nicotine patch to his upper left chest. At 8:12 a.m., the surveyor observed ULP-E hand R1 his Ventolin inhaler to self-administer. R1 compressed the inhaler and inhaled three consecutive puffs of the medicine then ULP-E handed R1 his Symbicort inhaler and instructed R1 to inhale only one puff. R1 compressed the inhaler and inhaled two consecutive puffs of the medicine. After use of the inhalers, R1 did not rinse his mouth as directed on the MAR. On February 7, 2024, at 9:00 a.m., the surveyor observed R1's MAR with ULP-E and licensed assisted living director (LALD)-A. ULP-E stated R1's MAR did not indicate R1 was able to self-administer his inhalers or apply his nicotine patch. ULP-E stated sometimes R1 wanted to administer his own inhaler and patch and other times R1 wanted staff to complete everything for him. LALD-A stated they want the residents to be involved in their care and try to do as much for themselves to encourage independence. On February 7, 2024, at 10:09 a.m., clinical nurse supervisor (CNS)-B stated staff handed R1 his inhalers to self-administer and R1 gave the inhalers back to staff to store. CNS-B stated she completes a medication assessment every 90 days or if there was a change in condition. CNS-B verified R1's assessments did not include a self-medication assessment to ensure R1 was able to correctly self-administer inhalers and the assessments indicated self-administration was not applicable. CNS-B stated there was no documentation in R1's medical record indicating R1 was able to self-administer own inhalers or apply nicotine patch. The licensee's Assessment and Reassessment	01710		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35192	A. BUILDING: _____ B. WING _____	02/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KIND HEART CARE HOME INC	1049 GLEN PAUL COURT SHOREVIEW, MN 55126

(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
01710	Continued From page 18 policy dated August 1, 2021, indicated an individualized initial evaluation of all new residents would be completed by a registered nurse in or order to develop a personalized service plan. The assessment shall be revised regularly and as appropriate. The licensee's Medication Administration policy dated August 1, 2021, indicated all staff with responsibility for medication administration have access to information about the medication being administered, including but not limited to instructions related to the medication and specific to the residents as appropriate. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01710		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were securely stored and only authorized personnel had access to medications being stored by the licensee. 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	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35192	A. BUILDING: _____ B. WING _____	02/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KIND HEART CARE HOME INC	1049 GLEN PAUL COURT SHOREVIEW, MN 55126

(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
01880	Continued From page 19 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: R1's diagnoses included anxiety, schizophrenia-affective disorder, bipolar, type two diabetes, and sleep apnea. R1's Service Plan dated November 8, 2023, indicated R1 received medication administration services. R1's 90-Day Assessment dated November 8, 2023, indicated R1's received storage and R1's medications would be secured and stored in a locked cabinet. On February 5, 2024, at 8:37 a.m., the surveyor and licensed assisted living director (LALD)-A observed the medication storage cabinets. LALD-A obtained R1's Ventolin and Symbicort inhalers from an unlocked desk drawer in the office and placed the inhalers in the medication cabinet. LALD-A stated staff must have just administered R1's inhalers and had not put them back in the medication cabinet. LALD-A R1's inhalers should have been stored and locked in the cabinet after administered. On February 7, 2024, at 7:33 a.m., the surveyor observed unlicensed personnel (ULP)-E prepare R1's morning medications in the office where medications were stored with LALD-A. LALD-A left the office and ULP-E completed R1's medication set up, gathered medications and	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35192	A. BUILDING: _____ B. WING _____	02/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KIND HEART CARE HOME INC	1049 GLEN PAUL COURT SHOREVIEW, MN 55126

