DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

May 14, 2024

Licensee
Noah Home Care Inc.
13521 Nicollet Lane
Burnsville, MN 55337

RE: Project Number(s) SL35988015

Dear Licensee:

On April 24, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the January 17, 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,

Bob Dehler, P.E.
Engineering Manager
Engineering Services Section
Health Regulation Division
Email: Robert.Dehler@state.mn.us
Telephone: 651-201-3710

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35988	A. BUILDING: _____ B. WING _____	R 04/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOAH HOME CARE INC	13521 NICOLLET LANE BURNSVILLE, MN 55337

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL35988015-1 On April 24, 2024, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on January 17, 2024. At the time of the survey, there were 02 residents; 02 receiving services under the Assisted Living license. As a result of the revisit, the licensee is in substantial compliance.	{0 000}		
{01610} SS=D	144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan 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. If necessitated by either the geographic distance between the prospective resident and	{01610}		

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{01610}	Continued From page 1 the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. This MN Requirement is not met as evidenced by: No further actions required	{01610}		
{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.	{01620}		

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{01620}	Continued From page 2 This MN Requirement is not met as evidenced by: No further actions required	{01620}		
{01750} SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: No further actions required	{01750}		
{01760} SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not	{01760}		

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{01760}	Continued From page 3 administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: No further actions required	{01760}		
{01910} SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: No further actions required	{01910}		

Electronically Delivered

February 6, 2024

Licensee
Noah Home Care, Inc.
13521 Nicollet Lane
Burnsville, MN 55337

RE: Project Number(s) SL35988015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 17, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5), MDH may impose fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment.
MDH may impose a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. MDH also

may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this survey:

St - 0 - 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

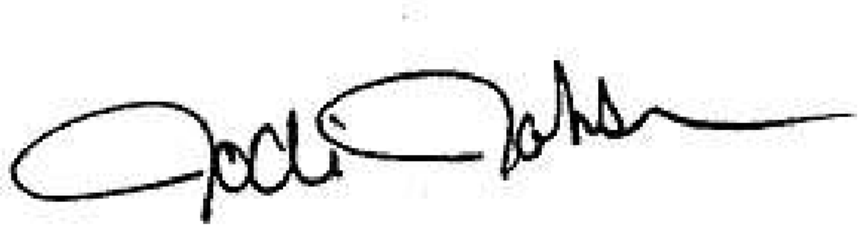
hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. 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.

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

PMB

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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: SL35988015 On January 16, 2024, through January 17, 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 two residents; one receiving services under the Assisted Living Facility 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.	
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with	0 780		

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0 780	Continued From page 1 the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that are interconnected throughout the facility so actuation of one alarm will cause all alarms in the dwelling to actuate. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when	0 780		

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0 780	Continued From page 2 problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On a facility tour on January 17, 2024, at 12:20 p.m., with owner/house manager (O/HM)-B, survey staff observed smoke alarms throughout the facility were not interconnected so actuation of one alarm will cause all alarms in the dwelling to actuate. This was discovered when O/HM-B tested the smoke alarms. On January 17, 2024, at 12:20 p.m., O/HM-B verbally confirmed survey staff observations during the facility tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall	0 810		

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0 810	Continued From page 3 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 a record review and interview, the licensee failed to develop a fire safety and evacuation plan with required elements. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On January 17, 2024, at 12:45 p.m., owner/house	0 810		

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0 810	Continued From page 4 manager (O/HM)-B provided documents on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review of the available documentation indicated the evacuation plan did not have an updated plan to include employee actions to be taken in the event of a fire or similar emergency. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate) but the plan was designed for a building with life safety systems such as fire doors and smoke compartments. The policy had not been updated to provide complete actions for employees to take in the event of a fire or similar emergency at the licensed facility which did not have life safety systems or a fire-resistant construction type. Record review of the available documentation indicated the evacuation plan did not include complete procedures for residents' evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. The plan included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation nor did it include instructions for staff to follow in case of relocation The plan inaccurately directed residents to stay behind smoke compartment doors. This plan also showed sprinklers to activate and magnetic holders to automatically close the fire doors and contain the fire. This facility was not equipped with fire rated doors with magnetic door holders or a sprinkler system. Fire safety and evacuation plan was not readily	0 810		

