Electronically Delivered

October 11, 2024

Licensee
Mercy Caregivers Of Minnesota
556 84th Avenue Northeast
Spring Lake Park, MN 55432

RE: Project Number(s) SL35733015

Dear Licensee:

On September 9, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the June 20, 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

July 12, 2024

Licensee
Mercy Caregivers Of Minnesota
556 84th Avenue Northeast
Spring Lake Park, MN 55432

RE: Project Number(s) SL35733015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 20, 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:

0820 - 144g.45 Subd. 2 (g) - Fire Protection And Physical Environment - $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,

Jodi Johnson, Supervisor
State Evaluation Team
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35733	A. BUILDING: _____ B. WING _____	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERCY CAREGIVERS OF MINNESOTA	556 84TH AVENUE 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: SL35733015-0 On June 17, 2024, through June 20, 2024, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were five residents; five receiving services under the provider's Assisted Living Facility license. 0820: An immediate order was issued on June 17, 2024, at a level 3/Widespread (I). The immediacy was lifted, but the deficiency remains at I.	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.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470		

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0 470	Continued From page 1 determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the required staffing plan was developed and posted, potentially affecting the licensee's 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, but was not likely to	0 470		

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0 470	Continued From page 2 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: The licensee held an Assisted Living license, was licensed for a capacity of five residents, and had a current census of five residents. During the entrance conference on June 17, 2024, at 11:35 a.m., licensed assisted living director (LALD)-A stated there were two unlicensed personnel (ULP) scheduled for day and evening shift, and one ULP for night shift. During the initial tour of the facility on June 17, 2024, at 12:23 p.m., the surveyor observed the facility consisted of a single-family style home, with two levels. The lower level consisted of two bedrooms, a bathroom, a laundry room, and common craft/game/meeting room. The upper level consisted of three bedrooms, a bathroom, a living room, dining room, and kitchen. On the main floor living room wall, there were postings for grievances, contact information for the Office of Ombudsman for Long-Term Care and Office of Ombudsman for Mental Health and Developmental Disabilities, disaster exit diagrams, reporting number for Minnesota Adult Abuse Reporting Center, and electronic monitoring; however, no staff schedule was observed. At this time, ULP-C stated the schedule was posted inside the locked medication cabinet and was not accessible to clients or visitors. ULP-C opened the locked medication cabinet, showed the surveyor, and then hung it on the outside of the cabinet.	0 470		

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0 470	Continued From page 3 The licensee failed to develop and implement a written staffing plan for determining its staffing level that: - included an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; - ensured sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and - ensured that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility. On June 17, 2024, at 12:23 p.m., LALD-A stated a staffing plan had not been developed or a schedule posted as required. LALD-A stated he was not aware of this requirement to have the written staffing plan and posting. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0180, Subp. 4., effective October 2022, the clinical nurse supervisor (CNS) must develop a 24-hour daily staffing schedule. The schedule must: (1) include direct-care staff work schedules for each direct-care staff member showing all shifts, including days and hours worked; and (2) identify the direct-care staff member's resident assignments or work location. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 470		

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0 480	Continued From page 4	0 480		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (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 June 17, 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		
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must	0 650		

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0 650	Continued From page 5 include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records contained the required content 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 was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include:	0 650		

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0 650	Continued From page 6 ULP-C started employment on August 1, 2020. On June 17, 2024, at 8:45 a.m. ULP-C was observed to administer medications to R1. ULP-C's record lacked evidence of the following: - current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; - verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and - documentation of the background study as required under section 144.057. On June 18, 2024, at 10:09 a.m. licensed assisted living director (LALD)-A stated the above content was missing from ULP-C's employee record. LALD-A printed ULP-C's background study clearance, obtained a copy of ULP-C's health screening, and obtained a job description for ULP-C to sign. The licensee's undated, Personnel Records policy noted the personnel record for each person would include: 4. Health screening (as required under 144A.4798) for those providing resident services and the dates of screening and results; 5. A current job description that includes qualifications, responsibilities, and the level of staff providing supervision. Job descriptions must be signed by the employee; and 7. Documentation of background study as required by MN Statute 144.057. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		

