Electronically Delivered

April 10, 2025

Licensee
Cc Group Home Care Inc
3633 Columbus Avenue
Minneapolis, MN 55407

RE: Project Number(s) SL37076015

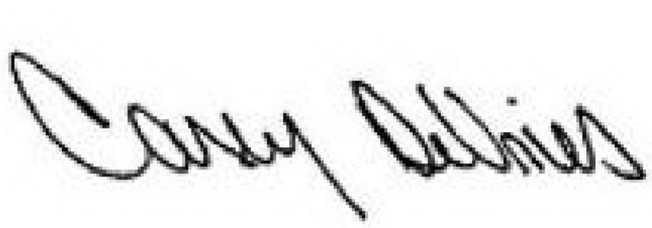
Dear Licensee:

On March 12, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the September 12, 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,



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

HHH

Electronically Delivered

February 3, 2025

Licensee
Cc Group Home Care Inc.
3633 Columbus Avenue
Minneapolis, MN 55407

RE: Project Number(s) SL37076015

Dear Licensee:

On December 12, 2024, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on September 12, 2024. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the September 12, 2024 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on September 12, 2024, found not corrected at the time of the December 12, 2024, follow-up survey and/or subject to penalty assessment are as follows:

0660 - Tuberculosis Prevention And Control - 144g.42 Subd. 9
1370 - Training And Evaluation Of Unlicensed Personn - 144g.61 Subd. 2 (a)
1380 - Training And Evaluation Of Unlicensed Personn - 144g.61 Subd. 2 (b)
1820 - Prescriptions - 144g.71 Subd. 13
1890 - Prescription Drugs - 144g.71 Subd. 20

The details of the violations noted at the time of this follow-up survey completed on December 12, 2024 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Also, at the time of this follow-up survey completed on December 12, 2024, we identified the following violation(s):

0495 - Minimum Requirements - 144g.41 Subdivision. 1 (13) - $3,000.00
0820 - Fire Protection And Physical Environment - 144g.45 Subd. 2 (g)
1750 - Delegation Of Medication Administration - 144g.71 Subd. 7 - $3,000.00

The details of the violation(s) noted at the time of this follow-up survey are delineated on the attached State Form. Only the ID Prefix Tag in the left hand column without brackets will identify these state correction orders. It is not necessary to develop a plan of correction.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $6,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

IMPOSITION OF FINES:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

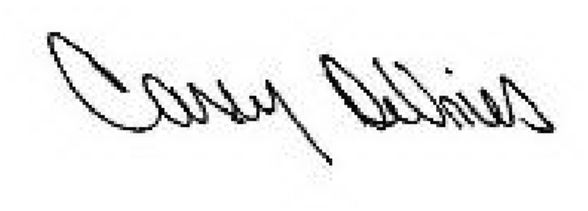
To submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

We urge you to review these orders carefully. If you have questions, please contact Casey DeVries at 651-201-5917.

