Electronically Delivered

November 14, 2024

Licensee
Infinity Care CORP.
14015 County Road 9
Minneapolis, MN 55447

RE: Project Number(s) SL36896015

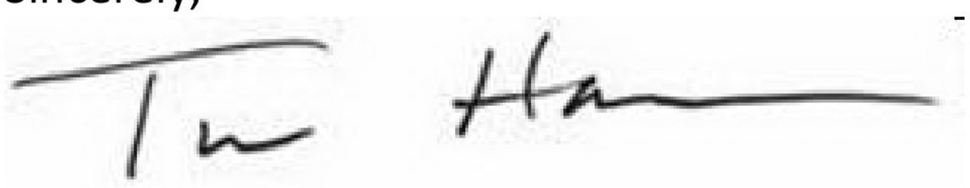
Dear Licensee:

On October 16, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the August 1, 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,



State Engineering Services Section
Email: Tim.Hanna@state.mn.us
Telephone: 507-208-8982 Fax: 1-866-890-9290

HHH

Electronically Delivered

August 29, 2024

Licensee
Infinity Care Corp
14015 County Road 9
Minneapolis, MN 55447

RE: Project Number(s) SL36896015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 1, 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.

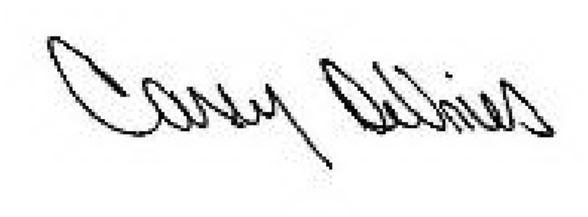
To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36896	A. BUILDING: _____ B. WING _____	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INFINITY CARE CORP	14015 COUNTY ROAD 9 MINNEAPOLIS, MN 55447

(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: SL36896015-0 On July 29, 2024, through, August 1, 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 three residents; all of whom were receiving services under the provider's Assisted Living Facility license. An immediate correction order was identified on July 30, 2024, issued for SL353130155-0, tag identification 0820. On July 31, 2024, the immediacy of correction order 0820 was removed, however non-compliance remained, and the scope and level remained unchanged.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness	0 680		

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0 680	Continued From page 1 (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to have a written emergency preparedness (EP) plan with all the required content. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	0 680		

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0 680	Continued From page 2 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's emergency disaster preparedness plan dated August 6, 2021, lacked evidence of the following required content: -conduct exercises to test the EP at least twice per year, including unannounced staff drills using the EP and must include the following: -participate in an annual full-scale exercise that is community based OR conduct an annual, individual, facility-based functional exercise OR if the facility experiences an actual emergency requiring activation of plan, facility is exempt from engaging in its next required full-scale exercise; -conduct an additional annual exercise that may include: a second full-scale exercise that is community-based or an individual, facility based functional exercise OR mock disaster drill OR table-top exercise; and -analyze the facility's response to and maintain documentation of all drills, tabletop exercises and emergency events & revise plan as needed. On July 30, 2024, at 8:28 a.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-C acknowledged the licensee was missing the above-mentioned items and stated, "No, we have not done that kind of a drill so I know I will need to take that tag, but that is a great idea to do a big drill so we will start doing that but so far we have not done one." No further information was provided.	0 680		

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0 680	Continued From page 3 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 780 SS=D	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so 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 so that the actuation of one alarm causes all alarms in the dwelling unit to actuate. This deficient condition had the ability to affect all	0 780		

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0 780	Continued From page 4 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) 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 July 30, 2024, at 2:15 p.m., survey staff toured the facility with the clinical nurse supervisor/licensed assisted living director (CNS/LALD)-C and manager (M)-A. During the facility tour, it was observed the sleeping room 1 on the main level that was equipped with smoke alarm was not interconnected upon testing, so actuation of one alarm would cause all alarms to operate. During the interview on July 30, 2024, at 3:00 p.m., LALD/CNS-C stated the smoke alarm in the resident room 1 was not interconnected, and the actuation of the alarm would not cause all alarms to operate. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping	0 810		

