Electronically Delivered

December 18, 2023

Licensee
Charity Care Inc
10909 Brittany Drive North
Champlin, MN 55316

RE: Project Number(s) SL36638015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on December 6, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the 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.

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

STATE CORRECTION ORDERS
The enclosed State Form documents the state correction orders. The 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 the 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/HRD-Appeals-Form

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,

Jessie Chenze, Supervisor
State Evaluation Team
Email: jessie.chenze@state.mn.us
Telephone: 218-332-5175 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
	36638	A. BUILDING: _____ B. WING _____	12/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARITY CARE INC	10909 BRITTANY DRIVE NORTH CHAMPLIN, MN 55316

(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: SL36638015 On December 4, 2023, through December 6, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 4 active residents; 4 receiving services under the Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that	0 510		

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0 510	Continued From page 1 complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure infection control standards was followed for hand hygiene for one of one licensed practical nurse (LPN)-C. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: On December 5, 2023, at 9:17 a.m., surveyor observed LPN-C obtain resident's (R1) blood sugar, blood pressure and heart rate, removed continuous positive airway pressure (CPAP) (a machine that uses mild air pressure to keep breathing airways open while sleeping), and administer morning scheduled medications. After performing tasks, LPN-C did not perform hand hygiene after the removal of gloves and	0 510		

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0 510	Continued From page 2 proceeded to touch computer and countertop on kitchen table. When surveyor asked about hand hygiene expectations following removal of disposable gloves, she stated we are to wash our hands or use hand sanitizer. On December 5, 2023, at 9:20 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated all staff are trained on proper hand hygiene, and staff are to wash hands or use hand sanitizer after the removal of gloves and in between resident cares. The licensee's Hand Washing policy dated August 1, 2021, indicated when conducting a procedure requiring the use of gloves, proper hand hygiene should be completed before donning gloves and after removing gloves. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
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;	0 680		

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0 680	Continued From page 3 and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop an emergency preparedness plan (EPP) with all the required content. This had the potential to affect residents, staff, and any visitors of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On December 6, 2023, at 9:00 a.m., surveyor reviewed the facility's EPP and related documentation. The licensee's EPP dated on August 1, 2023, included a hazard vulnerability assessment, and policies addressing missing resident, fire,	0 680		

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0 680	Continued From page 4 evacuation, pandemic, and generic instructions for power outage, threat of violence/terrorism, tornado/severe weather, suspicious person, hazardous materials, and emergency lockdown. The licensee's EPP lacked the following required content: -Development of emergency preparedness policies and procedures addressing: -how the facility will provide a means to shelter in place for residents, and volunteers; -provision of subsistence needs for staff and residents to include (food, water, medical supplies, pharmacy supplies, sewer and waste disposal, emergency lighting, fire detection, extinguishing and alarm systems); -a tracking system used to document locations of residents and staff; -medical record documentation system the facility has developed to preserve resident information security and availability of records; -emergency staffing strategies to include volunteers; and -the development of arrangements with other facilities and providers to receive residents if needed. -Development of communication plan to include: -names and contact information for staff, entities providing services under arrangement, resident physicians, other visitors, volunteers; -contact information for local emergency preparedness staff, ombudsman, state licensing and certification agencies; -primary and alternative means for communicating with facility staff, federal, state, tribal, regional, and local emergency management agencies; -methods for sharing information and medical documentation for residents; -means of providing information about the	0 680		

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0 680	Continued From page 5 facility's needs, and its ability to provide assistance to include information about their occupancy; and -methods for sharing information from the emergency plan with residents and families. On December 6, 2023, at 10:00 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she may have more EPP documents, she would need to look, however, no additional documents were provided. The licensee's Emergency Preparedness policy dated August 1, 2021, indicated the facility will have procedures in place to assure the safety and well-being of residents and staff during periods of emergency or disaster that disrupts services. Per Assisted Living Facilities: Minnesota Rules Chapter 4695, 4659.0100, sections A and B, assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.73, or successor requirements. This part references documents, specifications, methods, and standards in "State Operations Manual Appendix Z - Emergency Preparedness for All Providers and Certified Supplier Types: Interpretive Guidance," which is incorporated by reference. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment	0 780		

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0 780	Continued From page 6 (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide 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	0 780		