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

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
	37076	A. BUILDING: _____ B. WING _____	R 12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL37076015-1 On December 10, 2024, through December 12, 2024, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on September 12, 2024. At the time of the survey, there were three residents; three receiving services under the Assisted Living license. As a result of the follow-up survey, the following orders were issued/reissued. An immediate correction order was identified on December 9, 2024, issued for SL37076015-1, tag identification 0495. During the survey, the licensee took action to mitigate the immediate risk. However, noncompliance remained, and the scope and level remain 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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37076	A. BUILDING: _____ B. WING _____	R 12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(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}	Continued From page 1 An immediate correction order was identified on December 10, 2024, issued for SL37076015-1, tag identification 1750. During the survey, the licensee took action to mitigate the immediate risk. However, noncompliance remained, and the scope and level remain unchanged.	{0 000}		
{0 250} SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or staff of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or staff; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman	{0 250}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37076	A. BUILDING: _____ B. WING _____	R 12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(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
{0 250}	Continued From page 2 access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by:	{0 250}	Not reviewed during this survey.	
{0 480} SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626.	{0 480}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37076	A. BUILDING: _____ B. WING _____	R 12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(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
{0 480}	Continued From page 3 (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant	{0 480}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37076	A. BUILDING: _____ B. WING _____	R 12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(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
{0 480}	Continued From page 4 lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by:	{0 480}	Not reviewed during this survey.	
0 495 SS=I	144G.41 Subdivision. 1 (13) Minimum Requirements (13) provide staff access to an on-call registered nurse 24 hours per day, seven days per week. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure staff were able to contact a registered nurse (RN) twenty-four (24) hours per day, seven (7) days per week. This affected all residents and staff. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	0 495	During the survey, the licensee took action to mitigate the immediate risk. However, noncompliance remained, and the scope and level remain unchanged.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37076	A. BUILDING: _____ B. WING _____	R 12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(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
0 495	Continued From page 5 R1 R1 was admitted to the facility on August 18, 2023, and began receiving assisted living services. R1's Service Plan (Waiver) - Addendum to Contract dated September 11, 2024, indicated R1 received assistance with ambulation, bathing, dressing, grooming, housekeeping, incontinence care, behavior management, medication administration, oxygen delivery, vital sign recording, safety check, socialization, and transfers. R2 R2 admitted to the facility for services on May 21, 2024, and began receiving assisted living services. R2's Service Plan (Waiver) - Addendum to Contract dated September 11, 2024, indicated R2 received assistance with deep room cleaning, housekeeping, laundry, linen exchange, behavior management, meal reminder, medication administration, garbage removal, safety check, shopping assistance, socialization, and transportation assistance. R3 R3 admitted to the licensee for services on May 23, 2024, and began receiving assisted living services. R3's Service Plan (Waiver) - Addendum to Contract dated September 11, 2024, indicated R3 received assistance with activities, bedmaking, deep room cleaning, housekeeping, laundry, linen exchange, behavior management, meal reminder, medication administration, garbage removal, safety check, shopping assistance, and	0 495		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37076	A. BUILDING: _____ B. WING _____	R 12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(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
0 495	Continued From page 6 transportation assistance. On December 9, 2024, at 7:14 a.m., the surveyor observed the three-level home (facility). On the main floor was a common area with a computer and computer desk, a combined dining and kitchen area, a bathroom, stairs leading upstairs, and stairs leading downstairs. On the wall in the dining area were several postings, one of which was a document titled Staff Scheduling. The document indicated clinical nurse supervisor (CNS)-C was the registered nurse and included a telephone number for CNS-C. On December 9, 2024, at 7:21 a.m., unlicensed personnel (ULP)-N stated they were direct support staff and were hired two weeks ago. ULP-N stated they provided cares and administered medications to residents. The surveyor requested ULP-N contact the registered nurse (RN). The surveyor observed ULP-N looking around the main-level of the three-level facility, attempting to locate the telephone number for the RN. ULP-N stated they did not know where the telephone number was posted. The surveyor then observed ULP-N looking at a cellular phone. ULP-N stated they did not have the RN's phone number in their cellular phone. On December 9, 2024, at 7:27 a.m., the surveyor observed ULP-N go back to the bulletin board in the dining area to observe the document titled Staffing Schedule. ULP-N stated the phone number for CNS-C was posted. ULP-N called the telephone number posted. ULP-N stated the person who answered the phone stated they no longer worked for [licensee]. On December 9, 2024, at 7:35 a.m., ULP-N stated they were going to decline to answer	0 495		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37076	A. BUILDING: _____ B. WING _____	R 12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(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
0 495	Continued From page 7 further questions. On December 9, 2024, at 7:48 a.m., the surveyor called the telephone number for CNS-C from the document titled Staffing Schedule. The person acknowledged they were the CNS (CNS-C) from the previous survey and stated they no longer worked for [licensee] and had not worked for them for approximately two to three months. On December 9, 2024, at 8:35 a.m., owner/agent (O/A)-A stated the CNS was available for staff to contact 24 hours per day, seven days per week. O/A-A stated staff were trained to call the CNS if problems arose with residents. After the surveyor inquired where the current CNS' phone number was posted, the surveyor observed O/A-A looking through the main level of the three-level facility for the contact information. Without providing a response to the surveyor, O/A-A then walked into the kitchen and began to clean. The surveyor again inquired to O/A-A about the contact phone number for the CNS and where it was posted. The surveyor observed O/A-A make a phone call. The context of the call was not understood by the surveyor as O/A-A was speaking in a non-English language to the person on the other end of the call. After ending the call, O/A-A stated they did not know where the contact information was for the current CNS. O/A-A stated it had been written on a small piece of paperwork, and it might have fallen off the bulletin board. On December 9, 2024, at 8:45 a.m., the surveyor observed O/A-A again looking around the main-level of the facility. O/A-A showed the surveyor the document titled Staffing Schedule which contained the telephone number for CNS-C. The surveyor observed the same document was also posted in the common area	0 495		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37076	A. BUILDING: _____ B. WING _____	R 12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(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
