Electronically Delivered

January 14, 2025

Licensee
Charity Care Inc.
2816 92nd Crescent North
Brooklyn Park, MN 55443

RE: Project Number(s) SL35217015

Dear Licensee:

On December 16, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the September 26, 2024, survey were corrected. This follow-up survey verified that the facility is in 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,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: jess.schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

JMD

Electronically Delivered

October 11, 2024

Licensee
Charity Care Inc
2816 92nd Crescent North
Brooklyn Center, MN 55443

RE: Project Number(s) SL35217015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on September 26, 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 . . ."

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.

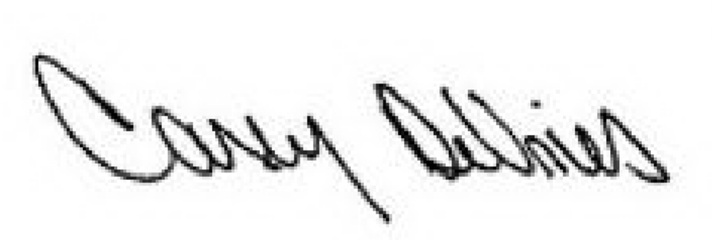
To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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,



Casey DeVries, Supervisor
State Evaluation Team
Email: Casey.DeVries@state.mn.us
Telephone: 651-201-5917 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35217	A. BUILDING: _____ B. WING _____	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARITY CARE INC	2816 92ND CRESCENT NORTH BROOKLYN CENTER, MN 55443

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL35217015-0 On September 23, 2024, through September 26, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were two residents; both of whom were receiving services under the Assisted Living license. An immediate correction order was identified on September 25, 2024, issued for SL35217015-0, tag identification 0820. During the survey, the licensee took action to mitigate the immediate risk. However, noncompliance remained, and the scope and level remain unchanged.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness	0 680		

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0 680	Continued From page 1 (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not 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	0 680		

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0 680	Continued From page 2 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: The licensee's emergency disaster preparedness plan reviewed on August 23, 2023, lacked evidence of the following required content: - Develop/implement EP policies/procedures (P/P) to address the use of volunteers and other emergency staffing strategies; - P/P to address role of facility under a waiver declared by the Secretary in accordance with section 1135 of the Act; - conduct exercises to test the EP at least twice per year, including unannounced staff drills using the EP that include the following: -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 September 24, 2024, at 12:58 p.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-C acknowledged the above-mentioned items were missing from the EP plan and stated, "I am missing some of those items and will need to get my trainings done separately instead of a general lumped together training."	0 680		

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0 680	Continued From page 3 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 780 SS=D	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity 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 interconnected smoke alarms	0 780		

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0 780	Continued From page 4 inside all sleeping rooms in the facility. This had the potential to directly affect a limited number of residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: During facility tour on September 25, 2024, from 11:00 a.m. through 11:30 a.m., with clinical nurse supervisor/licensed assisted living director (CNS/LALD)-C, the surveyor observed that the smoke alarm inside resident sleeping room 1 was 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 CNS/LALD-C tested the smoke alarms and verified the smoke alarm in resident sleeping room 1 was not interconnected so activation of one alarm activates all alarms throughout the facility. CNS/LALD-C stated they understood the requirements. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		

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0 810	Continued From page 5	0 810		
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 activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on interview and record review, the	0 810		

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0 810	Continued From page 6 licensee failed to develop the fire safety and evacuation plan with required content and failed to conduct the required drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On September 25, 2024, clinical nurse supervisor/licensed assisted living director (CNS/LALD)-C, provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee's FSEP, titled "Fire Safety", dated August 1, 2023, failed to provide the following: The FSEP included standard resident evacuation procedures and provided specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. However, the plan had not been updated to include the current residents at the facility. CNS/LALD-C stated that the plan had not been updated since the current residents had moved in.	0 810		

