Electronically Delivered

October 18, 2024

Licensee
Nova Ewing Home
5152 Ewing Avenue North
Brooklyn Center, MN 55429

RE: Project Number(s) SL36225015

Dear Licensee:

On September 24, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the July 11, 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 31, 2024

Licensee
Nova Ewing Home
5152 Ewing Avenue North
Brooklyn Center, MN 55429

RE: Project Number(s) SL36225015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 11, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

The correction order documentation should include the following:

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

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

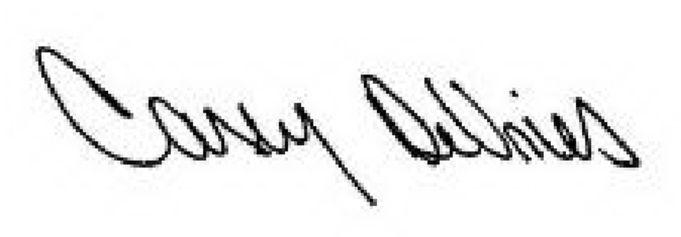
To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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

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

If you have any questions, please contact me.

Sincerely,



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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36225	A. BUILDING: _____ B. WING _____	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOVA EWING HOME	5152 EWING AVENUE NORTH BROOKLYN CENTER, MN 55429

(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: SL#36225015-0 On July 8, 2024, through, July 11, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were four residents; all of whom received services under the provider's Assisted Living Facility license. An immediate correction order was identified on July 9, 2024, issued for SL36225015-0, tag identification 0820. On July 10, 2024, the immediacy of correction order 0820 was removed, however non-compliance remained at an scope and level of 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.	

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0 480	Continued From page 1	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 July 8, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 650 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 2 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 interview and record review, the licensee failed to ensure one of two employees (unlicensed personnel (ULP)-C) had evidence of completing orientation to assisted living facility licensing requirements and regulations, before providing 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).	0 650		

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0 650	Continued From page 3 The findings include: ULP-C was hired November 24, 2021, and provided direct care services to the assisted living residents. ULP-C's record lacked evidence that orientation was completed prior to providing services, including: - Overview of Assisted Living statutes; - Review of provider's policies and procedures; - Handling emergencies and using emergency services; - Assisted Living bill of rights; - Handling of residents' complaints, reporting of complaints, where to report; - Consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; - Review of types of Assisted Living services the employee will provide and provider's scope of license; and - Principles of person-centered planning/service delivery and how they apply to direct support services provided by the staff person. On July 8, 2024, at 2:20 p.m., ULP-C stated when she first started with licensee, she completed orientation and competencies before she began working for the provider. On July 8, 2024, at 2:30 p.m., assistant director (AD)-B stated he did not have documentation that orientation was provided to ULP-C. AD-B also stated he believed when he was cleaning and deleting documents in Rtasks (training software),	0 650		

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0 650	Continued From page 4 he had deleted all of ULP-C's orientation documentation. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 650		
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:	0 680		

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0 680	Continued From page 5 Based on interview and record review, the licensee failed to have a written emergency preparedness plan (EPP) with all the required content in. In addition, the licensee failed to provide building emergency exit diagrams to all residents, and to post emergency exit diagrams on each floor. This had the potential to affect all residents receiving services under the assisted living license. 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 July 8, 2024, at 11:10 a.m. during the facility tour, the surveyor did not observe post emergency exit diagrams on each floor. On July 8, 2024, at 11:45 a.m., the surveyor requested for the licensee's EPP. The licensee's undated, emergency preparedness plan lacked the following required content: - emergency preparedness program patient population; - subsistence needs for staff and patients; - procedures for tracking of staff and patients; - policies and procedures for medical documents; - roles under a waiver declared by secretary; - primary/alternate means for communication; - methods for sharing information;	0 680		

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0 680	Continued From page 6 - sharing information on occupancy/needs; and - LTC family notifications. On July 9, 2024, at 12:20 p.m., clinical nurse supervisor (CNS)-A stated the licensee was still working on updating their EPP to be compliant with state requirements. The licensee's Emergency Preparedness policy dated September 1, 2022, indicated licensee will have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the 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	0 800		

