Electronically Delivered

April 16, 2024

Licensee
Jabez Customized Living Services
8350 Pierce Street Northeast
Spring Lake Park, MN 55432

RE: Project Number(s) SL35705015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 10, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

The correction order documentation should include the following:

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

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

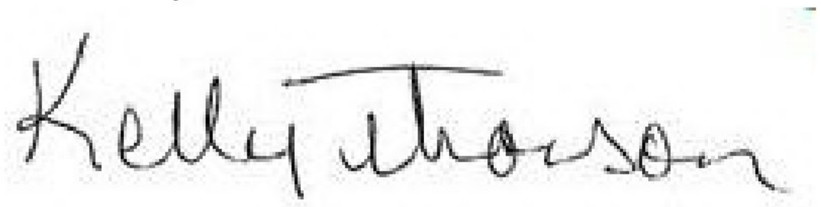
To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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

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

If you have any questions, please contact me.

Sincerely,



Kelly Thorson, Supervisor
State Evaluation Team
Email: kelly.thorson@state.mn.us
Telephone: 320-223-7336 Fax: 1-866-890-9290

AH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35705	A. BUILDING: _____ B. WING _____	04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JABEZ CUSTOMIZED LIVING SRVCS	8350 PIERCE STREET NE SPRING LAKE PARK, MN 55432

(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: SL35705015 On April 8, 2024 through April 10, 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 4 residents; 4 receiving services under the Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480		

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0 480	Continued From page 1 following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated April 8, 2024 , for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (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	0 680		

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0 680	Continued From page 2 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 develop an all-hazards risk assessment emergency preparedness program and plan to include Appendix Z required elements. 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 is 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:	0 680		

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0 680	Continued From page 3 The licensee's undated emergency preparedness plan (EPP), lacked the required content: - develop and maintain the EPP; - maintain annual updates; - identify program patient population; - a process for emergency preparedness (EP) collaboration with state and local EP officials/organizations; - the development of policies/procedures to address: - subsistence needs for staff and patients; - procedures for tracking staff and residents; - evacuation plan; - procedures for sheltering; - the medical record documentation system to preserve resident information; - use of volunteers; - arrangement with other facilities; and - roles under a wavier declared by secretary. - a communication plan that included: - names and contact information for staff, entities providing services, resident physicians, other facilities, and volunteers; - contact information for federal, state, tribal, local EP staff, state licensing and certification agency, or the ombudsman for long term care; - primary and alternative means for communicating with facility staff, or federal, state, regional and local emergency management agencies; - methods for sharing medical documentation for residents under the facility's care, as necessary, with other health care providers to maintain continuity of care; - means to provide information about the facility's occupancy, needs, and its ability to provide assistance to the authority having jurisdiction, the incident command center, or a designee; - method for sharing information from the emergency plan with residents and their	0 680		

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0 680	Continued From page 4 families/representatives; - emergency prep and training and testing; and - a quarterly review of missing resident policy. On April 9, 2024, at 9:50 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A agreed their emergency preparedness plan was missing some of the required content. LALD/CNS-A stated the plan is missing the policies because they are located in the office and that she is not reviewing the missing resident policy quarterly. The licensee's, undated Emergency Management policy, indicated the facility will develop and maintain a written emergency management plan describing the process for disaster readiness and emergency management and implements it as appropriate. 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. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the	0 800		

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0 800	Continued From page 5 health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On April 8, 2024, at 12:39 p.m., survey staff toured the home with licensed assisted living director/chief executive officer (LALD/CEO)-A. During the tour, survey staff observed a window in the living room covered with cardboard, and the window was broken. LALD/CEO-A explained during the facility tour interview a resident had thrown a TV through the window a few days ago. During an interview on April 10, 2024, at 8:30 a.m., LALD/CEO-A verified the middle windowpane was broken and stated the licensee had already received an estimate for the repair and a replacement window was ordered. The planned installation date for the new window was April 15, 2024.	0 800		

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0 800	Continued From page 6 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation 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.	0 810		