(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
01880	Continued From page 20 creams, and went to administer R1's medications in R1's bedroom which was located on the lower level of the home. When ULP-E exited the office, ULP-E left the medication cabinet door open and unlocked, R1's unlocked medication box was left on the desk, and the office door was left open. When ULP-E and the surveyor arrived at R1's room, LALD-A was observed standing outside of R1's room, leaving the office and medications unsecured and unattended. On February 8, 2024, at 8:10 a.m., LALD-A stated ULP-E left the office without securing the medications because LALD-A was still in the office. The surveyor informed LALD-A when ULP-E and the surveyor left the office and arrived at R1's room, LALD-A was not in the office and was standing outside of R1's door, leaving the office door and medication cabinet open and unlocked. The licensee's Storage/Control of Medications policy dated August 1, 2021, indicated all prescription drugs would be securely locked. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
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.	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35192	A. BUILDING: _____ B. WING _____	02/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KIND HEART CARE HOME INC	1049 GLEN PAUL COURT SHOREVIEW, MN 55126

(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 21 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were maintained bearing the original prescription and failed to include the opened or expiration date for time sensitive medications being stored by the licensee. 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 February 5, 2024, at 8:37 a.m., the surveyor observed the medication storage cabinets with licensed assisted living director (LALD)-A. LALD-A pulled R1's inhalers from the unlocked desk drawer and put the inhalers in the medication cabinet. LALD-A stated staff just administered R1's inhalers and had not put them back in the medication cabinet. LALD-A observed and confirmed the following: R1's opened Symbicort inhaler (used to treat wheezing) lacked an original prescription label with information to include: -directions for use, medication dosage, resident's name, prescription number and the pharmacy in which it had been issued; and -lacked the date the inhaler had been opened and when the inhaler would expire.	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35192	A. BUILDING: _____ B. WING _____	02/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KIND HEART CARE HOME INC	1049 GLEN PAUL COURT SHOREVIEW, MN 55126

(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 22 The manufacturer's instructions for Symbicort inhaler dated December 2017, indicated Symbicort inhaler should be discarded when the counter reaches zero or three months after Symbicort was removed of its foil pouch. The licensee's Storage/Control of Medications policy dated August 1, 2021, indicated all prescription drugs were securely locked in substantially constructed compartments according to the manufacturer's directions. Prescription drugs, prior to being set up for immediate or later administration, must be kept in the original container(s) in which dispensed by the pharmacy bearing the original prescription label with legible information. The label must include contain the following: -prescription number and name of the medication; -strength and quality; -expiration date for time-dated drugs; -directions for use; -resident's name; -prescriber's name; -date issued; and -name and address of licensed pharmacy issuing the medication. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
02310 SS=G	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35192	A. BUILDING: _____ B. WING _____	02/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KIND HEART CARE HOME INC	1049 GLEN PAUL COURT SHOREVIEW, MN 55126

(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
02310	Continued From page 23 resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical or nursing standards for one of one resident (R1) who utilized consumer bed rails. 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 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 February 5, 2024, at 11:47 a.m., clinical nurse supervisor (CNS)-B stated the licensee had one resident who had a grab bar attached to his bed ,which was initiated and installed by R1's father. CNS-B stated she was unaware if the Consumer Product Safety Commission (CSPC) website was checked to see if R1's bed rail had been recalled because R1's father worked with an outside therapy provider to obtain the grab bar. On February 5, 2024, at 1:43 p.m., during the facility tour with licensed assisted living director (LALD)-A and CNS-B, the surveyor observed R1 had a standard bed with a consumer rectangular shaped metal bed rail positioned on the right upper side of the bed. The base of the bed rail	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35192	A. BUILDING: _____ B. WING _____	02/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KIND HEART CARE HOME INC	1049 GLEN PAUL COURT SHOREVIEW, MN 55126