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0 780	Continued From page 7 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 a facility tour on December 4, 2023, at 1:14 p.m., with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A, 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 the LALD/CNS-A tested the smoke alarms. On December 4, 2023, at 1:14 p.m., LALD/CNS-A verbally confirmed the smoke alarm test did not actuate all alarms. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and	0 790		

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0 790	Continued From page 8 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide current documentation of monthly inspections of all the fire extinguishers. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On a facility tour on December 4, 2023, at 2:30 p.m., with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A, survey staff observed the fire extinguishers throughout the facility, did not have documentation to indicate monthly inspections had been performed as required. Annual and monthly inspections of the fire extinguishers are required to ensure that all systems are maintained and remain in working order. On December 4, 2023, at 2:30 p.m., LALD/CNS-A verbally confirmed survey fire extinguishers did not have required inspections. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 790		

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0 810	Continued From page 9	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:	0 810		

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0 810	Continued From page 10 Based on a record review and interview, the licensee failed to develop a fire safety and evacuation plan with required elements, failed to provide required employee and resident training on fire safety and evacuation, and failed to conduct required evacuation drills. 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 December 4, 2023, at 11:05 a.m., the surveyor requested documentation on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility from licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A. The licensee failed to have created a FSEP, training staff and residents on the fire safety and evacuation procedures nor conducted drills for fire safety and similar emergencies. This documentation was requested via email on December 4th and again on a phone conversation on December 4th at 3:01 pm. Documentation was not provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		

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0 930	Continued From page 11	0 930		
0 930 SS=C	144G.50 Subd. 2 (d-e; 1-4) Contract information (d) The contract must include a description of the facility's complaint resolution process available to residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints. (e) The contract must include a clear and conspicuous notice of: (1) the right under section 144G.54 to appeal the termination of an assisted living contract; (2) the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer; (3) contact information for the Office of Ombudsman for Long-Term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints; (4) the resident's right to obtain services from an unaffiliated service provider; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the assisted living contract included all required content for one of one resident (R1). 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	0 930		

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0 930	Continued From page 12 or has potential to affect a large portion or all of the residents). The findings include: R1's service plan dated August 17, 2021, indicated services included medication administration, laundry, housekeeping, assistance with glucose monitoring, and assistance with dressing, grooming, toileting, and bathing. On December 5, 2023, at 12:19 p.m., the surveyor observed licensed practical nurse (LPN)-C administer R1's scheduled afternoon medication. R1's Assisted Living Contract for Housing and Services dated August 17, 2021, lacked the contact information for the Ombudsman for Mental Health and Developmental Disabilities. On December 6, 2023, at 10:16 a.m., license assisted living director/clinical nurse supervisor (LALD/RN)-A stated the assisted living contract was used by the licensee for all residents. LALD/CNS-A reviewed the contract and stated the contract did not include the above noted content. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 930		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must	01620		

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	36638	A. BUILDING: _____ B. WING _____	12/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARITY CARE INC	10909 BRITTANY DRIVE NORTH CHAMPLIN, MN 55316

(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
01620	Continued From page 13 be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed 90-day comprehensive assessments and a change of condition assessment 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	01620		

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01620	Continued From page 14 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted and started to receive services under the assisted living license on August 11, 2022. R1's diagnoses included diabetes, hyperglycemia (high blood sugar) and high blood pressure. R1's service plan dated October 10, 2022, indicated the resident received services which included medication administration, including blood glucose monitoring, bathing, behavior monitoring, assistance with compression stockings, meal reminders, housekeeping, and laundry. On December 5, 2023, at 9:17 a.m., surveyor observed licensed practical nurse (LPN)-C obtain R1's blood sugar, blood pressure and heart rate, removed continuous positive airway pressure (CPAP) (a machine that uses mild air pressure to keep breathing airways open while sleeping), and administer morning scheduled medications. PROGRESS NOTES -July 20, 2023, at 6:27 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A noted: 90-day assessment, "Alert and oriented x 4. Noted to be forgetful at times. Diminished sensation to bilateral low extremities (BLE). Reports intermittent pain. Had early morning appointment. Vital signs stable. Continues to have weight checks daily. Weight of 304.4 pounds. Genitourinary (GU): incontinent of bladder, uses depends especially when out in the community, staff to encourage time toileting.	01620		