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0 810	Continued From page 7 This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to develop a fire safety and evacuation plan with the required content, and provide required training. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On April 8, 2024, the licensed assisted living director/chief executive officer (LALD/CEO)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and employee evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee failed to develop and maintain the FSEP evident by the following: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks.The FSEP included a fire safety program for the workplace policy. The employee actions for fire were limited to the acronyms RACE (Remove, Alarm, Confine,	0 810		

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0 810	Continued From page 8 and Extinguish or Evacuate) and PASS (Pull, Aim, Squeeze, and Sweep), and remaining in an evacuation area until ordered to move by the fire marshal. The evacuation area is not identified in the plan. The FSEP did not identify specific fire protection procedures for residents evident by limited instructions directing employees to assist residents away from immediate danger of fire or smoke and to close doors. No additional fire protection procedures necessary for residents were included in the plan. During an interview with survey staff on April 10, 2024, at 8:30 a.m., LALD/CEO-A verified the FSEP required revision and stated the facility would evacuate everyone immediately in the event of a fire. TRAINING Record review indicated the licensee failed to provide training to employees on the FSEP upon hire and/or at least twice per year as evident by the lack of training documentation to support this was completed. An employee training record documenting online training courses completed for emergency preparedness was provided. These online courses were not specific to the facility FSEP. During an interview with survey staff on April 10, 2024, at 8:30 a.m., LALD/CEO-A verified FSEP training records were not available and stated employees were trained on the FSEP at a frequency of twice a year, at the time of hire, and during fire drills. LALD/CEO-A explained employee training on the FSEP was completed but had not been documented. Record review indicated the licensee failed to provide annual training to residents on fire safety	0 810		

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0 810	Continued From page 9 and evacuation as evident by the lack of training documentation to support this was completed. During an interview with survey staff on April 10, 2024, at 8:30 a.m., LALD/CEO-A verified training records were not available and stated residents were trained when admitted to the facility, during fire drills, and then at a frequency of every month. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 950 SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a	0 950		

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0 950	Continued From page 10 designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to offer the resident the opportunity to identify a designated representative in writing with the required statutory language for 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 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 began receiving assisted living services from the licensee on July 24, 2023. R1's Resident Contract for Assisted Living was signed on July 24, 2023. R1's Resident Contract for Assisted Living did not include an area to designate a representative and lacked the verbatim "right to designate a representative for certain purposes" notice. On April 9, 2024, at 11:15 a.m., licensed assisted living director/ clinical nurse supervisor (LALD/CNS)-A stated the same contract was used for all the resident's and agreed it was	0 950		

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0 950	Continued From page 11 missing an area for the resident to identify a designated representative. LALD/CNS-A stated they used a separate sheet for the designated representative but was unable to locate it as she was unsure where the previously employed house manger had filed it. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 950		
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of	01470		

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JABEZ CUSTOMIZED LIVING SRVCS	8350 PIERCE STREET NE SPRING LAKE PARK, MN 55432

(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
01470	Continued From page 12 Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employees received orientation to assisted living facility licensing requirements before providing services for one of one employee unlicensed personnel (ULP)-C. This practice resulted in a level two violation (a	01470		

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	35705	A. BUILDING: _____ B. WING _____	04/10/2024

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JABEZ CUSTOMIZED LIVING SRVCS	8350 PIERCE STREET NE SPRING LAKE PARK, MN 55432

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01470	Continued From page 13 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-C was hired on August 1, 2021, to provide direct care services. On April 9, 2024, at 8:10 a.m., the surveyor observed ULP-C assisting residents with breakfast. ULP-C's employee record lacked orientation in the following Assisted Living topics: - Overview of Assisted Living Statutes; - Review of provider's policies and procedures; - Handling of resident complaints, reporting of complaints, where to report; - Consumer advocacy services; - Review of types of Assisted Living services the employee will provide and provider's scope of license; and - Principals of person-centered planning/service delivery. On April 9, 2024, at 1:30 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated they had missed assigning a class for ULP-C's orientation which is why ULP-C is missing some of the required orientation topics. LALD/CNS-A also stated the employees do review the policies and uniform disclose of assisted living services and amenities but she does not have this documented anywhere and this would be the same for all the employees.	01470		