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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; (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, practice and document testing of its EP plan at least twice annually as required and evaluate its missing person policy at least quarterly. This had the potential to affect all residents, staff, and visitors of the facility.	0 680		

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0 680	Continued From page 8 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: EMERGENCY PREPAREDNESS PLAN CONTENT The licensee's emergency preparedness plan consisted of several documents and policies in a white three-ringed binder dated as reviewed November 2023. The book included a risk assessment, a communication plan, and various policies/procedures. The licensee's plan lacked the following required content: - Policy/procedure for tracking staff and residents; - Policy/procedure to address safe evacuation from the facility to include (transportation and identification of evacuation location(s); - Policy/procedure to address system of medical documentation that preserves resident information, protects confidentiality, and secure/maintains availability of records; - Policy/procedure to address use of volunteers, including the process/role for integration; - Policy/procedure to address role of facility under a waiver declared by the Secretary in accordance with section 1135 of the Act; EP PLAN TESTING The EP plan lacked evidence the facility had tested its EP plan, conducted and/or participated in a full-scale community-based exercise, or	0 680		

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0 680	Continued From page 9 conducted a tabletop exercise to test its plan and document the results of testing at least twice annually as required. MISSING RESIDENT PLAN/POLICY The licensee's Missing Resident policy dated August 1, 2021, was included in the EP plan. The policy lacked evidence the assisted living director and clinical nurse supervisor reviewed or updated the policy and documented any changes, at least quarterly as required per Assisted Living Facilities: Minnesota Rules Chapter 4659.0110 Subp. 4. On June 18, 2024, at 12:19 p.m. licensed assisted living director (LALD)-A stated the licensee's EP plan lacked the above required components. The licensee's Emergency Preparedness Plan dated November 2023, identified the licensee is committed to preventing, protecting against, mitigating, responding to, and recovering from the threats and hazards that pose the greatest risk to the care and service of residents and to providing continuity of care and service during an emergency. The licensee's Missing Resident policy dated August 1, 2021, noted the missing resident procedure will be reviewed by the Director and Clinical Nurse Supervisor at least quarterly. Changes to the plan will be documented. 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	0 680		

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0 680	Continued From page 10 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. 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		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so	0 780		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35733	A. BUILDING: _____ B. WING _____	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERCY CAREGIVERS OF MINNESOTA	556 84TH AVENUE 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
0 780	Continued From page 11 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 smoke alarms that functioned and are interconnected so that the actuation of one alarm causes all alarms in the dwelling unit 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). Findings include: On June 17, 2024, at 1:45 p.m., survey staff toured the facility with licensed assisted living director (LALD)-A. Survey staff tested the smoke alarms throughout the home. Upon testing, it was found that the smoke alarms in the facility were not interconnected. These deficient conditions were visually verified by LALD-A accompanying on the tour.	0 780		

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0 780	Continued From page 12 During interview, on June 17, 2024, at 2:30 p.m. LALD-A stated they understood the smoke alarm requirements and would figure out how to get them interconnected. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
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 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 maintain 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 health, safety, comfort, and well-being of the residents. This deficient condition 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	0 800		

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0 800	Continued From page 13 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 June 17, 2024, at 1:45 p.m. survey staff toured the facility with licensed assisted living director (LALD)-A. It was observed that the residents were using a cookie tin filled with water as an ashtray in the designated smoking area. The facility did not have a non-combustible ashtray. Survey staff explained to the licensee that a fire-rated ashtray should be provided for resident use and that the discarded cigarette butts were a potential fire hazard if cigarettes were not completely extinguished before discarding them. During an interview on June 17, 2024, at 2:30 p.m., LALD-A stated they understood the above-listed deficiencies. TIME PERIOD FOR CORRECTION: Seven (7) 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,	0 810		

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0 810	Continued From page 14 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 licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training and 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	0 810		