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01620	Continued From page 15 Staff to continue to encourage [resident] to ambulate frequently and to avoid use of the urinal during the day, to foster increase of activity by ambulate to the bathroom. Continues to have international normalized ratio blood test (INR) check and dose as needed per the INR. INR check July 17, 2023, levels of 3.0 to continue with the same dose of 6 milligram (mg) and check the INR next week. Skin: skin dry and intact. BLE dusky and with diminished sensation. Otherwise, no open wounds. Diet: non-compliant with his recommendations, drinks alcohol at least 2 times a week. Physician (MD) aware. Staff to keep encouraging [resident] to make better food choices. Continues to have blood sugar checks 4 times a day. Insulin with meals. No bedtime insulin. Mental Health: does have some disorientation at times and forgetfulness. Anxiety, agitation, and aggressive behavior at times towards staff. Overall, easily directed. Continues to need housekeeping daily and incontinence care as needed. Socialization: likes to socialize with his roommate. Appointment: resident had eye appointment early this morning. Routine: goes to bed very late by 1:00-2:00 a.m., difficulty getting up in the morning. Sometimes refuses to take medication as scheduled and that delays some of his medication times. Staff continue to work with him as needed. Will continue to monitor." -September 21, 2023, at 1:25 p.m., LALD/CNS-A noted: 90-day assessment, "Alert and orientated x 4. Noted to be forgetful at times. Diminished sensation to BLE. Denies pain today. Vitals BP 109/63, HR 76, temp 97.3, BS 133. Weight of 304.4. Patient with urinary tract infection (UTI) at the moment and being treated by the antibiotics cycle finishing today. GU): incontinent of bladder, uses depends especially when out in the	01620		

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01620	Continued From page 16 community, staff to encourage time toileting. Staff to continue to encourage [resident] to ambulate frequently and to avoid use of the urinal during the day, to foster increase of activity by ambulate to the bathroom. Continues to have INR check and dose as needed per the INR. INR check yesterday September 20, 2023, levels of 2.1 to continue with the same dose of 6 mg and check the INR next week. Skin: skin dry and intact. BLE dusky and with diminished sensation. Otherwise, no open wounds. Diet: non-compliant with his recommendations, drinks alcohol at least 2 times a week. MD aware. Staff to keep encouraging [resident] to make better food choices. Continues to have blood sugar checks 4 times a day. Insulin with meals. No bedtime insulin. Mental Health: does have some disorientation at times and forgetfulness. Anxiety, agitation, and aggressive behavior at times towards staff. Overall, easily directed. Continues to need housekeeping daily and incontinence care as needed. Socialization: likes to socialize with his roommate. Routine: goes to bed very late by 1:00-2:00 a.m., difficulty getting up in the morning. Sometimes refuses to take medication as scheduled and that delays some of his medication times. Staff continue to work with him as needed. No recent medication changes noted other than the antibiotic cycle ending today. Will continue to monitor." -October 26, 2023, at 12:04 p.m., LALD/CNS-A noted: Infectious disease appointment: "Spoke with [doctor] and asked if we can assist [resident] with antibiotic injections. He will make a decision on what antibiotic and fax to [pharmacy] and [licensee]. He will try and consult [name] homecare for infusion; possibly place a midline intravenous (IV) route. [Resident] still at appointment".	01620		

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	36638	A. BUILDING: _____ B. WING _____	12/06/2023

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01620	Continued From page 17 -October 26, 2023, at 2:47 p.m., LALD/CNS-A noted: Infection disease: "Spoke with [physician]. [Resident] will be restarted on IV antibiotic. [Name] home health to assist in placing the midline". -October 26, 2023, at 6:57 p.m., LALD/CNS-A noted: Progress: "[Resident] alert and oriented. Does report some pains with urination. Appointment set up with the [physician]. Appointment set up with the urologist however its far out in January. [Resident] saw [physician] who ordered IV antibiotics for him for 2 weeks. [Name] home care to follow-up with the IV site management. OK for assisted living nurse to administer the IV doses while [name] home care manages site". On December 6, 2023, at 10:16 a.m., LALD/CNS-A stated the 90-day assessments are completed by reviewing the notes from the past 90 days, vitals are taken, and meets with the resident face to face. If nothing has changed, the information is documented in a progress note, otherwise she thinks its repetitive to use the uniform assessment tool. Additionally, she stated she did a progress note for the change in condition when R1 was prescribed a new IV order, she did not use the uniform assessment tool. The licensee's Assessment, Reviews and monitoring policy dated August 1, 2021, indicated the initial nursing assessment or reassessment must include all the elements of the uniform assessment tool as required, conducted in person, be in writing, dated, and signed by the registered nurse who conducted the assessment. The individualized review or subsequent reviews	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01620	Continued From page 18 must include all the required elements as specified in Rule, conducted in person, be in writing, dated and signed by the resident nurse who conducted the individualized review. 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. No further information was provided. TIME PERIOD TO CORRECT: 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 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 medications were documented as administered for one of one resident (R1) who received medication management services. This practice resulted in a level two violation (a	01750		