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0 810	Continued From page 5 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 interview and record review, the licensee failed to provide required employee training on fire safety and evacuation as required. 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	0 810		

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0 810	Continued From page 6 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 30, 2024, at 3:30 p.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-C provided documentation on the fire safety and evacuation plan (FSEP), fire safety and evacuation training for the facility, and fire safety and evacuation drills for the facility. TRAINING Record review of the available documentation indicated employees did not receive training twice per year after initial hire. During the interview on July 30, 2024, at 4:00 p.m., LALD/CNS-C stated the licensee provided annual training on the fire safety and evacuation plan to employees, but not twice per year after the initial hire, as required by statute. LALD/CNS-C confirmed that there was no further documented training for the staff on the fire safety and evacuation plan as required by statute. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 820 SS=G	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as	0 820		

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0 820	Continued From page 7 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 a resident bedroom with the minimum window opening meeting the minimum state standard for egress. This affected the occupied resident in bedroom 2 on the main level. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On July 30, 2024, at 2:15 p.m., survey staff toured the facility with the clinical nurse supervisor/licensed assisted living director (CNS/LALD)-C. During the facility tour, survey staff observed the following items:	0 820	This immediate correction order identified on July 30, 2024, has had the immediacy lifted as of July 31, 2024, however non-compliance remained a scope and level of G.	

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0 820	Continued From page 8 It was observed that occupied resident bedroom 2 on the upper level did not have a window that met the minimum size requirements for egress escape. The clear openable area of the opened window measured 22 inches in height and 28 ¾ inches in width, with a total openable area of 632.5 square inches. The windows did not meet the minimum requirements for total openable area. It was observed that unoccupied resident bedroom 1 on the upper level did not have a window that met the minimum size requirements for egress escape. The clear openable area of the opened window measured 22 inches in height and 28 ¾ inches in width, with a total openable area of 632.5 square inches. The windows did not meet the minimum requirements for a 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 CNS/LALD -C that at least one egress window in each bedroom must be provided to meet the minimum state standard for an egress window to be a complying bedroom for resident occupancy. CNS/LALD -C verbally confirmed the findings. On July 30, 2024, at 3:00 p.m., during the interview, survey staff explained to CNS/LALD -C that an immediate correction order was issued for the above finding. CNS/LALD -C acknowledged the above finding. No further information was provided.	0 820		

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0 820	Continued From page 9 TIME PERIOD FOR CORRECTION: Immediate	0 820		
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 the potential to affect a large portion or all the residents). The findings include: On June 29, 2024, at 11:43 a.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-C provided the surveyor with a blank Assisted Living Contract, and stated, "I am 99	0 970		

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0 970	Continued From page 10 percent sure they are all the same here, I have [R2's] you can look at and if they match then they are all the same." CNS/LALD-C looked at R2's contract and acknowledged the same contract was utilized for all residents. The licensee's Assisted Living Contract included the following sections that indicated a waiver of liability: "Miscellaneous Provisions: Insurance Liability and Release. The resident shall maintain at all times his or her own health, personal property, liability, automobile (if applicable), and other insurance coverages and shall provide evidence of same by copies of binders or policies provided to [licensee] upon request. The resident acknowledges that [licensee] is not an insurer of the resident's person or property. 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." Indemnification: "[Licensee] shall not be liable for any damage or injury to the resident, or any other person, or to any property, occurring on the premises, or any part thereof, or in common areas thereof, and the resident agrees to hold [licensee] harmless from any claims or damages unless caused solely by	0 970		