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0 800	Continued From page 7 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 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 July 9, 2024, from approximately 9:45 a.m. to 12:00 p.m. survey staff toured the facility with assistant director (AD)-B. The following was observed. - The basement staff bathroom light over the vanity had no cover. The bulbs were exposed to the bathroom. - The upstairs bathroom had a large (11 inches by 9 inches) hole under the pedestal sink. AD-B stated they completed plumbing work to remove a clog and had not repaired the wall yet. - The door trim outside and inside bedroom 4 was broken with parts missing. - The door to the basement had two large holes. On July 9, 2024, at 12:30 p.m., AD-B stated they understood the above-listed deficiencies. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800		

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0 810	Continued From page 8	0 810		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	0 810		

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0 810	Continued From page 9 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 the residents). The findings include: On July 9, 2024, assistant director (AD)-B provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee's FSEP, titled "Fire Safety", dated August 1, 2023, failed to include the following: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The provided FSEP was from a third-party provider and had not been updated to the specific facility. The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency.	0 810		

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0 810	Continued From page 10 The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. 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. During an interview on July 9, 2024, at 12:30 p.m., AD-B stated they understood the areas of their policy that were incomplete and would work on bringing them into compliance. The policy reviewed was an unedited policy purchased from a third-party provider that was not specific to the facility. TRAINING The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. The licensee's training records indicated staff were trained once in the last twelve (12) months. No other training documentation was provided. On July 9, 2024, at 12:30 p.m., AD-B stated they understood the requirements for training residents and staff and would implement a training program that was compliant with statute requirements. DRILLS The licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. Record review of licensee's evacuation drill log indicated evacuation drills were conducted on	0 810		

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0 810	Continued From page 11 January 10, 2024, February 5, 2024, March 1, 2024, and April 4, 2024. No other documentation was provided. On July 9, 2024, at 12:30 p.m., AD-B stated there were no additional documented drills for the facility. 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. 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.	0 820	This immediate correction order identified on July 9, 2024, has had the immediacy lifted as of July 10, 2024, however non-compliance remained a scope and level of I.	

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	36225	A. BUILDING: _____ B. WING _____	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOVA EWING HOME	5152 EWING AVENUE NORTH BROOKLYN CENTER, MN 55429

(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 12 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 July 09, 2024, at 10:00 a.m. survey staff toured the facility with assistant director (AD)-B. During the tour, survey staff asked AD-B to open the windows in the resident bedrooms for measurement. The noncompliant measurements were as follows: Occupied Sleeping Rooms: Bedroom #1 occupied by R4: two windows measuring 44 inches clear width, 12.5 inches clear height, and 550 square inches total open area per window. Bedroom #2 occupied by R1: two window measuring 44 inches clear width, 12.5 inches clear height, and 550 square inches total open area per window. Bedroom #3 occupied by R3: one window measuring 44 inches clear width, 18 inches clear height, and 792 square inches total open area. Bedroom #5 occupied by R2: one window measuring 31 inches clear width, 18.5 inches clear height, and 573.5 square inches total open area. Unoccupied Sleeping Rooms: Bedroom #4: one window measuring 44 inches clear width, 12.5 inches clear height, and 550 square inches total open area.	0 820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36225	A. BUILDING: _____ B. WING _____	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 13 The window in bedroom #1, #2, #3, #4, and #5 did not meet the minimum requirements for opening height and the windows in bedrooms #1, #2, #4, and #5 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 AD-B 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. AD-B verbally confirmed the findings. On July 09, 2024, survey staff explained to AD-B that an immediate correction order was issued for the above finding. AD-B acknowledged the above finding. No Further information was provided. TIME PERIOD FOR CORRECTION: Immediate.	0 820		
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider	0 910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36225	A. BUILDING: _____ B. WING _____	07/11/2024