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0 810	Continued From page 5 available. Emergency fire safety evacuation map was not available in the lower level of the facility. Also, when asked the O/HM-B to provide the fire safety plan she stated it was usually hung-up on the wall but during the time of survey it was not available and O/HM-B had to print one out. During interview on January 17, 2024, at 12:45 p.m., O/HM-B verified the fire safety and evacuation plan for the facility lacked these provisions. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 820 SS=G	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. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide a properly sized egress window for emergency escape for one of two residents (R3).	0 820		

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0 820	Continued From page 6 This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On January 17, 2024, at 12:18 p.m., survey staff conducted a facility tour with owner/house manager (O/HM)-B. During facility tour, survey staff observed the following: O/HM-B fully opened the proposed egress window in R3 room and survey staff verified the measurement of the openable area of the window to be 15 inches high x 31 inches wide for a total of 465 square inches. R3's room was located in the basement. Egress windows in existing facilities must have a minimum opening dimension of 648 square inches with an opening height and width dimension of no less than 20 inches. The facility had four total bedrooms, three bedrooms were located on the upper level and one bedroom, R3's room, was located in the basement. The upper level bedrooms had compliant egress window that met minimum required measurements. R1 was the only other resident to occupy a bedroom located on the upper level. During an interview on January 17, 2024, at 2:35	0 820		

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NOAH HOME CARE INC	13521 NICOLLET LANE BURNSVILLE, MN 55337

(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
0 820	Continued From page 7 p.m., the survey asked about R3's hospitalization anticipated duration and O/HM-B stated he thought R3 would returned the following day. The surveyor stated R3 could not return to his original room in the basement with non-compliant egress window. The surveyor asked O/HM-B to determine a safe plan for R3's return to the facility and stated options could be for a fire watch or relocation to a room with compliant windows. O/HM-B stated he would relocate R3 to another room [the upper level] upon his return from the hospital. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 820		
01610 SS=D	144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan 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. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. This MN Requirement is not met as evidenced	01610		

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01610	Continued From page 8 by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN) conducted an initial assessment for one of one resident (R1) prior to initiation of services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included depression, anxiety, and insomnia. R1's assisted living contract was signed by the resident on May 6, 2023. R1's move-in and start of care date for services was May 8, 2023. R1's Medication Management Plan and Treatment Plan were completed by the RN on May 8, 2023. The remainder of R1's assessments to comply with the Uniform Assessment Tool were not completed until May 11, 2023 (after the start of services). On January 17, 2023, at 1:40 p.m. licensed assisted living director/registered nurse (LALD/RN)-A stated R1 admitted the evening of May 8, 2023. LALD/RN-A completed the "important" tasks but did not complete the full assessment. LALD/RN-A stated he did the	01610		

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01610	Continued From page 9 medication assessment and put the orders into RTasks (electronic medical record) so the staff could administer R1's medications the next morning but did not complete the full assessment until May 11, 2023 (three days later). LALD/RN-A further stated thinking he had three days to complete the admission assessment. The licensee's 6.02 Assessment Schedules policy dated August 1, 2021, indicated the initial resident nursing assessment would be completed prior to the date on which a prospective resident executes a contract with the facility or the date on which a prospective resident moves in, whichever is earlier. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01610		
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	01620		

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01620	Continued From page 10 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 and every 90 days thereafter for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's was admitted on May 8, 2023, with diagnoses including depression, anxiety, and insomnia. R1's Service Plan dated May 8, 2023, indicated services included medication set-up and administration, housekeeping, and laundry. R1's record included a 14-day assessment dated May 23, 2023 (15 days after start of services) and	01620		

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01620	Continued From page 11 two 90-day assessments dated August 6, 2023, and November 6, 2023; 93 days had passed between the two 90-day assessments. On January 17, 2023, at 1:40 p.m. licensed assisted living director/registered nurse (LALD/RN)-A reviewed R1's assessments and stated the 14-day and 90-day assessments were late. The licensee's 6.01 Assessments, Reviews & Monitoring policy dated August 1, 2021, indicated: 3. Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of service. 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. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01750 SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel	01750		

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01750	Continued From page 12 about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure delegated procedures were followed for one of one resident (R1) observed during medication observation. In addition, the licensee failed to ensure the registered nurse documented resident-specific instructions for an as needed (PRN) medication for one of one resident (R1) whose medication administration was delegated to unlicensed personnel. 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: Medication observation: R1's Individualized Medication Management Plan dated November 6, 2023, indicated R1 could not self-administer medication safely. Staff were to assist R1 in administering medications as prescribed by the medical doctor. R1's Service Plan dated May 8, 2023, indicated services included medication administration by unlicensed personnel (ULP). R1's physician orders dated July 27, 2023, included: Nicotine gum 2 milligrams (mg) by	01750		