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0 970	Continued From page 11 negligence of [licensee]. It is recommended that renter's insurance be purchased at the resident's expense. Nothing contained herein is intended to create a waiver of facility liability for the health and safety or personal property of a resident. Liability: The resident agrees to be liable and responsible for all obligations herein referenced, monetary and otherwise, of the resident and where this Contract has been executed by a party designated below. Or where a separate Responsible Party Agreement has been executed by a third party, said third party and the resident shall be jointly and severally liable and responsible for all obligations, monetary and otherwise, of the resident herein referenced." On July 29, 2024, at 11:45 a.m., CNS/LALD-C stated, "We will need to get that fixed." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated	01060		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36896	A. BUILDING: _____ B. WING _____	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INFINITY CARE CORP	14015 COUNTY ROAD 9 MINNEAPOLIS, MN 55447

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01060	Continued From page 12 and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation to the resident, legal representative, or designated representative and failed to provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC) of the emergency	01060		

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01060	Continued From page 13 relocation greater than four days for one of one resident (R3). 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: R3 was admitted to the licensee and began receiving assisted living services on August 17, 2021. R3's Med Admin Summary - Actual - Month form, dated May 1, 2024, through May 31, 2024, indicated R3 had been in the hospital from May 22, 2024, through May 28, 2024. R3's record lacked evidence a written notice, with the required statutory content, was provided to resident, or resident representative. On July 29, 2024, at 11:28 a.m., the surveyor asked clinical nurse supervisor/licensed assisted living director (CNS/LALD)-C if an emergency relocation form had been completed or sent to the OOLTC for R3's most recent hospitalization. CNS/LALD-C stated, " I have not done that because I did not know that was something I needed to do. I know what you are talking about, but I never knew the hospital or emergency room was considered a relocation." No further information was provided.	01060		

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01060	Continued From page 14 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01820 SS=F	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain current medication orders for two of two residents (R2 and R3) who received medication administration by the licensee. 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: R2 R2 was admitted to the licensee and began receiving assisted living services on March 12, 2023. R2's diagnoses include Schizophrenia, schizoaffective disorder, major depression disorder, and bipolar disorder.	01820		

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	36896	A. BUILDING: _____ B. WING _____	08/01/2024

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INFINITY CARE CORP	14015 COUNTY ROAD 9 MINNEAPOLIS, MN 55447

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01820	Continued From page 15 R2's Service Plan signed May 9, 2023, indicated R2 received assistance with behavior management, housekeeping, laundry, vital sign monitoring, and medication administration. On July 29, 2024, the surveyor observed clinical nurse supervisor/licensed assisted living director (CNS/LALD)-C administer oral medication to R2. R2's Med Amin Summary- Actual- Month dated July 1, 2024, through July 31, 2024, indicated R2 took amlodipine 5 milligram (mg), lisinopril 10 mg, metformin 2000 mg, vitamin D3 1000 units (u), benophen [sic] 25 mg, and olanzapine 40 mg once daily, as well as famotidine 20 mg twice daily. On July 30, 2024, at 11:28 a.m., CNS/LALD-C acknowledged not having prescriber orders and called the pharmacy to request resident orders be faxed to the licensee. On July 30, 2024, at 12:03 p.m., CNS/LALD-C provided the surveyor with a fax and stated it was R2's prescriber orders. The fax was sent to the licensee on July 30, 2024, (during the survey) from Genoa Healthcare (R2's pharmacy) to CNS/LALD-C. The orders included all of the above listed medications. R3 R3 was admitted to the licensee and began receiving assisted living services on August 17, 2021. R3's diagnoses include Schizophrenia disorder, major depressive disorder, and bipolar disorder. R3 Service Plan signed April 5, 2021, indicated	01820		

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	36896	A. BUILDING: _____ B. WING _____	08/01/2024