(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
02310	Continued From page 24 was not secured to bed frame and was tucked between the frame and the mattress. CNS-B stated R1's father installed the bed rail and verified the bed rail was loose and not secured to the bed frame. R1's diagnoses included anxiety, schizophrenia-affective disorder, bipolar, type two diabetes, and sleep apnea. R1's Service Plan dated November 8, 2023, indicated R1 required assistance with medication management, blood glucose monitoring, dressing, grooming, bathing reminders, behavior management, housekeeping, shopping and transportation. R1's post hospitalization assessment dated August 1, 2023, indicated R1 had a standard bed frame and mattress and R1 was independent with bed mobility. R1's 90-Day Assessment dated November 8, 2023, indicated R1 had a standard bed frame and mattress. R1's assessment indicated a bed zone assessment was not applicable, either R1 did not have bed rails or R1 had a portable bed rail that was installed on a consumer bed. R1's Master Care Plan dated November 8, 2023, did not indicate R1 required the use of a bed rail and indicated R1 was independent with bed mobility. R1's record lacked the following: -type of consumer bed rail being used; -installation and use of the device according to manufacturer's guidelines; -evidence the licensee referred to the CSPC for bed rail recall information; and	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35192	A. BUILDING: _____ B. WING _____	02/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KIND HEART CARE HOME INC	1049 GLEN PAUL COURT SHOREVIEW, MN 55126

(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
02310	Continued From page 25 -on going assessment for the use of an assisted device as required in the uniform assessment tool; and -documentation of education provided to the resident and/or resident's representative on the risks versus benefits of the device. On February 6, 2024, at 9:42 a.m., LALD-A stated the manufacturer's directions for R1's consumer bed rail was obtained from R1's family and he was working on making sure the bed rail was appropriate and not on the CSPC website list of recalls. The Minnesota Department of Health Bed Rail Guidance and Portable Bed Rails dated January 1, 26, 2020, indicated On May 20, 2014, the United States Consumer Product Safety Commission (USCPSC), the overseeing body for portable bed rails not designed as part of the bed by the manufacturer, issued a recall of portable bed rails due to the risk of entrapment. The recall stated the use of portable bed rails, when used without a safety retention strap, can shift of place, creating a dangerous gap between the bed handle and side of the mattress. This posed a risk of entrapment, strangulation, and death. The Assisted Living Resources & Frequently Asked Questions (FAQs) last updated December 26, 2023, current recommendations for recall include the following "The United States Consumer Product Safety Commission (USCPSC) works to save lives and ensure safety by reducing the unreasonable risk of injuries and deaths associated with consumer products, such as portable bed rails. The CSPC posts information on its website related to portable bed rail recalls. Licensees should review the CSPC website regularly for updates on recalled portable	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35192	A. BUILDING: _____ B. WING _____	02/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KIND HEART CARE HOME INC	1049 GLEN PAUL COURT SHOREVIEW, MN 55126

(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
02310	Continued From page 26 bed rails. The opportune time to do this would be with the 90-day assessment due to the requirement included in the uniform assessment tool for assessing assistive devices. The licensee's Side Rail policy dated August 1, 2021, indicated before implementing side rails for a resident, the RN would conduct a side rail assessment that included the following: -level of mobility, including bed mobility; -level of consciousness; -level of cognition; -presence of orthostatic hypotension; and -vision. The policy further indicated the RN would discuss with the resident/representative(s) alternative to the use of a side rail, provide education related to the side rail and document the purpose of the side rail and education provided. The resident, resident's legal representative or resident's designated representative would co-sign the document agreeing to the benefits and risks of the side rails. The RN was responsible to ensure the side rail in use is of safe design and properly maintained. Side rails would be used consistent with the manufacturer's recommendations. If the manufacturer's recommendations were not available, the RN would use appropriate nursing judgement related to the implementation of the side rails. The need for the side rails would be reassessed and documented as needed, but not less than every 90 days. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate Immediacy is removed as confirmed by supervisor's review of licensee's action plan on February 8, 2024, however non-compliance	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35192	A. BUILDING: _____ B. WING _____	02/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KIND HEART CARE HOME INC	1049 GLEN PAUL COURT SHOREVIEW, MN 55126

