Electronically Delivered
May 1, 2024

Licensee
Renewed Spirit
319 Bellwood Avenue South
Maplewood, MN 55117

RE: Project Number(s) SL36992016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 16, 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.

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. 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,

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
	36992	A. BUILDING: _____ B. WING _____	04/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENEWED SPIRIT	319 BELLWOOD AVENUE SOUTH MAPLEWOOD, MN 55117

(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: SL36992016 On April 15, 2024, through April 16, 2024, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were four resident receiving services under the provider's Assisted Living with Dementia Care 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.	
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled	0 650		

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0 650	Continued From page 1 volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records contained a current annual performance review for one of two employees (clinical nurse supervisor (CNS)-B). 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 2 The findings include: CNS-B had a start date of August 18, 2016, and began providing assisted living services on August 1, 2021. During the course of the survey on April 15, 2024, the surveyor observed CNS-B provide services to the licensee's residents. CNS-B's employee record lacked evidence a current annual performance evaluation was completed for 2023. On April 16, 2024, at 12:00 p.m., licensed assisted living director (LALD)-A stated since the change of ownership, the licensee was behind on completing annual performance reviews and CNS-B did not have an annual performance evaluation completed for the year of 2023. The licensee's Employee Records policy dated March 1, 2023, indicated each employee record would include documentation of annual performance reviews that identify areas of improvement needed and training needs. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) 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	0 680		

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0 680	Continued From page 3 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 disaster plan with all 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 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).	0 680		

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0 680	Continued From page 4 The findings include: During entrance conference on April 15, 2024, at 11:44 a.m., licensed assisted living director (LALD)-A stated she was responsible for the licensee's emergency disaster plan and recently completed updates to the EP policies and procedures. The licensee's EPP dated March 2023, did not include the development of the following policies and procedures based on the licensee's risk assessment to include: -documentation the missing resident plan was reviewed quarterly; -process for emergency preparedness (EP) cooperation with state and local EP officials/organizations; -subsistence needs for staff and residents during an emergency to include (food, medical supplies, pharmacy supplies, waste disposal, and alternate sources of energy); -shelter in place for residents, staff, and volunteers who remain in the facility; -system of medical documentation that preserves resident information, protects confidentiality, and secures/maintains availability of records; -role of facility under a waiver declared by the Secretary in accordance with section 1135 of the Act -a communication plan that included: -emergency officials contact information to include: contact information for the following: Federal, State, tribal, regional & local EP staff, State Licensing and Certification Agency, MN Office of Ombudsman for LTC; and -an annual emergency prep training program. On April 16, 2024, at 3:13 p.m., the surveyor and	0 680		

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0 680	Continued From page 5 LALD-A reviewed the licensee's EPP and LALD-A stated she was not familiar with the the contents of Appendix Z and verified the licensee's current EPP did not include all required content. The licensee's Emergency Preparedness Plan-Appendix Z Compliance policy, dated March 1, 2023, indicated the licensee would have an effective and compliant Emergency Preparedness Plan aligned with the Centers for Medicare and Medicaid Services State Operations Manual Appendix Z. The licensee's emergency preparedness plan would include al required elements of appendix Z and reviewed annually. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
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 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;	01060		

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01060	Continued From page 6 (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 written notice with required content to the resident, legal representative, and designated representative for one of one resident (R1) reviewed for a hospitalization. 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	01060		

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01060	Continued From page 7 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: R1's diagnoses included acute gastrointestinal (GI) bleeding, dementia and anxiety. R1's Service Plan dated May 5, 2023, indicated R1 required assistance with dressing, grooming, toileting, ambulation, bathing, medication administration, housekeeping, and laundry. R1' Progress Note dated February 18, 2024, indicated R1 went to the hospital for evaluation for unknown internal bleeding. R1's Progress Note dated February 21, 2024, indicated R1 returned to the facility after being hospitalized for three days. R1's record did not include a written notice that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the Office of Ombudsman for Long Term Care (OOLTC) and the Office of Ombudsman for Mental Health and Developmental Disabilities; - 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 - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section	01060		

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01060	Continued From page 8 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. On April 15, 2023, at 3:26 p.m., clinical nurse supervisor (CNS)-B stated she had not been providing residents and or/resident's representatives a written notice of emergency relocation with the above noted content when residents were admitted to the hospital and was unaware of the requirement. The licensee's Emergency Relocation policy dated March 1, 2023, indicated in the event of an emergency relocation, the licensee would provide a written notice that contains, at a minimum: the reason for the relocation; the name and contact information for the location to which the resident has been relocated and any new service provider; and contact information for the OOLTC. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01060		
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the	01500		

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01500	Continued From page 9 exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology	01500		