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01820	Continued From page 16 R3 received assistance with bathing, behavior management, dressing, grooming, housekeeping, laundry, vital sign monitoring, and medication administration. On July 29, 2024, the surveyor observed unlicensed personnel (ULP)-B administer oral medications to R3. R3's Med Amin Summary- Actual- Month dated July 1, 2024, through July 31, 2024, indicated R3 took brimonidine 0.2 percent (%) one drop to left eye, and Timolol Maleate 0.5% one drop into left eye twice a day, famotidine 40 mg, ferrous sulfate 325 mg, magnesium oxide 400 mg, mirtazapine 25 mg, quetiapine 100 mg, Xarelto 20 mg, Gabapentin 300 mg, Rosuvastatin 5 mg, folic acid 1000 micrograms (mcg), pantoprazole 40 mg, and sertraline 50 mg once daily, as well as Keppra 750 mg, sucralfate 1 mg, and metoprolol 50 mg twice daily. On July 30, 2024, at 2:08 p.m., CNS/LALD-C provided the surveyor with a fax of R3's prescriber orders. The fax was sent to the licensee on July 30, 2024, (during the survey) from Genoa Healthcare (R3's pharmacy) to CNS/LALD-C. The orders included all of the above listed medications. On July 30, 2024, at 12:29 p.m., CNS/LALD-C stated, "Yeah, unless we request it, we don't have [current medication orders] here, but we know it is at the pharmacy, so we can always request it." The licensee's Prescriber's Orders, dated August 1, 2021, indicated, "Written orders from an authorized prescriber will be obtained for all medications and treatments with which the assisted living facility assists residents, including	01820		

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01820	Continued From page 17 over the counter medications." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		

Minnesota Department of Health

625 North Robert Street
Saint Paul, MN
651-201-5000

Type: Full
Date: *07/30/24*
Time: 13:00:00
Report: 8087241155

Food and Beverage Establishment Inspection Report

Location:

Infinity Care Corp
14015 County Road 9
Plymouth, MN55447
Hennepin County, 27

Establishment Info:

ID #: 0038994
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6128141255
ID #:

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

No NEW orders were issued during this inspection.

Food and Equipment Temperatures

Process/Item: Ambient Air
Temperature: 39 Degrees Fahrenheit - Location: STAND-UP REFRIGERATOR
Violation Issued: No

Process/Item: Cold Holding: MILK
Temperature: 38 Degrees Fahrenheit - Location: STAND-UP REFRIGERATOR
Violation Issued: No

Process/Item: Cold Holding: CUT LFY GRN
Temperature: 40 Degrees Fahrenheit - Location: STAND-UP REFRIGERATOR
Violation Issued: No

Process/Item: Ambient Air
Temperature: 6 Degrees Fahrenheit - Location: STAND-UP FREEZER
Violation Issued: No

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

THIS WAS AN ANNOUNCED AND SCHEDULED FULL INSPECTION.

INSPECTION CONDUCTED IN THE PRESENCE OF NURSE EVALUATOR I TESA BROWN.

FLOORS ARE LAMINATE, CABINETS ARE HARDWOOD AND CEILING IS TEXTURED, APPEARS TO BE DURABLE, BUT IS NOT SMOOTH OR EASILY CLEANABLE. ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT SUCH A TIME THEY ARE FOUND TO BE A CONCERN OR RISK OF CONTAMINATION, THEY WILL BE ORDERED TO BE REPLACED AND BROUGHT UP TO CODE.

MAYTAG BRAND DISHWASHER IS RESIDENTIAL BUT HAS SANITIZING RINSE CYCLE

OPTION.

HOT WATER TEMPERATURE AT THE KITCHEN SINK REACHED 123 DEGREES.

DESIGNATED HAND WASHING SINK IN THE KITCHEN, ON THE RIGHT SIDE OF A 2-BIN, STAINLESS STEEL RESIDENTIAL SINK.

INSPECTION REPORT EMAILED TO TESA BROWN.

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 8087241155 of 07/30/24.

Certified Food Protection Manager: FARDOZA M. YUSUF

Certification Number: FM112992 Expires: 09/01/25

Inspection report reviewed with person in charge and emailed.

Signed: _____

FARDOZA M. YUSUF
MANAGER

Signed: _____

John Boettcher
Public Health Sanitarian 3
St. Paul, MN / Freeman
651-201-5076
john.boettcher@state.mn.us