0 495	Continued From page 8 near the front window, also with CNS-C's contact information. On December 9, 2024, at 8:46 a.m., O/A-A stated ULP-N was confused about how to contact the RN. O/A-A stated ULP-N would contact house manager (HM)-E if a situation required attention. O/A-A then provided the surveyor with a telephone number for CNS-J. On December 9, 2024, at 9:18 a.m., CNS-J stated they were the CNS for the licensee and were responsible for the training for staff, including ULPs. CNS-J stated ULPs were trained to call the registered nurse (RN) if residents had a change of condition, or had questions related to medication administration. CNS-J stated their telephone contact information was required to be posted for staff to be able to call the RN if needed. CNS-J stated they were unsure why their contact phone number was not displayed in the facility. CNS-J stated the licensee may have forgotten to change the telephone number that was displayed. On December 9, 2024, at 11:15 a.m., the surveyor requested to house manager (HM)-E for the licensee's policy on how staff should contact the RN, the responsibility of the RN, and the RN's availability. On December 9, 2024, at 11:18 a.m., HM-E stated they were obtaining new policies from a consultant company which would be customized to [licensee]. On December 9, 2024, at 11:27 a.m., licensed assisted living director (LALD)-D stated all staff members had the contact telephone number for the CNS and there was a group chat where	0 495		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37076	A. BUILDING: _____ B. WING _____	R 12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(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
0 495	Continued From page 9 multiple people were included in all the messages. LALD-D stated they were aware of the requirement to post the current CNS' telephone number for staff members to access it. LALD-D stated the situation should not have occurred and was human error. On December 9, 2024, at 11:51 a.m., the surveyor again inquired to HM-E for the licensee's policy on how staff should contact the RN, the responsibility of the RN, and the RN's availability. On December 9, 2024, at 12:41 p.m., O/A-A stated they were still looking for the policies. On December 0, 2024, at 12:51 p.m., HM-E provided a document titled Contacting the Nurse at [licensee]. The licensee's undated Contacting the Nurse at [licensee] policy indicated CNS-J's telephone number, and indicated staff should contact the RN for the following situations: health emergencies, medication issues, health monitoring, routine updates, and consultation. Minnesota Statute 144G.62, subdivision 1, (a) , dated 2024, indicated all assisted living facilities must have a registered nurse available for consultation by staff performing delegated nursing tasks and must have an appropriate licensed health professional available if performing other delegated services such as therapies. Minnesota Statute 144G.62, subdivision 1, (b) , dated 2024, indicated the appropriate contact person must be readily available either in person, by telephone, or by other means to the staff at times when the staff is providing services.	0 495		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37076	A. BUILDING: _____ B. WING _____	R 12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(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
0 495	Continued From page 10 No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	0 495		
{0 660} SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) 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 establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included baseline screening for one of three employees (unlicensed personnel (ULP)-N). 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	{0 660}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37076	A. BUILDING: _____ B. WING _____	R 12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(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
{0 660}	Continued From page 11 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). Licensee's undated Employee List indicated ULP-N was hired November 22, 2024. On December 9, 2024, at 7:21 a.m., the surveyor observed ULP-N working alone in the facility. ULP-N stated they were direct support staff and were hired two weeks ago. ULP-N stated they provided cares and administered medications to residents. ULP-N departed the facility at approximately 7:45 a.m. ULP-N's employee record included a one-step Tuberculin Skin Test Report dated November 25, 2024, and indicated ULP-B was negative for TB. ULP-N's employee record lacked a completed baseline screening for TB to evaluatate for TB symptoms and TB risk history. The baseline screening was required to be completed before ULP-N began work. On December 11, 2024, at 7:56 a.m., clinical nurse supervisor (CNS)-J stated the TB screening should have been completed for ULP-N. CNS-J stated they had not met with ULP-N since their date of hire and ULP-N should not have been providing direct care services to residents without the TB screening being completed. On December 11, 2024, at 8:23 a.m., licensed assisted living director (LALD)-D stated the CNS was responsible for completing the TB	{0 660}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37076	A. BUILDING: _____ B. WING _____	R 12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(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
{0 660}	Continued From page 12 screenings for all employees. LALD-D stated ULP-N should not be providing direct care services without completing the TB screening. The licensee's undated, 4.05 Employee Records policy indicated the licensee would keep a copy of TB screenings within the employee record. The licensee's undated 8.16 Tuberculosis Screening policy indicated staff will receive a TB screening upon hire. The Minnesota Department of Health Tuberculosis Prevention and Control Program dated July 2013 recommended a TB screening was required for all healthcare workers, which consisted of assessment for current symptoms of active TB disease, assessing TB history, testing for the presence of infection Mycobacterium tuberculosis by administered either a two-step tuberculosis skin test (TST), or single interferon gamma release assay (a blood test to determine if a person has been infected with TB). The document noted, if TB symptoms are present, promptly refer the employee for a chest X-ray and medical evaluation before starting work. Do not wait for the TST or TB blood test result. The CDC Clinical Testing Guidance for Tuberculosis: Health Care Personnel dated December 15, 2023, recommended all United States health care personnel should be screened for TB upon hire. No further information was provided.	{0 660}		
{0 780} SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment	{0 780}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37076	A. BUILDING: _____ B. WING _____	R 12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(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
{0 780}	Continued From page 13 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:	{0 780}	Not reviewed during this survey.	
{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	{0 790}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37076	A. BUILDING: _____ B. WING _____	R 12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(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
{0 790}	Continued From page 14 maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by:	{0 790}	Not reviewed during this survey.	
{0 800} SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by:	{0 800}	Not reviewed during this survey.	
{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) staff 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,	{0 810}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37076	A. BUILDING: _____ B. WING _____	R 12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(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
{0 810}	Continued From page 15 evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff 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 staff 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}	Not reviewed during this survey.	