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0 810	Continued From page 7 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 September 25, 2024, at 12:15 p.m., CNS/LALD-C stated they understood the areas of the policy that were incomplete and would work on bringing them into compliance. DRILLS Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift. Documentation provided showed that evacuation drills were conducted during the even months in 2024 but failed to show that each shift had participated in at least two evacuation drills. During an interview on September 25, 2024, at 12:15 p.m., CNS/LALD-C stated that they had not been providing evacuation drills for all work shifts. The surveyor showed CNS/LALD-C where the requirement for evacuation drills was stated in their policy. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 820 SS=I	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use	0 820		

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0 820	Continued From page 8 does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide facilities that were not a distinct hazard to life. This had the potential to directly affect all of the residents and staff. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a 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 September 25, 2024, from 11:00 a.m., through 11:30 a.m. with clinical nurse supervisor/licensed assisted living director (CNS/LALD)-C, the surveyor observed that compliant emergency escape and rescue openings were not provided in resident sleeping rooms 2, 3, and 4. OCCUPIED SLEEPING ROOMS Resident sleeping room 3, located on the second	0 820	During the survey, the licensee took action to mitigate the immediate risk. However, noncompliance remained, and the scope and level remain unchanged.	

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0 820	Continued From page 9 floor, occupied, emergency escape and rescue clear window opening measurements are 16 inches wide, 43 inches in height and 688 square inches in openable area. CNS/LALD-C opened the window, and the window was measured with CNS/LALD-C, and the surveyor. The window did not meet the minimum requirements for clear opening width. UNOCCUPIED SLEEPING ROOMS Resident sleeping room 2, located on the second floor, unoccupied, emergency escape and rescue clear window opening measurements are 16 inches wide, 43 inches in height and 688 square inches in openable area. CNS/LALD-C opened the window, and the window was measured with CNS/LALD-C, and the surveyor. The window did not meet the minimum requirements for clear opening width. Resident sleeping room 4, located on the second floor, unoccupied, emergency escape and rescue clear window opening measurements are 16 inches wide, 43 inches in height and 688 square inches in openable area. CNS/LALD-C opened the window, and the window was measured with CNS/LALD-C, and the surveyor. The window did not meet the minimum requirements for clear opening width. It was explained to CNS/LALD-C, that at least one compliant emergency escape and rescue opening is required within each resident sleeping room. Existing emergency escape and rescue openings are required to meet a minimum clear opening area of 648 square inches and have a minimum dimension of 20 inches in height and a minimum	0 820		

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0 820	Continued From page 10 dimension of 20 inches in width. The windowsill height from the floor to the clear opening shall be not more than 48 inches. These deficient conditions were visually verified by CNS/LALD-C, accompanying on the tour. The surveyor explained that an immediate correction order was issued for the above findings. TIME PERIOD FOR CORRECTION: Immediate.	0 820		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident	01060		

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01060	Continued From page 11 may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation to the resident, legal representative, or designated representative and failed to provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC) of an emergency relocation greater than four days for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when 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:	01060		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35217	A. BUILDING: _____ B. WING _____	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARITY CARE INC	2816 92ND CRESCENT NORTH BROOKLYN CENTER, MN 55443

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01060	Continued From page 12 R2 was admitted to the licensee and began receiving assisted living services on January 31, 2023. R2's progress notes dated July 27, 2024, indicated R2 was sent to the emergency room on July 27, 2024; although, the progress note did not identify when R2 was admitted to the hospital. On September 24, 2024, at 2:13 p.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-C sent the surveyor an email that read, "[R2] Hospitalization Dates :7/27-8/21" R2's record lacked a written notice with the required statutory content provided to the resident or resident representative of the emergency relocation. On September 24, 2024, at 12:51 p.m. CNS/LALD-C stated, " No, I didn't send one (emergency relocation form) are we supposed to? I honestly had no idea about that." The licensee's 9.01 Emergency Preparedness Plan - Appendix Z Compliance policy, dated January 1, 2024, read, "[Licensee] emergency preparedness plan will include all required elements of appendix Z. The plan will be in writing and reviewed annually. The plan is based on our assisted living-based and community-based risk assessments, utilizing an all-hazards approach." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		