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01500	Continued From page 10 that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an employee received all of the required annual training content for each 12 months of employment for one of two employees registered nurse (RN)-D. 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: During entrance conference on April 15, 2024, at 11:44 a.m., clinical nurse supervisor (CNS)-B stated RN-D was employed part-time by the licensee and shared rotation as an on-call nurse. RN-D had a start date of October 10, 2016, and began providing assisted living services on August 1, 2021. RN-D's employee record lacked evidence RN-D completed the following required annual training: - training on reporting of maltreatment of vulnerable adults under Mandated Reporting of Maltreatment of Vulnerable Adults Chapter 626,	01500		

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01500	Continued From page 11 sections section 557 & 5572. On April 16, 2024, at 11:59 a.m., licensed assisted living director (LALD)-A stated RN-D's employee record did not indicate RN-D completed reporting of maltreatment and vulnerable adult annual training for 2023. The licensee's Annual Required Staff Training policy dated March 1, 2023, indicated all staff perform direct care services at the licensee would complete at least eight hours of annual training for each 12 months of employment. The training elements would include: - training on reporting of maltreatment of vulnerable adults under section 626.557 - review of the facility's policies and procedures related to the provision of assisted living services and how to implement those policies and procedures; and - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		
01880 SS=D	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by:	01880		

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01880	Continued From page 12 Based on observation, interview, and record review, the licensee failed to ensure medications were securely stored and only authorized personnel had access to medication being stored by the licensee for one of one resident (R2) who required medication refrigerator storage. 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: During entrance conference on April 15, 2024, at 11:44 a.m., clinical nurse supervisor (CNS)-B stated the license provided secured medication storage. R2's diagnosis included glaucoma (increase eye pressure). R2's Service Plan dated May 4, 2023, indicated R2 required medication administration services. R2's prescriber orders dated September 12, 2023, included orders for Rhopressa Opthalmic drops 0.002% one drop in both eyes nightly. R2's Medication Administration Record dated April 1, through April 15, 2024, indicated R2 received Rhopressa eye drop every night and to store unopened bottles of Rhopressa in the refrigerator.	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36992	A. BUILDING: _____ B. WING _____	04/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENEWED SPIRIT	319 BELLWOOD AVENUE SOUTH MAPLEWOOD, MN 55117

(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
01880	Continued From page 13 On April 15, 2024, at 2:32 p.m., CNS-B stated the licensee had stored resident medications requiring medication storage in the main kitchen refrigerator. CNS-B provided the surveyor a plastic clear zip lock bag with three unopened bottles of C2's Rhopressa eye drops (used to reduce eye pressure) which were being stored in a produce drawer along with food items. CNS-B stated staff were monitoring refrigerator temperature daily in Rtasks (an electronic documenting system). C2's eye drops were not securely stored and were available for access by unauthorized personnel. On April 16, 2024, at 11:50 a.m., licensed assisted living director (LALD)-A stated she was unaware medications were stored in the main refrigerator and were not securely stored. The manufacturer's instructions for Rhopressa ophthalmic solution dated 2017, indicated to store unopened bottles of Rhopressa in the refrigerator at 36 to 46 degrees Fahrenheit (F). The licensee's Medication Storage policy, dated March 1, 2023, indicated when medications are managed and stored by the licensee, medications would be kept securely locked and stored per manufacturer directions and only staff would have access to stored medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
02410 SS=D	144G.91 Subd. 13 Personal and treatment privacy	02410		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36992	A. BUILDING: _____ B. WING _____	04/16/2024

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
02410	Continued From page 14 (a) Residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Staff must respect the privacy of a resident's space by knocking on the door and seeking consent before entering, except in an emergency or unless otherwise documented in the resident's service plan. (b) Residents have the right to have and use a lockable door to the resident's unit. The facility shall provide locks on the resident's unit. Only a staff member with a specific need to enter the unit shall have keys. This right may be restricted in certain circumstances if necessary for a resident's health and safety and documented in the resident's service plan. (c) Residents have the right to respect and privacy regarding the resident's service plan. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure privacy was maintained for one of one resident (R3) during person cares. 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	02410		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36992	A. BUILDING: _____ B. WING _____	04/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENEWED SPIRIT	319 BELLWOOD AVENUE SOUTH MAPLEWOOD, MN 55117