0 820 SS=F	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the	0 820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37076	A. BUILDING: _____ B. WING _____	R 12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 820	Continued From page 16 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 safe smoking practices at the facility. This had the potential to affect some residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On December 9, 2024, at 10:15 a.m. the surveyor conducted a follow-up with owner/agent (O/A)-A for orders issued pursuant to a survey completed on September 9, 2024. The surveyor asked O/A-A where the facility's designated smoking area was. O/A-A indicated that smoking was taking place on the front porch of the facility. The surveyor observed several large piles of smoking materials discarded in the landscaping in the front of the facility. The surveyor also observed smoking materials randomly scattered throughout the ground on the outside of the facility.	0 820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37076	A. BUILDING: _____ B. WING _____	R 12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 820	Continued From page 17 The facility lacked noncombustible an ash tray in the designated smoking area. The surveyor asked O/A-A if there was a noncombustible ash tray located anywhere at the facility for purposes of disposing of smoking materials. O/A-A stated that they had purchased an ash tray, and it was supposed to be located on the porch in front of the facility. O/A-A stated they believed that one of the residents had dumped out the ash tray and had taken it from the front porch. No further information was provided.	0 820		
{01370} SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders;	{01370}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37076	A. BUILDING: _____ B. WING _____	R 12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(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
{01370}	Continued From page 18 (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency evaluations were completed for all required skill areas prior to providing services for one of three employees (unlicensed personnel (ULP-N). 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: Licensee's undated Employee List indicated ULP-N was hired November 22, 2024.	{01370}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37076	A. BUILDING: _____ B. WING _____	R 12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(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
{01370}	Continued From page 19 On December 9, 2024, at 7:21 a.m., the surveyor observed ULP-N working alone in the facility. ULP-N stated they were direct support staff and were hired two weeks ago. ULP-N stated they provided cares and administered medications to residents. ULP-N departed the facility at approximately 7:45 a.m. ULP-N's training record consisted of the following certificates of completion done via Educare (online training program): - .75 credit hour of Aging Process completed on November 23, 2024; - .75 credit hour of Assisted Living Bill of Rights-MN completed on November 23, 2024; - 1.0 credit hour of Activities for Older Adults completed on November 23, 2024; - 1.0 credit hour of Customer Service training completed November 24, 2024; - .75 credit hour of Client Mobility- Range of Motion training completed November 24, 2024; - .50 credit hour of Client Mobility- Positioning training completed November 24, 2024; - .50 credit hour of Dementia- Problem Solving-Anger and Aggression training completed November 24, 2024; - .75 credit hour of Dementia- Person Centered Care training completed November 24, 2024; - .75 credit hour of Fall Prevention training November 25, 2024; - .75 credit hour Emergency Preparedness-Human Hazards- MN AL training November 25, 2024; - .75 credit hour Emergency Preparedness-Overview- MN AL training November 25, 2024; - .75 credit hour Dementia 5- The Journey training completed November 25, 2024; - 1.0 credit hour Dementia 1- Introduction and Overview training completed November 25, 2024;	{01370}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37076	A. BUILDING: _____ B. WING _____	R 12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(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
{01370}	Continued From page 20 - 1.25 credit hour Guide to Assisted Living- MN training completed November 25, 2024; - .75 credit hour Medication and Treatment- CPAP training completed November 25, 2024; - .75 credit hour Medication and Treatment- Feeding Tubes training completed November 25, 2024; - .50 credit hour Medication and Treatment- Nebulizer and Inhalers training completed November 25, 2024; - .75 credit hour Medication and Treatment- O2 SATS training completed November 25, 2024; - .75 credit hour Medication and Treatment- Insulin Administration training completed November 25, 2024; - .50 credit hour Medication and Treatment- Insulin Pen training completed November 25, 2024; - .50 credit hour of Client Mobility Exercise and Ambulation completed on December 8, 2024; - 1.25 credit hour of Medication Administration Overview completed on December 8, 2024; - .50 credit hour of Medication Administration- Blood Glucose Testing completed on December 8, 2024; - 1.5 credit hour of Medication Administration- Routes completed on December 8, 2024; - .75 credit hour of Medication Administration- Catheter Cares completed on December 8, 2024; and - 1.25 credit hour Dementia Management and Abuse Prevention training completed December 8, 2024. ULP-N's employee record lacked the following: Training: - documentation requirements for all services provided; - reports of changes in the resident's condition to the supervisor designated by the assisted living	{01370}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37076	A. BUILDING: _____ B. WING _____	R 12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(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
{01370}	Continued From page 21 provider; - maintenance of a clean and safe environment; - training on the prevention of falls for providers working with the elderly or individuals at risk of falls; - medication, exercise, and treatment reminders; - basic nutrition, meal preparation, food safety, and assistance with eating; - preparation of modified diets as ordered by a licensed health professional; - communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; - awareness of confidentiality and privacy; - understanding appropriate boundaries between staff and residents and the resident's family; - procedures to utilize in handling various emergency situations, and; - awareness of commonly used health technology equipment and assistive devices. Competencies: - appropriate and safe techniques in personal hygiene and grooming, including: - hair care and bathing; - care of teeth, gums, and oral prosthetic devices; - care and use of hearing aids; - dressing and assisting with toileting; and - standby assistance techniques and how to perform them. On December 10, 2024, at 10:59 a.m., the surveyor attempted to call ULP-N at the phone number provided by the licensee. The number dialed indicated the call could not be completed as dialed. The surveyor confirmed the phone number with house manager (HM)-E and requested an email address to attempt to reach ULP-N.	{01370}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37076	A. BUILDING: _____ B. WING _____	R 12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(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
{01370}	Continued From page 22 On December 10, 2024, at 11:18 a.m., HM-E stated job responsibilities for ULP entailed providing resident cares such as offering assistance with activities of daily living, medication administration, socialization, mental health support, facility cleaning, assistance with making meals, etc. HM-E stated the normal hiring process for new employees was to have the employee complete a background study and TB testing. After those items were done, the new employee shadowed with other ULP who worked at the facility. HM-E stated new employees normally shadowed anywhere from two to five shifts before they worked on their own. Following shadowing, HM-E stated employees were supposed to complete all of their on-line trainings and have a competency check with the RN, which HM-E normally scheduled. HM-E stated regarding ULP-N, they were not aware of what ULP-N's background prior to working for the assisted living facility was. HM-E stated applicants should put that information on their job application, but ULP-N had not. HM-E stated they requested for ULP-N to add that information to their application, but they had not done so yet. HM-E stated they believed ULP-N had three days of shadowing before being assigned the resident care tasks. On December 10, 2024, at 11:20 a.m., when the surveyor inquired when clinical nurse supervisor (CNS)-J planned to have ULP-N demonstrate competency on their trainings. CNS-J looked to HM-E and licensed assisted living director (LALD)-D and asked who the surveyor was talking about. Both HM-E and LALD-D stated the surveyor was referring to the newest employee, ULP-N. CNS-J stated, "they usually tell me; it hasn't been scheduled yet".	{01370}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37076	A. BUILDING: _____ B. WING _____	R 12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(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