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0 810	Continued From page 15 the residents). The findings include: On June 17, 2024, at 3:14 p.m. surveyor emailed licensed assisted living director (LALD)-A requesting the fire safety and evacuation plan (FSEP). On June 20, 2024, at 8:07 a.m., the surveyor emailed the LALD-A requesting documentation again for the fire safety and evacuation policy. Surveyor informed LALD-A that a citation would be issued if no documentation was received. On June 21, 2024, at 6:00 p.m. no records had been received for the FSEP, training, and drills. No further information was provided. 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 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.	0 820		

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0 820	Continued From page 16 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure physical facility elements did not constitute a distinct hazard to life. The licensee failed to provide resident bedrooms with the minimum window opening meeting the minimum state standard for egress. This had the potential to affect some residents, staff, and visitors. 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: On June 17, 2024, at 10:00 a.m. surveyor toured the facility with licensed assisted living director (LALD)-A. During the tour, LALD-A opened the windows in the resident bedrooms for measurement. The noncompliant measurements were as follows: Occupied Sleeping Rooms: Bedroom #1 occupied by R2: two windows measuring 35.5 inches clear width, 5.5 inches clear height, and 195.25 square inches total open area each window. Bedroom #2 occupied by R1: one window measuring 35.5 inches clear width, 14 inches clear height, and 497 square inches total open area.	0 820		

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0 820	Continued From page 17 Bedroom #3 occupied by R3: one window measuring 35.5 inches clear width, 15.5 inches clear height, and 550.25 square inches total open area. One window measuring 35.5 inches clear width, 12.75 inches clear height, and 452.5 square inches total open area. The window in bedroom #1, #2, and #3 did not meet the minimum requirements for opening height and did not meet the minimum requirements for total openable area. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. Survey staff explained to LALD-A that at least one window in each bedroom in a state-licensed facility must meet the minimum state fire code standard for an egress window to be a complying bedroom for resident occupancy. LALD-A verbally confirmed the findings. On June 17, 2024, survey staff explained to LALD-A that an immediate correction order was issued for the above finding. LALD-A acknowledged the above finding. No Further information was provided. TIME PERIOD FOR CORRECTION: Immediate.	0 820		
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	0 950		

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0 950	Continued From page 18 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 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 provide the required notice for right to a designated representative on a document separate from the contract for one of one resident (R1). 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	0 950		

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0 950	Continued From page 19 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: R1 began receiving assisted living services on June 6, 2023. R1's record lacked evidence in writing of providing on a document separate from the contact verbatim notice of "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." R1's Resident Contract for Assisted Living dated June 7, 2023, included a name/address/email/telephone number line to identify a designated representative and a line to initial if the resident declined to name a designated representative; however, the designated representative information was blank and the line to initial if the resident declined to name a designated representative was also blank. In addition, it lacked the required statutory language provided on a form separate from the contract.	0 950		

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0 950	Continued From page 20 On June 18, 2024, at 9:20 a.m. licensed assisted living director (LALD)-A stated the right to designate a representative statutory language was not present in the current assisted living contract. LALD-A indicated a consultant developed the contract and he was not aware of the requirement. LALD-A further stated all residents were provided the same contract. The licensee's undated, Assisted Living Contract policy indicated residents have the right to designate a representative before they sign a contract. The facility must offer the resident the opportunity to identify a representative in writing on the contract and must provide the following notice on a document separate from the contract: a. "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 they decline to name a representative. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950		

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01620	Continued From page 21	01620		
01620 SS=D	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 by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed a resident assessment within 14 days of admission for one of one resident (R1) and ongoing resident reassessments that did not exceed 90 days 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	01620		

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01620	Continued From page 22 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 began receiving assisted living services on June 6, 2023. R1's Service Plan dated June 7, 2023, indicated R1 received services including assistance with medication administration and vital sign monitoring. R1's record included an Evaluation/Baseline/Post Hospital Assessment (identified as the admission assessment) dated June 6, 2023, and a Nurse Reassessment Visit (identified as the 14-day assessment) dated June 21, 2023. The 14-day assessment was 15 days from the date of the move-in assessment, exceeding 14 calendar days. In addition, R1's record included Nurse Reassessment Visits (identified as 90-day assessments) dated September 8, 2023, December 7, 2023, and March 7, 2024. The March 7, 2024, assessment was 91 days from the last date of the assessment on December 7, 2023, exceeding 90 calendar days. On June 18, 2024, at 10:41 a.m. clinical nurse supervisor (CNS)-B stated R1's assessments as noted above were late. CNS-B indicated she gets distracted and could incorrectly date the assessments.	01620		