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NOVA EWING HOME	5152 EWING AVENUE NORTH BROOKLYN CENTER, MN 55429

(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
0 910	Continued From page 14 when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for all the licensee's residents. This had the potential to affect all residents living in the assisted living facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: On July 8, 2024, at 11:20 a.m., clinical nurse supervisor (CNS)-A provided the surveyor with licensee's blank contract, and stated the same contract was used by all the licensee's residents. The licensee's Assisted Living Contract lacked documentation of the Health Facility Identification (HFID) number of the facility in a conspicuous place and manner. On July 8, 2024, at 11:45 a.m., CNS-A stated licensee was not aware of the requirement and all resident contracts will be missing the HFID number.	0 910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36225	A. BUILDING: _____ B. WING _____	07/11/2024

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NOVA EWING HOME	5152 EWING AVENUE NORTH BROOKLYN CENTER, MN 55429

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0 910	Continued From page 15 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 910		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety, or personal property of a resident. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a 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 July 8, 2024, at 11:20 a.m., clinical nurse supervisor (CNS)-A provided the surveyor with	0 970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36225	A. BUILDING: _____ B. WING _____	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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0 970	Continued From page 16 licensee's blank contract, and stated the same was used by all licensee's residents. The licensee's Assisted Living Contract read, under section miscellaneous provisions "the resident agrees that [licensee] will not be liable to the resident for any personal injury or property damage (including, without limitation, damage to, or loss or theft of, automobiles or personal property of resident) suffered by the resident or the resident's agents, guests or invitees, unless and to the extent that the injury or damage is caused by the negligence of [licensee] or its employees or agents. The resident hereby releases [licensee] from liability for any personal injury or property damage suffered by the resident or the resident's agents, guests, or invitees, unless caused by the negligence of [licensee] or its employees or agents". On July 8, 2024, at 11:45 a.m., CNS-A stated all of the resident contracts had liability language in them, and the licensee was not aware of the liability clause in the contract. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01530 SS=D	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working	01530		

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	36225	A. BUILDING: _____ B. WING _____	07/11/2024

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01530	Continued From page 17 hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of two employees (unlicensed personnel (ULP)-C) received eight hours of initial dementia care training within the first 160 working hours of the employment start date. 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).	01530		

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01530	Continued From page 18 The findings include: ULP-C was hired November 24, 2022, and provided direct care services to assisted living residents. ULP-C's employee record lacked the required initial dementia training in the following topics: - an explanation of Alzheimer's disease and other dementias; - assistance with activities of daily living; - problem solving with challenging behaviors; - communication skills; and - person-centered planning and service delivery. On July 8, 2024, at 2:45 p.m., assistant director (AD)-B stated even though the licensee was not a dementia care facility, they were aware they were required to complete the initial eight hours of dementia training. AD-B further stated that they could not find ULP-C's dementia training records. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01650	Continued From page 19 assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plan included the required content for all the licensee's 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). The findings include:	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01650	Continued From page 20 R1 was admitted for assisted living services on March 21, 2023. R1's diagnoses included paraplegia, opioid dependence, and panic disorder. R1's Service Plan dated March 21, 2023, indicated R1 received the following services: medication management services, resident review/reassessment, and catheter care. R1's service plan lacked the following content: - the action to be taken if the scheduled service cannot be provided. On July 9, 2024, at 2:10 p.m., assistant director (AD)-B stated the service plan was part of the contract and that the contract had the information and method to contact facility. When the surveyor requested AD-B to point to the section in the contract containing the action to be taken if the scheduled service cannot be provided, AD-B was unable to identify where it was located. The licensee's Service Plan policy dated September 9, 2022, indicated the service plan includes the following: a. A description of the services that are to be provided based on the most recent assessment and resident preferences; b. Fees for services to be provided; c. The frequency of each service to be provided based on the most recent assessment and resident preferences; d. An identification of staff or categories of staff who will be providing services; e. A schedule and method for the next planned assessment or monitoring; f. A schedule and method for the next planned monitoring of staff providing services; and,	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36225	A. BUILDING: _____ B. WING _____	07/11/2024

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01650	Continued From page 21 g. A contingency plan that includes: - Actions licensee will take if scheduled services cannot be provided; - Information regarding how the resident can contact licensee; - The names and contact information the resident wishes, if any, to have notified in an emergency or if there is a significant adverse change in the resident's condition; - Identification and contact information of who the resident has authorized, if any, to sign for the resident in an emergency; and, - How the facility will support documented resident health care directive decisions, if any - including circumstances when emergency medical services are not to be summoned. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		

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

Type: Full
Date: *07/08/24*
Time: 11:00:00
Report: 1025241100

Food and Beverage Establishment Inspection Report

Location:
Nova Ewing Home
5152 Ewing Avenue North
Brooklyn Center, MN55429
Hennepin County, 27

Establishment Info:
ID #: 0038197
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 6126015843
ID #:

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

The following orders were issued during this inspection.