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01750	Continued From page 13 mouth. Chew one gum (2 mg) every hour while awake as needed for nicotine craving. On January 17, 2024, at 11:34 a.m. ULP-C was observed administering R1's scheduled 11:00 a.m. medications. While taking the medication, R1 asked ULP-C if he could also get his PRN nicotine gum at that time. ULP-C asked R1 if he wanted a full pack (a card of 10 individual wrapped pieces of nicotine gum); R1 stated "no". ULP-C then gave R1 six pieces of the nicotine gum and stated to the surveyor that way he could use them throughout the day. When questioned further, ULP-C stated licensed assisted living director/registered nurse (LALD/RN)-A had directed ULP-C to provide R1 with a full card of the nicotine gum as he would take them to work with him. ULP-C further stated R1 would sometimes "misplace" the nicotine gum, so it helped him if he only received a partial card. On January 17, 2024, at 1:09 p.m. LALD/RN-A stated R1 didn't like to come downstairs from his room every hour to ask for the nicotine gum; that was why he was given more than one piece at a time. LALD/RN-A stated R1 did not have a physician order to self-administer his nicotine gum. Resident specific instructions: R1's physician orders dated July 27, 2023, included: Trazodone 50 mg, take one to two tablets by mouth at bedtime as needed for sleep. On January 17, 2024, at 10:58 a.m. ULP-C stated if R1 requested the PRN Trazodone, she would probably give one tablet and if it wasn't effective then give a second tablet. The surveyor asked ULP-C if the electronic record included specific instructions related to when a second tablet could	01750		

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01750	Continued From page 14 be administered. ULP-C reviewed R1's electronic record and could not find further instructions related to the PRN Trazodone. On January 17, 2024, at 1:09 p.m. LALD/RN-A stated R1 didn't take the PRN Trazodone very often and usually only took one tablet when requested as staff could ask him how many he wanted. The licensee's 7.27 PRN Medications policy dated August 1, 2021, indicated PRN medications must be administered according to the prescriber's orders. The licensee's 6.14 Delegation of Assisted Living Services policy dated August 1, 2021, indicated: 3. The registered nurse or licensed heath professional will document instructions for the delegated tasks in the resident's record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any	01760		

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01760	Continued From page 15 follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered as ordered for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's Individualized Medication Management Plan dated November 6, 2023, indicated R1 could not self-administer medication safely. Staff were to assist R1 in administering medications as prescribed by the medical doctor. R1's Service Plan dated May 8, 2023, indicated services included medication administration by unlicensed personnel (ULP). R1's physician orders dated July 27, 2023, included: Nicotine gum 2 milligrams (mg) by mouth. Chew one gum (2 mg) every hour while awake as needed for nicotine craving. On January 17, 2024, at 11:34 a.m. ULP-C was	01760		

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01760	Continued From page 16 observed administering R1's scheduled 11:00 a.m. medications. While taking the medication, R1 asked ULP-C if he could also get his PRN nicotine gum at that time. ULP-C asked R1 if he wanted a full pack (a card of 10 individual wrapped pieces of nicotine gum); R1 stated "no". ULP-C then gave R1 six pieces of the nicotine gum and stated to the surveyor that way he could use them throughout the day. When questioned further, ULP-C stated licensed assisted living director/registered nurse (LALD/RN)-A had directed ULP-C to provide R1 with a full card of the nicotine gum as he would take them to work with him. ULP-C further stated R1 would sometimes "misplace" the nicotine gum, so it helped him if he only received a partial card. At 11:58 a.m., the surveyor asked ULP-C to show documentation of the PRN nicotine gum administered to R1 in the electronic record. ULP-C obtained the documentation which indicated R1 had only received one piece (not six) of the nicotine gum previously administered. ULP-C stated she had misunderstood the directions given by LALD/RN-A, and thought that one card of 10 pieces of gum wound be the same as one administration. On January 17, 2024, at 1:09 p.m. LALD/RN-A stated R1 didn't like to come downstairs from his room every hour to ask for the nicotine gum; that was why he was given more than one piece at a time. LALD/RN-A stated R1 did not have a physician order to self-administer his nicotine gum, and further stated the electronic record did not reflect the correct amount given to the resident. LALD/RN-A further stated when medication was sent with a resident when leaving the home, the procedure for planned and unplanned time away should be followed.	01760		