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01620	Continued From page 23 The licensee's undated, Nursing Assessment and Reassessment of Residents policy indicated a registered nurse would complete resident reassessment and monitoring 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. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management	01730		

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01730	Continued From page 24 tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an individualized medication management plan with the required content 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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on June 17,	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35733	A. BUILDING: _____ B. WING _____	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERCY CAREGIVERS OF MINNESOTA	556 84TH AVENUE 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
01730	Continued From page 25 2024, at 11:35 a.m. licensed assisted living director (LALD)-A stated the licensee provided medication management services to their residents. R1's diagnoses included diabetes and schizophrenia (a mental disorder characterized by delusions, hallucinations, disorganized thoughts, speech and behavior). R1's Service Plan dated June 7, 2023, indicated R1 received services including assistance with medication administration and vital sign monitoring. On June 17, 2024, at 8:45 a.m. the surveyor observed unlicensed personnel (ULP)-C administer medications to R1. R1's signed prescriber orders dated September 19, 2023, included Tresiba insulin (diabetes), orders dated December 21, 2023, included atorvastatin (cholesterol), orders dated January 29, 2024, included omeprazole (reflux) and Miralax (constipation), orders dated April 8, 2024, included lisinopril (blood pressure), orders dated May 8, 2024, included lubiprostone (constipation), and orders dated May 30, 2024, included hydroxyzine (anxiety). R1's records lacked evidence of a medication management plan to include: -a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; - identification of persons responsible for monitoring medication supplies and ensuring medication refills are ordered on a timely basis; - procedures for staff notifying a registered nurse	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35733	A. BUILDING: _____ B. WING _____	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERCY CAREGIVERS OF MINNESOTA	556 84TH AVENUE 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
01730	Continued From page 26 (RN) when a problem arose with medication management services and; - any resident-specific requirements relating to documenting mediation administration, verifications that all medications are administered as prescribed, and monitoring of medication to use to prevent possible complications or adverse reactions. On June 18, 2024, at 10:36 a.m. clinical nurse supervisor (CNS)-B stated R1's record lacked a medication management plan to include the required components as noted above. In addition, RN-B stated the same medication management plan was used for all residents. The licensee's undated, Individualized Medication Management Plan and Record policy noted following completion of the nursing assessment, including an assessment of the resident's need for medication management, the RN develops an individualized medication management record for the resident in conjunction with the resident and/or the resident's representative. The plan must include the following: b. description of how medications will be stored, based on the resident's needs, risk of diversion and consistent with the manufacturer's directions; d. identification of the person responsible for monitoring medication supplies and ensuring refills are ordered on a timely basis; f. procedure for staff to notify a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and g. any resident-specific requirements relating to documentation of medication administration, verification that all medications are administered as prescribed and monitoring of medication use	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35733	A. BUILDING: _____ B. WING _____	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERCY CAREGIVERS OF MINNESOTA	556 84TH AVENUE NE SPRING LAKE PARK, MN 55432