{01370}	Continued From page 23 On December 10, 2024, HM-E stated, they had not scheduled ULP-N's competency testing with the RN and verified ULP-N had been passing medications and documenting on the MARs for residents without prior demonstration of competency. HM-E stated they thought it was acceptable as ULP-N worked with other staff who were "supervising". The surveyor inquired who the other staff were, and HM-E stated other ULPs. The licensee's undated, 5.02 Competency Training evaluations policy indicated a registered nurse would ensure staff were competent at performing each tasks or procedures. The licensee's undated, 5.10 Training Records indicated the licensee would maintain a record of staffing training and required competencies. No further information was provided.	{01370}		
{01380} SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation;	{01380}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37076	A. BUILDING: _____ B. WING _____	R 12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(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
{01380}	Continued From page 24 (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency evaluations were completed for all required skill areas prior to providing services for one of three employees (unlicensed personnel (ULP-N). 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: Licensee's undated Employee List indicated ULP-N was hired November 22, 2024. On December 9, 2024, at 7:21 a.m., the surveyor observed ULP-N working alone in the facility. ULP-N stated they were direct support staff and were hired two weeks ago. ULP-N stated they provided cares and administered medications to residents. ULP-N departed the facility at approximately 7:45 a.m. ULP-N's training record consisted of the following certificates of completion done via Educare (online training program): - .75 credit hour of Aging Process completed on	{01380}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37076	A. BUILDING: _____ B. WING _____	R 12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(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
{01380}	Continued From page 25 November 23, 2024; - .75 credit hour of Assisted Living Bill of Rights-MN completed on November 23, 2024; - 1.0 credit hour of Activities for Older Adults completed on November 23, 2024; - 1.0 credit hour of Customer Service training completed November 24, 2024; - .75 credit hour of Client Mobility- Range of Motion training completed November 24, 2024; - .50 credit hour of Client Mobility- Positioning training completed November 24, 2024; - .50 credit hour of Dementia- Problem Solving-Anger and Aggression training completed November 24, 2024; - .75 credit hour of Dementia- Person Centered Care training completed November 24, 2024; - .75 credit hour of Fall Prevention training November 25, 2024; - .75 credit hour Emergency Preparedness-Human Hazards- MN AL training November 25, 2024; - .75 credit hour Emergency Preparedness-Overview- MN AL training November 25, 2024; - .75 credit hour Dementia 5- The Journey training completed November 25, 2024; - 1.0 credit hour Dementia 1- Introduction and Overview training completed November 25, 2024; - 1.25 credit hour Guide to Assisted Living- MN training completed November 25, 2024; - .75 credit hour Medication and Treatment-CPAP training completed November 25, 2024; - .75 credit hour Medication and Treatment-Feeding Tubes training completed November 25, 2024; - .50 credit hour Medication and Treatment-Nebulizer and Inhalers training completed November 25, 2024; - .75 credit hour Medication and Treatment- O2 SATS training completed November 25, 2024; - .75 credit hour Medication and Treatment-	{01380}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37076	A. BUILDING: _____ B. WING _____	R 12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(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
{01380}	Continued From page 26 Insulin Administration training completed November 25, 2024; - .50 credit hour Medication and Treatment-Insulin Pen training completed November 25, 2024; - .50 credit hour of Client Mobility Exercise and Ambulation completed on December 8, 2024; - 1.25 credit hour of Medication Administration Overview completed on December 8, 2024; - .50 credit hour of Medication Administration-Blood Glucose Testing completed on December 8, 2024; - 1.5 credit hour of Medication Administration-Routes completed on December 8, 2024; - .75 credit hour of Medication Administration-Catheter Cares completed on December 8, 2024; and - 1.25 credit hour Dementia Management and Abuse Prevention training completed December 8, 2024. ULP-N's employee record lacked the following: Training: - observation, reporting, and documenting of resident status; - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel. Competencies: - reading and recording temperature, pulse, and respirations of the resident; - safe transfer techniques and ambulation; - range of motioning and positioning, and; - administering medications or treatments as required. On December 10, 2024, at 10:59 a.m., the surveyor attempted to call ULP-N at the phone number provided by the licensee. The number	{01380}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37076	A. BUILDING: _____ B. WING _____	R 12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(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
{01380}	Continued From page 27 dialed indicated the call could not be completed as dialed. The surveyor confirmed the phone number with house manager (HM)-E and requested an email address to attempt to reach ULP-N. On December 10, 2024, at 11:18 a.m., HM-E stated job responsibilities for ULP entailed providing resident cares such as offering assistance with activities of daily living, medication administration, socialization, mental health support, facility cleaning, assistance with making meals, etc. HM-E stated the normal hiring process for new employees was to have the employee complete a background study and TB testing. After those items were done, the new employee shadowed with other ULP who worked at the facility. HM-E stated new employees normally shadowed anywhere from two to five shifts before they worked on their own. Following shadowing, HM-E stated employees were supposed to complete all of their on-line trainings and have a competency check with the RN, which HM-E normally scheduled. HM-E stated regarding ULP-N, they were not aware of what ULP-N's background prior to working for the assisted living facility was. HM-E stated applicants should put that information on their job application, but ULP-N had not. HM-E stated they requested for ULP-N to add that information to their application, but they had not done so yet. HM-E stated they believed ULP-N had three days of shadowing before being assigned the resident care tasks. On December 10, 2024, at 11:20 a.m., when the surveyor inquired when clinical nurse supervisor (CNS)-J planned to have ULP-N demonstrate competency on their trainings. CNS-J looked to HM-E and licensed assisted living director (LALD)-D and asked who the surveyor was	{01380}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37076	A. BUILDING: _____ B. WING _____	R 12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(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
{01380}	Continued From page 28 talking about. Both HM-E and LALD-D stated the surveyor was referring to the newest employee, ULP-N. CNS-J stated, "they usually tell me; it hasn't been scheduled yet". On December 10, 2024, HM-E stated, they had not scheduled ULP-N's competency testing with the RN and verified ULP-N had been passing medications and documenting on the MARs for residents without prior demonstration of competency. HM-E stated they thought it was acceptable as ULP-N worked with other staff who were "supervising". The surveyor inquired who the other staff were, and HM-E stated other ULPs. The licensee's undated, 5.02 Competency Training evaluations policy indicated a registered nurse would ensure staff were competent at performing each tasks or procedures. The licensee's undated, 5.10 Training Records indicated the licensee would maintain a record of staffing training and required competencies. No further information was provided.	{01380}		
01750 SS=G	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	01750		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37076	A. BUILDING: _____ B. WING _____	R 12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(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