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01470	Continued From page 14 The licensee's undated Facility Employee Orientation policy indicated the state required orientation to home care must include the following: - An overview of Minnesota's home care law (MN Statutes 144A.43 to 144.4798); - An introduction and review of the facility's policies and procedures related to the provision of home care services; - Handling of emergencies and use of emergency services - Reporting the maltreatment of vulnerable minors or adults under Minnesota Statutes 626.556 and 626.557; - The home care bill of rights (Minnesota Statutes 144A.44); 1. Overview of the home care statute and license rules 2. Handling of emergencies and use of emergency services 3. Reporting the maltreatment of vulnerable minors or adults 4. Assisted living Bill of Rights 5. Handling of residents' complaints and reporting of complaints to the Office of Health Facility Complaints 6. Consumer advocacy services of the Ombudsman for Long-Term care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county managed care advocates and other relevant advocacy services. 7. A review of the types of services the employee will be providing and the scope of the facility's services under the specific license. No further information was provided.	01470		

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01470	Continued From page 15 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person.	01500		

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01500	Continued From page 16 (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employees received at least eight (8) hours of annual training for each 12 months of employment in the required topics for one of one employee unlicensed personnel (ULP)-C. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is 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).	01500		

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01500	Continued From page 17 The findings include: ULP-C was hired on August 1, 2021, to provide direct care services. On April 9, 2024, at 8:10 a.m., the surveyor observed ULP-C assisting residents with breakfast. ULP-C's record lacked documentation of eight hours of annual training completed to include the following required topics: - Review of provider's policies and procedures. On April 9, 2024, at 1:45 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the facility policies and procedures were missed on the annual training due to not having a sign off sheet and this would be the case for all employees. LALD/CNS-A also agreed ULP-C's record showed they had completed 7.5 hours of annual training not the required 8 hours and this must have been a oversight. The licensee's undated Annual Training Requirements policy indicated all staff that provide direct care services and assisted living must complete at least 8 hours of annual training for each 12 months of employment. Annual training must include a review of the facilities policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		

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01530 SS=D	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure all direct care staff received at least eight hours of initial dementia care training within the first 160 working hours of employment for direct care employees as required for one of one employee unlicensed personnel (ULP)-C.	01530		

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01530	Continued From page 19 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: ULP-C was hired on August 1, 2021, to provide direct care services. On April 9, 2024, at 8:10 a.m., the surveyor observed ULP-C assisting residents with breakfast. ULP-C's employee record indicated ULP-C completed 2.75 hours of initial dementia training, thus did not contain documentation ULP-C completed the required initial eight hours of dementia training, within 160 working hours of ULP-C's employment start date under the assisted living license. On April 9, 2024, at 2:00 p.m., licensed assisted living director/clinical nurse supervisor (LALD/ CNS)-A stated they are aware employees are required to complete 8 hours of initial dementia training and did not assign the correct amount of hours to ULP-C. The licensee's undated Dementia Care Training policy indicated direct care employees must have completed at least 8 hours of initial training on required topics in the 160 hours from employment. Until this training is complete, the employee must not provide direct care unless	01530		

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01530	Continued From page 20 there is another employee on site who has completed the initial 8 hours of training related to dementia care and who can act as a resource and assist if issues arise. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01530		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced	01620		

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01620	Continued From page 21 by: Based on interview and record review the licensee failed to ensure the registered nurse (RN) completed ongoing reassessment and monitoring on or before day 14 and day 90 and failed to use the uniform assessment tool 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) 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: R1 was admitted and began receiving services on July 23, 2022. R1's record included a 14-day assessment dated August 7, 2023, which was 15 days after the previous assessment (one day late). R1's record also included two 90-day assessments the first assessment dated November 7, 2023, which was 92 days after the previous assessment (two days late) and a second assessment dated February 6, 2024, which was 91 days after the previous assessment (one day late). All of these assessments lacked all the required elements on the uniform assessment tool. On April 9, 2024, at 11:30 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CAN)-A stated the assessments were a couple of days late due to the resident being out in the community the days they were due. LALD/CNS-A stated the assessment form is the	01620		