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01730	Continued From page 27 to prevent complications or adverse reactions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01770 SS=F	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure documentation of medication set-up included all the required content for the licensee's one of one resident (R4) receiving a medication set-up. 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: During the entrance conference on June 17, 2024, at 11:35 a.m. licensed assisted living director (LALD)-A stated the licensee provided	01770		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35733	A. BUILDING: _____ B. WING _____	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERCY CAREGIVERS OF MINNESOTA	556 84TH AVENUE 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
01770	Continued From page 28 medication management services to their residents, including medication set-up. R4 was admitted on August 27, 2020, with diagnoses that included anxiety, panic attacks, and paranoia (mental health condition causing feelings of distrust and suspicion about others without a good reason). R4's service plan dated August 27, 2020, indicated R4 received medication administration. R4's service plan did not include medication set up. R4's prescriber orders dated May 20, 2024, included: - Imuran (immunosuppressive) 50 milligrams (mg) two tablets by mouth twice daily - azithromycin (antibiotic) 250 mg by mouth every morning - Buspar (for anxiety) 30 mg by mouth twice daily - Vantin (antibiotic) 200 mg by mouth twice daily - ferrous gluconate (iron supplement) 324 mg by mouth daily - Fiber-lax (constipation) 625 mg two tablets by mouth daily - fluticasone (allergies) 50 micrograms (mcg)/actuation nasal spray two sprays in each nostril daily - folic acid (supplement) 400 mcg 2.5 tablets by mouth daily - gabapentin (anticonvulsant) 300 mg three capsules by mouth three times a day - hydroxyzine (anxiety) 50 mg by mouth daily - lurasidone (antipsychotic) 40 mg by mouth every evening - levoflxacin (antibiotic) 750 mg by mouth daily - liraglutide (diabetes) 10 mg/3 milliliters (ml) 1.8 mg subcutaneously daily - lorsartan (blood pressure) 100 mg by mouth	01770		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35733	A. BUILDING: _____ B. WING _____	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERCY CAREGIVERS OF MINNESOTA	556 84TH AVENUE 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
01770	Continued From page 29 daily - Singulair (allergies) 10 mg by mouth at bedtime - nicotine patch (for nicotine dependence) 21 mg/24 hour to skin every 24 hours - pantoprazole (reflux) 40 mg by mouth twice daily - potassium chloride (supplement) 10 milliequivalents (meq) two tablets by mouth twice daily - sertraline (antidepressant) 100 mg two tablets by mouth at bedtime - Symbicort (bronchodilator) 160-4.5 mcg/actuation inhaler 2 puffs by mouth twice a day - topiramate (anticonvulsant) 25 mg by mouth twice daily - varenicline (for nicotine dependence) 0.5 mg by mouth twice daily R1's record lacked documentation by the licensed nurse at the time of setup to include the name of medication, quantity of dose, times to be administered, and route of administration. On June 18, 2024, at 9:32 a.m., clinical nurse supervisor (CNS)-B stated she completed a weekly medication set-up into a dosage box for R4. CNS-B stated she followed R4's medication profile to complete the medication set-up but did not document the name of the medication, quantity of dose, times to be administered, or route of administration anywhere in the resident record. The licensee's undated, Medication Set up policy indicated staff setting up medications would follow accepted standards of practice and a medication administration record (MAR) or other medication documentation method should be used to set up the medications.	01770		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35733	A. BUILDING: _____ B. WING _____	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERCY CAREGIVERS OF MINNESOTA	556 84TH AVENUE 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
01770	Continued From page 30 No further information was provided. TIME PERIOD TO CORRECT: Seven (7) Days	01770		

Minnesota Department of Health
Food, Pools, and Lodging Services
625 Robert Street North
St. Paul
6512014500

Type: Full
Date: *06/17/24*
Time: 13:12:43
Report: 1029241188

Food and Beverage Establishment Inspection Report

Location:

Mercy Caregivers Of Minnesota
556 84th Avenue NE
Spring Lake Park, MN55432
Anoka County, 02

Establishment Info:

ID #: 0038845
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 6122221829
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.

3-700 Contaminated Food: discarded

3-701.11A ***** Priority 1 *****

MN Rule 4626.0445A Discard or recondition food that is unsafe, adulterated or not honestly presented.

SHELL EGGS IN REFRIGERATOR WITH SELL-BY DATES FROM JANUARY AND FEBRUARY. OPERATOR DISCARDED.

Comply By: 06/17/24

3-500C Microbial Control: date marking

3-501.17A ***** Priority 2 *****

MN Rule 4626.0400A Mark the refrigerated, ready-to-eat, TCS food prepared and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded.