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01290	Continued From page 13	01290		
01290 SS=E	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study (BGS) was submitted and a clearance received in affiliation with the assisted living licensee's current health facility identification (HFID) for four of fifteen employees (unlicensed personnel (ULP)-F, ULP-G, ULP-H and ULP-I). This had the potential to affect all residents living within 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not	01290		

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01290	Continued From page 14 found to be pervasive). The findings include: ULP-F ULP-F was hired on September 4, 2024, to perform direct care services to the licensee's residents. ULP-F's employee record contained a background study dated August 13, 2024, affiliated with the licensee's sister facility under HFID 34750. ULP-F's employee record lacked evidence of a current, cleared background study affiliated with the licensee's current assisted living HFID license 35217. ULP-G ULP-G was hired on May 28, 2024, to perform direct care services to the licensee's residents. ULP-G's employee record contained a background study dated January 25, 2023, affiliated with the licensee's sister facility under HFID 36638. ULP-G's employee record lacked evidence of a current, cleared background study affiliated with the licensee's current assisted living HFID license 35217. ULP-H ULP-H was hired on April 15, 2024, to perform direct care services to the licensee's residents. ULP-H's employee record contained a background study dated March 28, 2024, affiliated with the licensee's sister facility under HFID 36638. ULP-H's employee record lacked evidence of a current, cleared background study affiliated with the licensee's current assisted living HFID license 35217.	01290		

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01290	Continued From page 15 ULP-I ULP-I was hired on March 26, 2024, to perform direct care services to the licensee's residents. ULP-I's employee record contained a background study dated February 15, 2024, affiliated with the licensee's sister facility under HFID 36638. ULP-I's employee record lacked evidence of a current, cleared background study affiliated with the licensee's current assisted living HFID license 35217. On September 24, 2024, at 9:25 a.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-C stated, "I tried to pull up my net study roster for this HFID yesterday as I knew you would need it, and I could not find this HFID so I emailed them because I can only find my other two HFIDs. So like, [ULP-B] is ran [sic] under another HFID, but I need to affiliate him to this HFID still. When someone is hired at any of my HFIDs I try to affiliate them to all the HFIDs but some of the employees here started at a different HFID and then came to this one to work or pick up hours and I still need to run them under this HFID." The licensee's 4.02 Background Studies policy, dated January 1, 2024, read, "No employee may provide direct services and have independent direct contact with any residents until acceptable result of the background study have been received. Charity Care will not employ individuals whose results of the background study indicate disqualification for the position." No further information was provided. TIME PERIOD OF CORRECTION: Two (2) days	01290		

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01750 SS=F	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure prior to delegating the task of medication administration, the registered nurse (RN) trained the unlicensed personnel (ULP) in the proper methods to perform the task or procedure for each resident and verified the ULPs were able to demonstrate the ability to competently follow the procedure. 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: R2's Service Plan signed May 23, 2023, indicated R2 received assistance with dressing,	01750		

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01750	Continued From page 17 grooming, toileting, laundry, medication administration, housekeeping, incontinence care, vitals, positioning and re-positioning, and behavior management. R2's physician order signed April 30, 2024, included diclofenac gel one percent (%) (a nonsteroidal anti-inflammatory drug (NSAID)) apply topically two grams (gm) to the affected area four times per day. On September 24, 2024, at 8:44 a.m., the surveyor observed ULP-B place a large ribbon of diclofenac gel 1% directly onto R2's right forearm. On September 24, 2024, at 8:44 a.m., the surveyor inquired how diclofenac gel 1% was measured. ULP-B stated, "[R2] is supposed to get 2 grams, when we administer the cream, we are to administer 2 grams as we were trained by the nurse but we don't have anything to measure 2 grams so we do what we can without measuring." On September 24, 2024, at 10:56 a.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-C stated, "I train them to wash hands put on gloves and administer, I just tell them to take a small amount and just don't take too much. We have never had a measuring tool, so we just put some on." Food and Drug Administration document titled Highlights of Prescribing Information dated last revised May 2016 indicated dosing for diclofenac sodium topical gel 1% (Voltaren Gel) should be measured onto a dosing card supplied in the drug product carton. The licensee's 7.22 Medication & Treatment	01750		