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01620	Continued From page 22 same for all resident's and agreed the assessment form she was using does not meet the requirements of the uniform assessment tool. The Minnesota Administrative Rule 4659.0150 dated August 11, 1021, indicated each facility must develop a uniform assessment tool to include all the required elements. The licensee's undated Nursing Assessment and Reassessment of Residents policy indicated resident reassessment and monitoring must be conducted no more than 14 calendar days after initiating services. On-going reassessment and monitoring will be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last assessment. The assessment includes but is not limited to the requirements outlined in MN rules. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		

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

Type: Full
Date: *04/08/24*
Time: 13:45:27
Report: 1021241073

Food and Beverage Establishment Inspection Report

Location:
Jabez Customized Living Srvcs
8350 Pierce Street Ne
Spring Lake Park, MN55432
Anoka County, 02

Establishment Info:
ID #: 0038387
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 7637104084
ID #:

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

The following orders were issued during this inspection.

5-200C Plumbing: Maintenance, fixture location

5-205.11AB ***** Priority 2 *****

MN Rule 4626.1110AB The handwashing sink must be accessible at all times for employee use, and must be used only for handwashing.

THE KITCHEN SINK IS A ONE COMPARTMENT SINK. STAFF HAS DESIGNATED THAT SINK AS A HANDWASHING SINK. ESTABLISHMENT WILL NEED TO REPLACE THE ONE COMPARTMENT SINK TO A TWO COMPARTMENT SINK TO BE ABLE TO USE THE SINK TO PREPARE FOOD. SEE COMMENTS.

Comply By: 10/08/24

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

NO CERTIFIED FOOD PROTECTION MANAGER (CFPM) EMPLOYED AT THIS ESTABLISHMENT. ONE STAFF HAS A SERVSAFE CERTIFICATE BUT NOT A CFPM CERTIFICATE. INFORMATION ON HOW TO OBTAIN A CFPM CERTIFICATE SENT WITH REPORT.

Comply By: 05/08/24

6-200 Physical Facility Design and Construction

6-201.14A

MN Rule 4626.1350A Remove carpeting or similar material from the following unapproved areas: food preparation areas; walk-in refrigerators or freezers; warewashing areas; toilet room areas where handwashing sinks, toilets and urinals are located; refuse storage areas; wait stations; dressing rooms; locker rooms; janitorial areas; within 3 feet around permanently installed bars and salad bars, other food service equipment, and food storage rooms; or other areas where the floor is subject to moisture, flushing, or spray cleaning methods.

THERE IS A MINI FRIDGE IN ONE OF THE DOWNSTAIRS ROOMS. THAT ROOM ONLY HAS CARPET INSTALLED. STAFF WILL PLACE A PLASTIC MAT UNDER THE MINI FRIDGE. ALL FINISHES UNDER EQUIPMENT SHOULD BE SMOOTH, EASILY CLEANABLE AND DURABLE.

Comply By: 04/12/24

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: SOUR CREAM - FRIGIDAIRE REFRIGERATOR
Violation Issued: No

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: COTTAGE CHEESE - FRIGIDAIRE REFRIGERATOR

Violation Issued: No

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

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

ALL FINDINGS ON THIS REPORT WERE DISCUSSED WITH LALD/RN, PANDORA WHITE AND HEALTH REGULATION DIVISION NURSE EVALUATOR, SARABETH REMKER.

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

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

CONTINUATION OF MN Rule 4626.1110AB
ESTABLISHMENT WILL NEED TO FULLY SANITIZE THE KITCHEN SINK BEFORE USING IT AS A PREP SINK UNTIL THEY GET THE TWO COMPARTMENT SINK.

THE KITCHEN HAS RESIDENTIAL EQUIPMENT, WOOD CABINETS, LAMINATE FLOORS AND TEXTURED CEILING. PHYSICAL FACILITY ITEMS WILL BE MONITORED AT FUTURE INSPECTIONS.

Type: Full
Date: *04/08/24*
Time: 13:45:27
Report: 1021241073
Jabez Customized Living Srvcs

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 1021241073 of 04/08/24.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed:_____
PANDORA WHITE
LALD/RN

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