CHOPPED LETTUCE, COOKED RICE, AND OTHER RTE TCS ITEMS WITHOUT DATE MARKINGS. INSTRUCTED OPERATOR TO HAVE ITEMS DATE MARKED.

Comply By: 06/17/24

3-500C Microbial Control: date marking

3-501.17B ***** Priority 2 *****

MN Rule 4626.0400B Mark the refrigerated, ready-to-eat, TCS food prepared and packaged in a processing plant and opened and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded. The date must not exceed the manufacturer's use-by-date.

OPENED DELI MEAT WITHOUT DATE MARKINGS. INSTRUCTED REP TO DATE MARK RTE TCS FOODS WITH THE OPENING DATE USED AS DAY 1 FOR THE 7 DAYS.

Comply By: 06/17/24

Type: Full
Date: *06/17/24*
Time: 13:12:43
Report: 1029241188
Mercy Caregivers Of Minnesota

Food and Beverage Establishment Inspection Report

4-300 Equipment Numbers and Capacities

4-302.13B ***** Priority 2 *****

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

ESTABLISHMENT USES THERMAL STICKERS TO TEST DISHWASHER'S HIGH TEMP. REP INDICATED THEY RAN OUT LAST WEEK. OPERATOR INSTRUCTED TO OBTAIN AND MAINTAIN MEANS TO VERIFY DISHWASHER'S SANITIZING TEMP.

Comply By: 06/25/24

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.

HANDWASHING SINK USED FOR FOOD PREP. INSTRUCTED REP TO ONLY USE HANDWASHING SINK FOR HANDWASHING.

Comply By: 06/17/24

Surface and Equipment Sanitizers

HOT WATER: = at 160 Degrees Fahrenheit
Location: DISHWASHER
Violation Issued: No

QUATERNARY AMMONIUM: = 200 PPM at Degrees Fahrenheit
Location: WIPES
Violation Issued: No

Food and Equipment Temperatures

Process/Item: DELI MEAT
Temperature: 32 Degrees Fahrenheit - Location: REFRIGERATOR - INTERIOR CAVITY
Violation Issued: No

Process/Item: MILK
Temperature: 40 Degrees Fahrenheit - Location: REFRIGERATOR - DOOR
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	1	4	0

Discussed employee illness procedures, vomit/fecal matter cleanup; common reportable foodborne illness pathogens and common signs of foodborne illness; datemarking; delivery, holding, and cooking temperatures; employee hygiene; and sanitizing. Operator indicated clients are not elderly or immunocompromised.

Dishwasher is NSF/ANSI Standard 184 with a sanitize option which the manufacturer states will reach a temperature of 162°F. Establishment without means to test high temperature. A thermal sticker was provided which registered a temperature at least 160°F. All identified issues addressed with representatives throughout the inspection.

Type: Full
Date: *06/17/24*
Time: 13:12:43
Report: 1029241188
Mercy Caregivers Of Minnesota

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 1029241188 of 06/17/24.

Certified Food Protection Manager: ADELEKE IJIYODE

Certification Number: FM110890 Expires: 04/14/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
ADELEKE IJIYODE
LALD

Signed: *Trevor McCliment*
Trevor McCliment
Public Health Sanitarian
Metro District Office
651-201-3957
trevor.mccliment@state.mn.us

Report #: 1029241188

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Food, Pools, and Lodging Services
625 Robert Street North
St. Paul

No. of RF/PHI Categories Out	3	Date	06/17/24
No. of Repeat RF/PHI Categories Out	0	Time In	13:12:43
Legal Authority MN Rules Chapter 4626		Time Out	

Mercy Caregivers Of Minnesota	Address	City/State	Zip Code	Telephone
	556 84th Avenue NE	Spring Lake Park, MN	55432	6122221829

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
0038845		Full		

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
	Supervision			
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

		Safe Food and Water	COS	R
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		Thermometers provided & accurate		
		Food Identification		
37		Food properly labled; original container		
		Prevention of Food Contamination		
38		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		

		Proper Use of Utensils	COS	R
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		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48	X	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:** 06/18/24

Inspector (Signature) *Trevor McCliment*