01750	Continued From page 29 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 prior to delegating the task of medication administration, the registered nurse (RN) trained in the proper methods to perform the task or procedure for each resident and verified the ULP was able to demonstrate the ability to competently follow the procedure for one of three employees (unlicensed personnel (ULP)-N). This resulted in an immediate correction order on December 10, 2024. 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 December 9, 2024, at 7:21 a.m., the surveyor observed ULP-N working alone in the facility. ULP-N stated they were direct support staff and were hired two weeks ago. ULP-N stated they provided cares and administered medications to residents. ULP-N departed the facility at approximately 7:45 a.m. Licensee's undated Employee List indicated ULP-N was hired November 22, 2024.	01750	During the survey, the licensee took action to mitigate the immediate risk. However, noncompliance remained, and the scope and level remain unchanged.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37076	A. BUILDING: _____ B. WING _____	R 12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(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
01750	Continued From page 30 ULP-N's training record consisted of the following certificates of completion done via Educare (online training program): - .75 credit hour of Aging Process completed on November 23, 2024; - .75 credit hour of Assisted Living Bill of Rights-MN completed on November 23, 2024; - 1.0 credit hour of Activities for Older Adults completed on November 23, 2024; - 1.0 credit hour of Customer Service training completed November 24, 2024; - .75 credit hour of Client Mobility- Range of Motion training completed November 24, 2024; - .50 credit hour of Client Mobility- Positioning training completed November 24, 2024; - .50 credit hour of Dementia- Problem Solving-Anger and Aggression training completed November 24, 2024; - .75 credit hour of Dementia- Person Centered Care training completed November 24, 2024; - .75 credit hour of Fall Prevention training November 25, 2024; - .75 credit hour Emergency Preparedness-Human Hazards- MN AL training November 25, 2024; - .75 credit hour Emergency Preparedness-Overview- MN AL training November 25, 2024; - .75 credit hour Dementia 5- The Journey training completed November 25, 2024; - 1.0 credit hour Dementia 1- Introduction and Overview training completed November 25, 2024; - 1.25 credit hour Guide to Assisted Living- MN training completed November 25, 2024; - .75 credit hour Medication and Treatment-CPAP training completed November 25, 2024; - .75 credit hour Medication and Treatment-Feeding Tubes training completed November 25,	01750		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37076	A. BUILDING: _____ B. WING _____	R 12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(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
01750	Continued From page 31 2024; - .50 credit hour Medication and Treatment-Nebulizer and Inhalers training completed November 25, 2024; - .75 credit hour Medication and Treatment- O2 SATS training completed November 25, 2024; - .75 credit hour Medication and Treatment-Insulin Administration training completed November 25, 2024; - .50 credit hour Medication and Treatment-Insulin Pen training completed November 25, 2024; - .50 credit hour of Client Mobility Exercise and Ambulation completed on December 8, 2024; - 1.25 credit hour of Medication Administration Overview completed on December 8, 2024; - .50 credit hour of Medication Administration-Blood Glucose Testing completed on December 8, 2024; - 1.5 credit hour of Medication Administration-Routes completed on December 8, 2024; - .75 credit hour of Medication Administration-Catheter Cares completed on December 8, 2024; and - 1.25 credit hour Dementia Management and Abuse Prevention training completed December 8, 2024. ULP-N's training record lacked evidence of any return demonstration or competency testing by the RN. R1 R1's Service Plan (Waiver) - Addendum to Contract dated September 11, 2024, indicated R1 received assistance with ambulation, bathing, dressing, grooming, housekeeping, incontinence care, behavior management, medication administration, oxygen delivery, vital sign	01750		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37076	A. BUILDING: _____ B. WING _____	R 12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(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
01750	Continued From page 32 recording, safety check, socialization, and transfers. R1's December 2024 Medication Administration Record (MAR) indicated ULP-N administered medications to R1 on December 1, 7, and 8, 2024. R2 R2's Service Plan (Waiver) - Addendum to Contract dated September 11, 2024, indicated R2 received assistance with deep room cleaning, housekeeping, laundry, linen exchange, behavior management, meal reminder, medication administration, garbage removal, safety check, shopping assistance, socialization, and transportation assistance. R2's December 2024 MAR indicated ULP-N administered medications to R2 on December 1, 7, and 8, 2024. R3 R3's Service Plan (Waiver) - Addendum to Contract dated September 11, 2024, indicated R3 received assistance with activities, bedmaking, deep room cleaning, housekeeping, laundry, linen exchange, behavior management, meal reminder, medication administration, garbage removal, safety check, shopping assistance, and transportation assistance. R3's December 2024 MAR indicated ULP-N administered medications to R3 on December 1, 7, and 8, 2024. On December 10, 2024, at 10:59 a.m., the surveyor attempted to call ULP-N at the phone number provided by the licensee. The number dialed indicated the call could not be completed	01750		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37076	A. BUILDING: _____ B. WING _____	R 12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(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
01750	Continued From page 33 as dialed. The surveyor confirmed the phone number with house manager (HM)-E and requested an email address to attempt to reach ULP-N. On December 10, 2024, at 11:18 a.m., HM-E stated job responsibilities for ULP entailed providing resident cares such as offering assistance with activities of daily living, medication administration, socialization, mental health support, facility cleaning, assistance with making meals, etc. HM-E stated the normal hiring process for new employees was to have the employee complete a background study and TB testing. After those items were done, the new employee shadowed with other ULP who worked at the facility. HM-E stated new employees normally shadowed anywhere from two to five shifts before they worked on their own. Following shadowing, HM-E stated employees were supposed to complete all of their on-line trainings and have a competency check with the RN, which HM-E normally scheduled. HM-E stated regarding ULP-N, they were not aware of what ULP-N's background prior to working for the assisted living facility was. HM-E stated applicants should put that information on their job application, but ULP-N had not. HM-E stated they requested for ULP-N to add that information to their application, but they had not done so yet. HM-E stated they believed ULP-N had three days of shadowing before being assigned the resident care tasks. On December 10, 2024, at 11:20 a.m., when the surveyor inquired when clinical nurse supervisor (CNS)-J planned to have ULP-N demonstrate competency on their trainings. CNS-J looked to HM-E and licensed assisted living director (LALD)-D and asked who the surveyor was talking about. Both HM-E and LALD-D stated the	01750		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37076	A. BUILDING: _____ B. WING _____	R 12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(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
01750	Continued From page 34 surveyor was referring to the newest employee, ULP-N. CNS-J stated, "they usually tell me; it hasn't been scheduled yet". On December 10, 2024, HM-E stated, they had not scheduled ULP-N's competency testing with the RN and verified ULP-N had been passing medications and documenting on the MARs for residents without prior demonstration of competency. HM-E stated they thought it was acceptable as ULP-N worked with other staff who were "supervising". The surveyor inquired who the other staff were, and HM-E stated other ULPs. The licensee's Staff Orientation and Education policy dated January 7, 2022, indicated upon hire and before providing services to residents, all employees attend a general orientation conducted by the licensee. Additionally, the policy indicated those providing direct services will complete a competency evaluation as part of their orientation process. The policy further indicated no one may provide direct care to residents on behalf of the licensee without completing the organization's orientation program. TIME PERIOD FOR CORRECTION: Immediate	01750		