(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
02410	Continued From page 15 situation has occurred only occasionally). The findings include: R3's diagnosis included major neurocognitive disorder (a decrease in mental function). R3's Service Plan dated May 9, 2023, indicated R3 received services to include assistance with dressing, grooming, bathing, toileting, transferring, ambulation, medication administration, housekeeping and laundry. R3's Services Delivered dated April 1,2024, through April 16, 2024, indicated R3 received daily assistance with dressing, grooming, toileting, and mobility assistance. On April 16, 2024, at 8:24 a.m., the surveyor observed unlicensed personnel (ULP)-C assist R3 out of bed while R3's bedroom door was opened with clear sight to R3 from the main hallway to resident bedrooms and public/resident shared bathrooms. ULP-C assisted R3 into the bathroom and proceed to assist R3 onto the toilet, undress R3, wash R3's face, back, underarms, under breasts, abdomen, and perineal area while the bathroom door was left open with clear sight into the bathroom. Before ULP-C assisted R3 with dressing, ULP-C partially closed the bathroom pocket door less than halfway, still exposing R3 while completing R3's personal cares. At 9:10 a.m., ULP-C stated she normally provided privacy during personal cares and stated she closed the bathroom door slightly but did not close the door all the way. On April 16, 2024, at 10:59 a.m., licensed assisted living director (LALD)-A stated it was important to make sure privacy was provided for	02410		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02410	Continued From page 16 residents during resident cares. The licensee's Minnesota Assisted Living Bill of Rights dated November 8, 2022, indicated a person who resides in an assisted living community privacy must be respected during toileting, bathing, and other activated of personal hygiene, expect as needed for resident safety or assistance. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02410		

Minnesota Department of Health
Food, Pools, & Lodging Services
P.O. Box 64975
Saint Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *04/16/24*
Time: 10:00:00
Report: 1005241093

Food and Beverage Establishment Inspection Report

Location:
Renewed Spirit Inc
319 Bellwood Avenue South
Maplewood, MN55117
Ramsey County, 62

Establishment Info:
ID #: 0038347
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6512267123
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.

2-200 Employee Health

2-201.11C ***** Priority 1 *****

MN Rule 4626.0040C The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority.

EMPLOYEE ILLNESS LOG NOT ON SITE. DISCUSSED REQUIREMENTS WITH PERSON IN CHARGE AND LEFT A BLANK LOG ON SITE.

Comply By: 04/16/24

4-200 Equipment Design and Construction

4-201.11GMN

MN Rule 4626.0506G Discontinue serving TCS foods that are held for more than same-day service in an adult or child care center or boarding establishment or provide equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

FACILITY SOMETIMES MAKES LARGE BATCHES OF SOUPS, PORTIONS, AND FREEZES THEM FOR LATER USE. DISCUSSED THAT BECAUSE FACILITY HAS RESIDENTIAL EQUIPMENT, FOODS MUST BE PREPARED SAME DAY TO ELIMINATE THE RISKS ASSOCIATED WITH IMPROPER COOLING.

Comply By: 04/16/24

Surface and Equipment Sanitizers

Utensil Surface Temp.: = at 160+ Degrees Fahrenheit
Location: DISHWASHER
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Hold/QUICHE
Temperature: 41 Degrees Fahrenheit - Location: KITCHEN REFRIGERATOR
Violation Issued: No

Process/Item: Cold Hold/CUT MELON
Temperature: 40 Degrees Fahrenheit - Location: KITCHEN REFRIGERATOR
Violation Issued: No

Process/Item: Cold Hold/TURKEY
Temperature: 40 Degrees Fahrenheit - Location: KITCHEN REFRIGERATOR
Violation Issued: No

Process/Item: Cold Hold/LETTUCE
Temperature: 38 Degrees Fahrenheit - Location: GARAGE REFRIGERATOR
Violation Issued: No

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

INSPECTION COMPLETED WITH MANAGER AND REVIEWED WITH HRD NURSE EVALUATOR SATIVA BUSHEY.

DISCUSSED ALL ORDERS ON REPORT AS WELL AS EMPLOYEE ILLNESS, GLOVE USE, COOKING TEMPERATURES, DATE MARKING, SANITIZATION, AND CROSS-CONTAMINATION.

KITCHEN IS RESIDENTIAL AND FOOD CAN BE PREPARED FOR SAME DAY SERVICE ONLY, UNLESS EQUIPMENT IS REPLACED WITH ANSI-CERTIFIED UNITS.

FLOORING IS LAMINATE, CABINETS ARE WOOD WITH HOLLOW BASE, AND COUNTERS ARE LAMINATE. 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.

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 1005241093 of 04/16/24.

Certified Food Protection Manager: ANNA N. DECORSEY

Certification Number: FM122227 Expires: 03/11/27

Inspection report reviewed with person in charge and emailed.

Signed: _____
ANNA DECORSEY
MANAGER

Signed: _____
Jessica Davis
Public Health Sanitarian III
651-201-3961
jessica.davis@state.mn.us