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01760	Continued From page 17 The licensee's 7.27 PRN Medications policy dated August 1, 2021, indicated PRN medications must be administered according to the prescriber's orders. The licensee's 7.10 Medication Management - Planned & Unplanned Time Away policy dated August 1, 2021, indicated: For planned time away, the medications must be obtained by the pharmacy or set up by a licensed nurse. For unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or properly trained and competency tested unlicensed personnel may give the resident or resident's representative medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven (7) calendar days with the following requirements: 1. The resident, or the residents' representative, must be provided written information on medications including any special instructions for administering or handling the medications including controlled substances. 2. The medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. 3. The resident or resident's representative must be provided in writing the facility's contact information in case they have questions. 4. The process must be properly documented in the MAR (medication administration record) including documenting the date the medications were given to the resident or the resident's representative and who received the medications, the person who gave the medications to the resident, the number of medications that were given to the resident, and other required	01760		

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01760	Continued From page 18 information. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident's record the disposition of the medication including the medication's prescription number as applicable, for one of one discharged resident	01910		

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01910	Continued From page 19 (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The discharge resident roster provided by the licensee indicated R2 discharged on August 17, 2023, to another facility. R2's Service Plan dated September 16, 2021, indicated the resident received services including medication administration. R2's Current Medications at Discharge form dated August 17, 2023, included medications that had been sent with the resident. The document identified the medication name, strength, quantity, and signature of the licensee's staff that counted the medications and the person receiving the medications. The document did not include the prescription number for any of the identified medications including daily vitamin, melatonin (insomnia/sleep), oxcarbazepine (mood stabilization), quetiapine (antipsychotic), diphenhydramine (EPSE (extrapyramidal side effects)/allergies), nicotine gum (nicotine cravings), and Trazodone (insomnia/sleep). On January 16, 2024, at approximately 1:30 p.m. licensed assisted living director/registered nurse (LALD/RN)-A and owner/house manager	01910		

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01910	Continued From page 20 (O/HM)-B reviewed the Current Medications at Discharge document utilized for all discharging residents and stated prescription numbers were not included, and they were unaware of the requirement. The licensee's 7.23 Medication Disposal policy dated June 2021, indicated: Unused Prescription Drugs: Current unused medications managed by [licensee name] will be returned to the pharmacy for credit, or given to the resident or the resident's representative, when the residents medications are no longer managed by the facility or the medication has been discontinued by the prescriber. Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		

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

Type: Full
Date: *01/17/24*
Time: 18:21:20
Report: 1050241005

Food and Beverage Establishment Inspection Report

Location:
Noah Home Care Inc
13521 Nicollet Lane
Burnsville, MN55337
Dakota County, 19

Establishment Info:
ID #: 0038285
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6123664932
ID #:

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

No NEW orders were issued during this inspection.

Food and Equipment Temperatures

Process/Item: Cold Holding/ Milk
Temperature: 38F Degrees Fahrenheit - Location: Kitchen Refrigerator
Violation Issued: No

Process/Item: Cold Holding/ Strawberry's
Temperature: 41F Degrees Fahrenheit - Location: Kitchen Refrigerator
Violation Issued: No

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

Inspection was completed with Barkuni Abu. Wendy was the lead Health Regulation Division Nurse Evaluator. Facility had two residents on site at time of inspection. Meals are prepared on site. This establishment has a residential kitchen. Food must be prepared for same day service only. The kitchen has wood cabinets with a hollow base and wood flooring. All found to be in good condition. Upon entry a water leak coming from the sink was mentioned and a work order was already placed.

A two basin sink is being used in the kitchen with one sink basin designated for handwashing. Dish machine was tested using thermal label and had a utensil surface temperature of at least 160F.

Discussed the following:
-Employee illness policy and logging requirements
-Handwashing
-Glove-use and bare hand contact
-Food storage and preventing cross contamination
-Date marking
-Vomit clean up procedures

Type: Full
Date: *01/17/24*
Time: 18:21:20
Report: 1050241005
Noah Home Care Inc

Food and Beverage Establishment Inspection Report

-Restrictions concerning serving a highly susceptible population

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 1050241005 of 01/17/24.

Certified Food Protection Manager Barkuni Abu

Certification Number: 009600009 Expires: 09/26/26

Inspection report reviewed with person in charge and emailed.

Signed: _____

Barkuni Abu
Owner/ Operator

Signed: _____

Andrew Spaulding
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