{01820} SS=E	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:	{01820}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37076	A. BUILDING: _____ B. WING _____	R 12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(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
{01820}	Continued From page 35 Based on observation, interview, and record review, the licensee failed to maintain current medication orders for two of three residents (R2, 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, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R2 R2 admitted to the facility on May 21, 2024, and began receiving assisted living services. R2's Service Plan (Waiver) - Addendum to Contract dated September 11, 2024, indicated R2 received assistance with deep room cleaning, housekeeping, laundry, linen exchange, behavior management, meal reminder, medication administration, garbage removal, safety check, shopping assistance, socialization, and transportation assistance. R2's medication administration record (MAR) dated December 1, 2024, through December 10, 2024, indicated R2 received the following medications: clozapine 100 milligram (mg), docusate sodium 100 mg, metformin hydrochloride 500 mg, polyethylene glycol 17 mg as needed, and clozapine 350 mg at bedtime. The licensee lacked signed provider orders for	{01820}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37076	A. BUILDING: _____ B. WING _____	R 12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(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
{01820}	Continued From page 36 the following medications: - docusate sodium 100 mg. R3 R3 admitted to the licensee on May 23, 2024, and began receiving assisted living services. R3's Service Plan (Waiver) - Addendum to Contract dated September 11, 2024, indicated R3 received assistance with medication administration. R3's MAR dated December 1, 2024 through December 9, 2024 indicated R3 received the following medications: polyethylene glycol powder, 17 grams (gm) as needed, olanzapine 20 mg 1 tablet at bedtime, bisacodyl rectal suppository once daily, hydroxyzine pamoate 25 mg 1 capsule three times as needed, magnesium drink contents of the bottle, nicotine chew 1 piece as needed, olanzapine 5 mg 1 tablet three times daily as needed, and polyethylene glycol 17 grams mixed with water as needed. The licensee lacked signed provider orders for the following medications: - bisacodyl rectal suppository once daily; - hydroxyzine pamoate 25 mg 1 capsule three times as needed; - magnesium drink contents of the bottle; - nicotine chew 1 piece as needed; - olanzapine 5 mg 1 tablet three times daily as needed; and - polyethylene glycol 17 grams mixed with water as needed On December 11, 2024, at 8:00 a.m., clinical nurse supervisor (CNS)-J stated they periodically check the prescriber orders against resident MARs but was not able to define the timeframe	{01820}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37076	A. BUILDING: _____ B. WING _____	R 12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(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
{01820}	Continued From page 37 for periodically. CNS-J stated the medication orders should be signed by the prescriber. On December 11, 2024, 8:30 a.m., licensed assisted living director (LALD)-D stated the CNS was responsible for ensuring there were signed medical prescriber orders for medications and the medical prescriber orders reflected resident MARs. LALD-D stated they thought it was an error for having that documentation in the resident file. On December 12, 2024, at 8:59 a.m., CNS-J stated they were unsure why the prescriber orders were not in the resident files and was aware those prescriber orders were required to be available. The licensee's undated, 7.12 Medications - Prescribed, Not Prescribed & OTC (over the counter) policy indicated [licensee] will determine whether the facility shall require a prescription for all medications the provider manages. No further information was provided.	{01820}		
{01890} SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	{01890}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37076	A. BUILDING: _____ B. WING _____	R 12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(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
{01890}	Continued From page 38 review, the licensee failed to discard expired medication for one of three residents (R1). The licensee also failed to store medications correctly for one of three residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: EXPIRED MEDICATIONS R1 was admitted to the facility on August 18, 2023, and began receiving assisted living services. R1's Service Plan (Waiver) - Addendum to Contract dated September 11, 2024, indicated R1 received assistance with medication administration. On December 10, 2024, at 1:36 p.m., the surveyor observed two plastic containers with R1's identifiers. In one plastic container was an expired epinephrine autoinjector (a method that injects medications directly into the person) expired October 2023. In the other plastic container were the following expired medications: - one box of individual albuterol nebulizer 0.5 percent (%) solution expired October 2024, five medication cards containing loperamide 2 milligram (mg) expired October 2024, three medication cards containing acetaminophen 325	{01890}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37076	A. BUILDING: _____ B. WING _____	R 12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(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
{01890}	Continued From page 39 mg expired March 30, 2024, and one medication card gabapentin 600 mg expired November 2024. On December 11, 2024, at 8:14 a.m., clinical nurse supervisor (CNS)-J stated they perform an audit to check for expired medications weekly. CNS-J stated when medications expired, they were required to complete a medication disposition and dispose of the medications. CNS-J stated they did not document the audit that was performed. CNS-J stated the expired medications should not be stored with current unexpired medications. CNS-J stated that was a mistake. The licensee's undated, 7.23 Medication Disposal policy indicated the licensee would dispose of expired medications according to the accepted practices of the Minnesota board of Pharmacy. MEDICATIONS NOT STORED CORRECTLY. On December 10, 2024, at 1:36 p.m., the surveyor observed a zip lock bag inside of a large plastic container labeled with R1's identifier. In the plastic container was several medication cards, a package of medications, and a zip lock bag with tablets. The zip lock bag had a printed pharmacy label that read, "[R1] Suboxone Sublingual (under the tongue) film 4 milligrams/1 milligram." On the same printed pharmacy label, there was a line drawn in ink pen through the identifier for R1, and a line drawn in ink pen through the words "Suboxone Sublingual." In ink pen the words, "tiazanadine 1, Buspion 5, and Ibprofen" had been handwritten onto the printed pharmacy label. In the zip lock bag contained a total of 33 and one-half tablets; 19 white rectangular tablets with the markings, "B3" which WebMD identified as buspirone 10 mg, 1 circular	{01890}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37076	A. BUILDING: _____ B. WING _____	R 12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(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
{01890}	Continued From page 40 tablet with the markings, "ZC80" which WebMD identified as lamotrigine 100 mg, and 9 and one-half tablets with the markings, "R180" which Medicine.com identified as tizanidine 4 mg. The zip lock bag was identical to the zip lock bag observed on the previous Minnesota Department of Health surveyor dated September 12, 2024, that was used to store medications for R1. On December 11, 2024, at 8:17 a.m., CNS-J stated medications for R1 should be stored in the original manufacturer's container. CNS-J stated the reason for the medications being stored in the zip lock bag was they were going to be destroyed. CNS-J stated the medications should not be stored in the zip lock bag with current medications. The licensee undated, 7.11 Medication Storage policy indicated medications will be kept securely locked and stored per manufacturer directions. The Center for Disease Control (CDC) Tips for Safe Storage and Disposal dated August 5, 2022, recommends prescription medication is stored in the original packaging with the safety lock tightened and secured. No further information was provided.	{01890}		