(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
02310	Continued From page 27 remains at a scope and level of level three, isolated (G).	02310		
02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care medical or nursing standards for medication administration by unlicensed personnel (ULP)-E for one of one resident (R1) whose medications were not administered as directed and whose medications were documented prior to administration. 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 Service Plan dated November 8, 2023,	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35192	A. BUILDING: _____ B. WING _____	02/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KIND HEART CARE HOME INC	1049 GLEN PAUL COURT SHOREVIEW, MN 55126

(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
02320	Continued From page 28 indicated R1 received medication administration services. R1's prescriber's orders dated November 2, 2023, included: -Ventolin 90 micrograms (mcg) inhale one to two puffs every four hours while awake for shortness of breath; and -Symbicort 160 mcg inhale two puffs by mouth two times a day. R1's February 2024 Medication Administration Record (MAR) directed Symbicort inhaler 160/4.6 mcg inhale two puffs by mouth twice daily then rinse mouth after every use; and Ventolin inhaler 90 mcg inhale one to two puffs by mouth every four hours while awake. On February 7, 2024, at 7:33 a.m., the surveyor observed ULP-E administering R1's morning pills and topical creams. After administering R1's medications, ULP-E documented in R1's electronic medical record all scheduled morning medications were administered including R1's Ventolin and Symbicort inhalers, which ULP-E did not administer at the time of the medication observation. ULP-E stated he forgot to bring R1's inhalers with when he administered R1's medications and went back to R1's room to administer the inhalers. ULP-E handed R1 his Ventolin inhaler to self-administer. R1 compressed the inhaler and inhaled three consecutive puffs of the medicine then ULP-E handed R1 his Symbicort inhaler and instructed R1 to inhale only one puff. R1 compressed the inhaler and inhaled two consecutive puffs of the medicine. ULP-E did not instruct R1 to shake the inhalers before use, wait in-between puffs of the medications or instruct R1 to rinse his mouth after the use of the inhalers.	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35192	A. BUILDING: _____ B. WING _____	02/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KIND HEART CARE HOME INC	1049 GLEN PAUL COURT SHOREVIEW, MN 55126

(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
02320	Continued From page 29 On February 7, 2024, at 9:00 a.m., the surveyor observed R1's MAR with ULP-E and licensed assisted living director (LALD)-A and ULP-E stated R1's MAR indicated to administer R1's Ventolin inhaler one to two puffs every four hours while awake and administer Symbicort two puffs and to rinse mouth after use. ULP-E verified he did not instruct R1 to wait in-between puffs of the medication or remind R1 to rinse his mouth after use of the inhalers. On February 7, 2024, at 10:09 a.m., clinical nurse supervisor (CNS)-B stated staff have been trained to document medication administration after the medications were administered and not before and to follow directions on the MAR. CNS-B stated R1's MAR directed to rinse mouth after use of Symbicort inhaler and the Inhalant Protocol written instructions were to shake the inhaler before use, inhale the medicine, hold for a few seconds, then exhale. CNS-B stated staff had access to written procedures located in a binder in the office for reference. The Medication Protocol for Inhalants dated 2020, indicated to position the resident correctly either sitting or standing, instruct the resident to exhale, place mouthpiece in mouth, inhale while compressing the inhaler once, hold breath for three seconds, exhale slowly and repeat until medication is delivered as prescribed and document on appropriate charting sheet. The manufacturer's instructions for Symbicort inhaler dated 2017, directed to shake the inhaler before each use and rinse mouth with water without swallowing after use to prevent thrush. The manufacturer's instructions for Ventolin	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35192	A. BUILDING: _____ B. WING _____	02/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KIND HEART CARE HOME INC	1049 GLEN PAUL COURT SHOREVIEW, MN 55126

(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
02320	Continued From page 30 inhaler dated 2014, directed to shake the inhaler well before each spray. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		

Minnesota Department of Health
Division of Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *02/06/24*
Time: 11:30:00
Report: 1025241022

Food and Beverage Establishment Inspection Report

Location:
Kind Heart Care Home Inc
Kind Heart Care Home Inc.
1049 Glen Paul Court
Shoreview, MN55126
Ramsey County, 62

Establishment Info:
ID #: 0038362
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 7632699830
ID #:

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

The following orders were issued during this inspection.