4-200 Equipment Design and Construction

4-202.17

MN Rule 4626.0545 Remove kick plates that are not designed to be easily removed for cleaning and inspection.

Provide cabinetry without a hollow enclosed base for easy of cleaning, reduction of harborage conditions, and observation of pest activity

Comply By: 07/08/24

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.11

MN Rule 4626.1515 Maintain the physical facilities in good repair.

Repair/seal holes in drywall behind sink and behind stove (finish areas with painted drywall or tile as appropriate)

Comply By: 07/31/24

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.111ABD

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

Mouse droppings observed in cabinet beside refrigerator and under sink. Provide control of pests and eliminate harborage conditions - clean surfaces, cabinets, and floors, and repair cabinets and seal holes and openings in the cabinets and walls.

Comply By: 07/31/24

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.12A

MN Rule 4626.1520A Clean and maintain all physical facilities clean.

Clean the interior and exterior of cabinets and the floor of the kitchen (pull out appliances and clean underneath and behind)

Comply By: 07/12/24

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

Discussed pest control; reported there was a mouse caught approx. 1 year prior and mice have not been observed since. Thoroughly clean and sanitize the interior of the cabinets and the floor in the kitchen (pull out appliances and clean under and behind), as there were some mouse droppings observed in cabinet beside the refrigerator and under the sink.

Continue storing opened food items in storage containers, and provide food storage containers that are easy enough to clean/sanitize (something small enough and dishwasher safe would probably be the easiest).

Facility has a food thermometer and a TMD for measuring interior contact temperature of dish washer.

FACILITY
Appliances are residential, linoleum counter, stick tile and painted walls, painted wood cabinets

SINK USAGE
Facility has a two (2) compartment sink
Facility has a dishwasher with a sanitize cycle
Facility does not have a 3 compartment sink
Facility does not have a dedicated food preparation sink

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

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

EQUIPMENT

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

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

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

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

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

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

FACT SHEETS
Please search "MDH Fact Sheets" for the Food Business fact sheets page
"Cleaning and Sanitizing" https://www.health.state.mn.us/communities/environment/food/docs/fs/cleansanfs.pdf
"Food Cooking Temperatures"
https://www.health.state.mn.us/communities/environment/food/docs/fs/timetempfs.pdf
"Date Marking TCS foods"
https://www.health.state.mn.us/communities/environment/food/docs/fs/datemarkingfs.pdf
"Highly Susceptible Populations" - no service or raw or undercooked animal food, use Pasteurized eggs when preparing eggs raw or undercooked or batching scrambled eggs
https://www.health.state.mn.us/communities/environment/food/docs/fs/highsuspopfs.pdf

Type: Full
Date: *07/08/24*
Time: 11:00:00
Report: 1025241100
Nova Ewing Home

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 1025241100 of 07/08/24.

Certified Food Protection Manager: Dheeraj Karki

Certification Number: FM109346 Expires: 11/18/24

Inspection report reviewed with person in charge and emailed.

Signed: _____
Establishment Representative

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

Report #: 1025241100

Food Establishment Inspection Report

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

No. of RF/PHI Categories Out	0
No. of Repeat RF/PHI Categories Out	0
Legal Authority MN Rules Chapter 4626	

Date 07/08/24
Time In 11:00:00
Time Out

	Address	City/State	Zip Code	Telephone
Nova Ewing Home	5152 Ewing Avenue North	Brooklyn Center, MN	55429	6126015843

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
0038197		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

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

			COS	R
Proper Use of Utensils				
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
Utensil Equipment and Vending				
47	X	Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48		Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
Physical Facilities				
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55	X	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:** 07/08/24

Inspector (Signature) Cory King