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01750	Continued From page 18 Record - Documentation & Refusal policy, dated January 1, 2024, read, "[Licensee] will create and maintain a correct and accurate medication and/or treatment/therapy record for each resident receiving medication assistance or administration and or treatments and therapies. 1) The following must be documented in the resident's medication and/or treatment/therapy records after providing medication assistance or administration: a. The date, b. The time, c. The quantity of dosage, d. The method of administration of all prescribed legend and over-the-counter medications and or treatments/therapy e. Signature and title of the authorized person who provided the assistance and/or administration of medications/treatment/therapy 2) If medication and or treatment/therapy assistance and/or administration were not completed as prescribed, documentation must include the reason why it was not completed and any follow up procedures that were provided." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this	03090		

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03090	Continued From page 19 subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure a required notice was posted at the main entry way of the facility to display statutory language to disclose electronic monitoring activity. This had the potential to affect all six residents, staff, and visitors to the facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On September 23, 2024, at 10:00 a.m. the surveyor observed no electronic monitoring notice posted in the facility with the statutory required language. On September 24, 2024, at 12:58 p.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-C stated, "No I do not have a sign up because I do not use electronic monitoring." CNS/LALD-C acknowledged that the residents could be using electronic monitoring without her knowledge and the need for the signage. The licensee's 1.23 Emergency Relocation policy, dated January 1, 2024, read, "1. In the event of an emergency relocation, [Licensee] will provide a written notice that contains, at a minimum: a. The reason for the relocation	03090		

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03090	Continued From page 20 b. The name and contact information for the location to which the resident has been relocated and any new service provider c. Contact information for the Office of Ombudsman for Long-Term Care d. If known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known, and e. A statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal. 3. The facility will provide contact information for the agency to which the resident may submit an appeal. 4. The notice required will be delivered as soon as practicable to: a. The resident, legal representative, and designated representative b. For residents who receive home and community-based waiver services, the resident's case manager, and c. The Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090		

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

Type: Full
Date: *09/23/24*
Time: 11:40:03
Report: 8058241248

Food and Beverage Establishment Inspection Report

Location:
Charity Care Inc
2816 92nd Crescent North
Brooklyn Park, MN55443
Hennepin County, 27

Establishment Info:
ID #: 0037885
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7632736110
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.

Surface and Equipment Sanitizers

Hot Water: = --- at 160 Degrees Fahrenheit
Location: DISH WASHER
Violation Issued: No

Food and Equipment Temperatures

Process/Item: DELI MEAT
Temperature: 41 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

Process/Item: TOMATO
Temperature: 40 Degrees Fahrenheit - Location: COOELR
Violation Issued: No

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

HRD INSPECTOR: TESA BROWN

RESIDENTIAL HOME WITH NON COMMERCIAL APPLIANCES AND FINISHES

Type: Full
Date: *09/23/24*
Time: 11:40:03
Report: 8058241248
Charity Care Inc

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 8058241248 of 09/23/24.

Certified Food Protection Manager: RICHARDLYN HENRY

Certification Number: 120446 Expires: 11/07/26

Inspection report reviewed with person in charge and emailed.

Signed: _____
CHARITY ONGERI
DIRECTOR

Signed: _____
Aaron Gertz
Sanitarian 3
MDH Metro Office
651 201 4500
health.foodlodging@state.mn.us