4-300 Equipment Numbers and Capacities

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

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

Provide a working food thermometer as above for the kitchen (bimetal TMD and a deltarak provided, however the unit was not working during inspection).

Comply By: 02/09/24

4-100 Equipment Construction Materials

4-101.11BCDE

MN Rule 4626.0450BCDE Remove all multi-use equipment, utensils, and food storage containers that are not durable, corrosion-resistant, nonabsorbent, smooth, easily cleanable, resistant to pitting, chipping, scratching or not able to withstand repeated warewashing.

Discontinue use and remove the "red" pants from the establishment, as the non-stick coating on these has been scratched/damaged. (Pans pulled from cabinet and set on counter during inspection).

Corrected on Site

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.111ABD

MN Rule 4626.1565ABD Provide control of insects, rodents, and other pests by routinely inspecting incoming food and supply shipments; routinely inspecting the premises for evidence of pests; and eliminating harborage conditions.

Bait box out for mice; loose sugar, crumbs, in cabinets. Clean the interior of cabinets and under equipment to reduce food/harborage condition for potential pests. Clean the interior of the drawer under the stove, wipe out cabinets, underside by stove...

Type: Full
Date: *02/06/24*
Time: 11:30:00
Report: 1025241022
Kind Heart Care Home Inc

Food and Beverage Establishment Inspection Report

Comply By: 02/09/24

Food and Equipment Temperatures

Process/Item: Sour cream
Temperature: 40 Degrees Fahrenheit - Location: Refrigerator
Violation Issued: No

Process/Item: Cheese, pkg
Temperature: 41 Degrees Fahrenheit - Location: Refrigerator, dining room
Violation Issued: No

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

Discussed resident food – if residents independently prepare or purchase their own meals without staff intervention, it can be considered a personal item. TCS food should still be discarded within seven days of opening/preparation. It was discussed a resident is combative with staff over their food – a resident does not necessarily need to date label their own personal item, but as MN 4626 considers it unsafe past seven days, it shouldn't be consumed past that point (there may be an HRD requirement which would compel the licensee to discard any food available to residents considered unsafe, for example).

Staff food is their own personal item and would need to be maintained separate from resident and establishment-provided food.

Mark the date on establishment provided TCS food when prepared or opened (only TCS foods in the refrigerator were cultured dairy; it's a good practice to date-mark condiments and other items, though only marking of TCS foods is required). TCS food must be made for same-day service for equipment to fall under 4626.0506 G.

Deltatrak thermometer available but needs a new battery or replacement. There was a min/max in the dishwasher, but also requires a new batter or replacement. The Deltratrak can be used both as a food thermometer and to test the maximum temperature inside of the dishwasher.

For dry food items, suggest to store in airtight/pest proof containers.

Hand sanitizer gel and Dawn soap provided at sink. Sanitizer gel can be used after handwashing. Provide a dispenser and more gentle soap for hands at the sink (Dawn is better for dishes than hands, though it is still technically soap).

SINK USAGE
Facility has a two (2) compartment sink
Facility has a dishwasher with NSF 184 certfication
Facility does not have a 3 compartment sink
Facility does not have a food preparation sink
Facility does not have a stand-alone/dedicated handwashing sink

FACILITY
Kitchen has tile floor, solid surface countertops, wood cabinets, hollow enclosed cabinet bases
Appliances are residential

COUNTERTOPS AND FOOD CONTACT SURFACES
Provide a smooth, non-porous food contact surface (e.g. cutting boards) that can be easily washed, rinsed, and sanitized (e.g. run through the dishwasher). Soap and water can be used to clean non-food contact surfaces. By provided a cutting board or other non-porous food contact surface, the countertops can be kept clean without the use of substances which may damage the finish. Do not use wood as a food contact surface.