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01750	Continued From page 19 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1 was admitted and started to receive services under the assisted living license on August 11, 2022. R1's diagnoses included diabetes, hyperglycemia (high blood sugar) and high blood pressure. On December 5, 2023, at 9:17 a.m., surveyor observed licensed practical nurse (LPN)-C obtain R1's blood sugar, blood pressure and heart rate, removed continuous positive airway pressure (CPAP) (a machine that uses mild air pressure to keep breathing airways open while sleeping), and administer morning scheduled medications. R1's service plan dated October 10, 2022, indicated the resident received services which included medication administration, including blood glucose monitoring, bathing, behavior monitoring, assistance with compression stockings, meal reminders, housekeeping, and laundry. R1's prescriber orders dated November 16, 2023, included an order for Azithromycin 250 milligram (mg), take 2 tablets on day 1, and 1 tablet on days 2-5 for dental procedure, including routine cleaning. R1's November 17, 2023, through November 20,	01750		

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01750	Continued From page 20 2023, electronic medication administration record (EMAR) indicated staff to administer azithromycin 250 mg tablet, take 2 tablets (500 mg) by mouth on day 1, then take 1 tablet by mouth once daily on days 2-5. EMAR documentation summary indicated the medication was declined or skipped for the following days: -November 17, 2023 -November 18, 2023 -November 19, 2023 -November 20, 2023 On December 6, 2023, at 10:15 a.m., surveyor reviewed R1's November 2023 EMAR with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A. LALD/CNS-A stated the incorrect documentation was her fault as she didn't click set-up in EMAR, the unlicensed personnel (ULP) reached out as the medication came in and staff did not know what to do with the medication. Additionally, she stated pharmacy puts in medications into their EMAR, the medication was in the EMAR, staff was documenting as not given, but staff was administering the medication. LALD/CNS-A stated no medication errors were written for the incorrect documentation. The licensee's Resident Record-Documention dated August 1, 2021 indicated for medications administered or treatments and/or therapies administered, documentation in a resident's chart must include the date and time of the administration. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		

Minnesota Department of Health
Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975
6512014500

Type: Full
Date: *12/05/23*
Time: 10:55:13
Report: 1047231093

Food and Beverage Establishment Inspection Report

Location:
Charity Care Inc
10909 Brittany Drive North
Champlin, MN55316
Hennepin County, 27

Establishment Info:
ID #: 0038540
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7632736110
ID #:

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

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Hot Water: = at 160F Degrees Fahrenheit
Location: Dishmachine
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: Inside refrigerator- cheese
Violation Issued: No

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: Inside refrigerator- butter
Violation Issued: No

Process/Item: Ambient Air
Temperature: 34 Degrees Fahrenheit - Location: Outside refrigerator
Violation Issued: No

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

The inspection was completed with the operator and reviewed with MDH Nurse Evaluator A. Boutwell

The establishment has a residential kitchen and serves food that is prepared that day. The kitchen has wood cabinets, laminate floor, painted walls, solid counter top, and a painted ceiling.

A two basin sink is located in the kitchen. One sink basin is designated for hand washing.

A residential dish machine is located in the kitchen.

Type: Full
Date: *12/05/23*
Time: 10:55:13
Report: 1047231093
Charity Care Inc

Food and Beverage Establishment Inspection Report

Discussed hand washing, ware washing, staff illness policy, temperature control, final cook temperatures, cleaning, serving highly susceptible populations, and food handling procedures.

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 1047231093 of 12/05/23.

Certified Food Protection Manager Charity Ongeri

Certification Number: FM107652 Expires: 08/16/24

Inspection report reviewed with person in charge and emailed.

Signed: _____
Charity Ongeri
PIC

Signed: _____
Holly Sievers
Public Health Sanitarian 2
Metro Office
6512015946
Holly.Sievers@state.mn.us