DISHWASHING – NSF 184
Dishwasher has a sanitizing rinse option (NSF/ANSI Standard 184) – use this option to sanitize utensils
Provide a means of testing the internal contact temperature of utensil in the dishwasher
If the sanitize cycle on the dishwasher will not be used, provide an alternate means of chemical sanitizing (e.g. a bus tub or other basin, to be filled with water and sanitizing solution e.g. chlorine bleach (non-scented, labeled for Sanitizing Food Contact Surfaces) at 50-100 PPM; provide a test kit for chemical sanitizing)
Recommend having an alternative means of sanitizing available case of emergency or service interruption

EQUIPMENT
MN 4626.0506 includes alternate equipment and finish requirements for adult care facilities which serve TCS foods for same-day service only:

MN 4626.0506 G. A food establishment that is an adult care center, child care center, or boarding establishment does not need to comply with item A [certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program for food service equipment] if approved by the regulatory authority and the food establishment:
(1) serves only non-TCS food; or
(2) prepares TCS foods only for same-day service.

Discontinue any service of TCS food for multiple day service (e.g. cooling and reservice of leftovers of prepared and cooked TCS food), or upgrade finishes and equipment in the kitchen

GENERAL COMMENTS
CFPM (Certified Food Protection Manager)
For information, please search "MDH CFPM"

Discussed employee health and hygiene, exclusion for individuals from the kitchen with vomiting and/or diarrheal illness, sore throat with fever, or reportable illness; food cooking and holding temperatures, cross-contamination, allergens, food storage order in refrigerator, separating resident food from medication or staff food, avoiding bare hand contact with foods which will not be cooked (cut fruit, deli sandwiches), pest control, quarantine meals

Date marking TCS foods (when packages are opened or food is prepared, date mark and discard after 7 days, except for certain cultured dairy products)
Chemical label, use, and storage
Discussed food source, recalls, and refusing food which has signs of tampering or temperature abuse
Information on food recalls available "MDA Food Recall"
https://www.mda.state.mn.us/food-feed/food-recalls-consumer-advisories-minnesota

FACT SHEETS
Please search "MDH Fact Sheets" for the Food Business fact sheets page

"Cleaning and Sanitizing" https://www.health.state.mn.us/communities/environment/food/docs/fs/cleansanfs.pdf
"Food Cooking Temperatures"
https://www.health.state.mn.us/communities/environment/food/docs/fs/timetempfs.pdf
"Date Marking TCS foods"
https://www.health.state.mn.us/communities/environment/food/docs/fs/datemarkingfs.pdf
"Highly Susceptible Populations" - no service or raw or undercooked animal food, use Pasteurized eggs when preparing eggs raw or undercooked or batching scrambled eggs
https://www.health.state.mn.us/communities/environment/food/docs/fs/highsuspopfs.pdf

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 1025241022 of 02/06/24.

Certified Food Protection Manager: Mohamed D Subane

Certification Number: FM115162 Expires: 02/07/26

Inspection report reviewed with person in charge and emailed.

Signed: _____
Establishment Representative

Signed: _____
Casey Kipping
Public Health Sanitarian III
Freeman Building St Paul
651-201-4513
casey.kipping@state.mn.us

Report #: 1025241022

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Division of Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975

No. of RF/PHI Categories Out	0	Date	02/06/24
No. of Repeat RF/PHI Categories Out	0	Time In	11:30:00
Legal Authority MN Rules Chapter 4626		Time Out	

Kind Heart Care Home Inc	Address: Kind Heart Care Home Inc.	City/State: Shoreview, MN	Zip Code: 55126	Telephone: 7632699830
License/Permit #: 0038362	Permit Holder:	Purpose of Inspection: Full	Est Type:	Risk Category:

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item — Mark "X" in appropriate box for COS and/or R

IN= in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

Compliance Status						COS	R
Surpervision							
1	(IN)	OUT			PIC knowledgeable; duties & oversight		
2	(IN)	OUT	N/A		Certified food protection manager, duties		
Employee Health							
3	(IN)	OUT			Mgmt/Staff;knowledge,responsibilities&reporting		
4	(IN)	OUT			Proper use of reporting, restriction & exclusion		
5	(IN)	OUT			Procedures for responding to vomiting & diarrheal events		
Good Hygenic Practices							
6	(IN)	OUT		N/O	Proper eating, tasting, drinking, or tobacco use		
7	(IN)	OUT		N/O	No discharge from eyes, nose, & mouth		
Preventing Contamination by Hands							
8	(IN)	OUT		N/O	Hands clean & properly washed		
9	(IN)	OUT	N/A	N/O	No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10	(IN)	OUT			Adequate handwashing sinks supplied/accessible		
Approved Source							
11	(IN)	OUT			Food obtained from approved source		
12	IN	OUT	N/A	(N/O)	Food received at proper temperature		
13	(IN)	OUT			Food in good condition, safe, & unadulterated		
14	IN	OUT	(N/A)	N/O	Required records available; shellstock tags, parasite destruction		
Protection from Contamination							
15	(IN)	OUT	N/A	N/O	Food separated and protected		
16	(IN)	OUT	N/A		Food contact surfaces: cleaned & sanitized		
17	(IN)	OUT			Proper disposition of returned, previously served, reconditioned, & unsafe food		

Compliance Status						COS	R
Time/Temperature Control for Safety							
18	IN	OUT	N/A	(N/O)	Proper cooking time & temperature		
19	IN	OUT	N/A	(N/O)	Proper reheating procedures for hot holding		
20	IN	OUT	N/A	(N/O)	Proper cooling time & temperature		
21	IN	OUT	N/A	(N/O)	Proper hot holding temperatures		
22	(IN)	OUT	N/A		Proper cold holding temperatures		
23	(IN)	OUT	N/A	N/O	Proper date marking & disposition		
24	IN	OUT	(N/A)	N/O	Time as a public health control: procedures & records		
Consumer Advisory							
25	IN	OUT	(N/A)		Consumer advisory provided for raw/undercooked food		
Highly Susceptible Populations							
26	(IN)	OUT	N/A		Pasteurized foods used; prohibited foods not offered		
Food and Color Additives and Toxic Substances							
27	IN	OUT	(N/A)		Food additives: approved & properly used		
28	(IN)	OUT			Toxic substances properly identified, stored, & used		
Conformance with Approved Procedures							
29	IN	OUT	(N/A)		Compliance with variance/specialized process/HACCP		

Risk factors (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

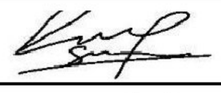
Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is **not** in compliance — Mark "X" in appropriate box for COS and/or R — **COS=** corrected on-site during inspection **R=** repeat violation

			COS	R
Safe Food and Water				
30	IN OUT (N/A)	Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32	IN OUT (N/A)	Variance obtained for specialized processing methods		
Food Temperature Control				
33		Proper cooling methods used; adequate equipment for temperature control		
34	IN OUT N/A (N/O)	Plant food properly cooked for hot holding		
35	IN OUT N/A (N/O)	Approved thawing methods used		
36	X	Thermometers provided & accurate		
Food Identification				
37		Food properly labled; original container		
Prevention of Food Contamination				
38	X	Insects, rodents, & animals not present		
39		Contamination prevented during food prep, storage & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
Proper Use of Utensils				
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
Utensil Equipment and Vending				
47	X	Food & non-food contact surfaces cleanable, properly designed, constructed, & used	X	
48		Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
Physical Facilities				
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) 

Date: 02/06/24

Inspector (Signature)