Electronically Delivered

October 17, 2024

Licensee
Cc Group Home Care Inc.
3633 Columbus Avenue
Minneapolis, MN 55407

RE: Project Number(s) SL37076015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on September 12, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

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

0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00
1290 - 144g.60 Subdivision 1 - Background Studies Required - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. to submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

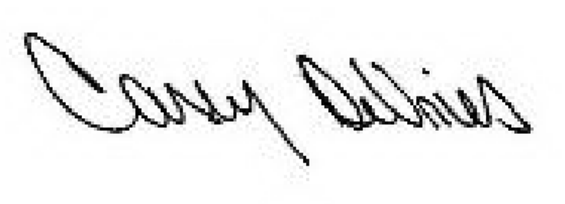
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

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
	37076	A. BUILDING: _____ B. WING _____	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL# 37076015-0 On September 9, 2024, through September 12, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were three residents; three receiving services under the Assisted Living license. 1290: An immediate order was issued on September 10, 2024, at a level 3/Isolated (G).	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.	
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a	0 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37076	A. BUILDING: _____ B. WING _____	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(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
0 250	Continued From page 1 provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter;	0 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37076	A. BUILDING: _____ B. WING _____	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(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
0 250	Continued From page 2 (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required with records reviewed. 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 is 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: During the entrance conference on September 9,	0 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37076	A. BUILDING: _____ B. WING _____	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(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
0 250	Continued From page 3 2024, at 9:43 a.m. licensed assisted living director (LALD)-D stated the licensee's employees in charge of the facility were familiar with the assisted living regulations and the licensee provided medication and treatment management services. The licensee's Application for Assisted Living License, section titled Official Verification of Owner or Authorized Agent, (page four and five of the application), identified, I certify I have read and understand the following: [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17. - I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G. - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659. - Reporting of Maltreatment of Vulnerable Adults. - Electronic Monitoring in Certain Facilities. - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will	0 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37076	A. BUILDING: _____ B. WING _____	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(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
0 250	Continued From page 4 use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license. - I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract.	0 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37076	A. BUILDING: _____ B. WING _____	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(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
0 250	Continued From page 5 - I have examined this application and all attachments and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required. - I attest to have all required policies and procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page five was electronically signed by owner/agent (O/A)-A on April 30, 2024. The licensee had an assisted living license issued on July 1, 2024, with an expiration date of June 30, 2025. The licensee failed to ensure the following policies and procedures were developed and/or implemented: - requirements in section 626.557, reporting of maltreatment of vulnerable adults; - conducting and handling background studies on employees; - orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; - infection control practices; - conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; - medication and treatment management, and; - supervision of unlicensed personnel performing	0 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37076	A. BUILDING: _____ B. WING _____	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(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
0 250	Continued From page 6 delegated tasks. On September 9, 2024, at 9:43 a.m., LALD-D stated the licensee provided assisted living services but failed to implement corresponding policies and procedures, as required. As a result of this survey, the following orders were issued: 0510, 0620, 0650, 0660, 1290, 1370, 1380, 1730, 1820, and 1890, indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. On September 9, 2024, at 9:43 a.m. and at 10:41 a.m., LALD-D stated they had been assisting with LALD coverage at this facility since May 30, 2024, while their regular LALD (LALD-B) was on leave. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250		
0 460 SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to	0 460		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37076	A. BUILDING: _____ B. WING _____	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(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
0 460	Continued From page 7 have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide a means for residents to request assistance for health and safety needs 24 hours a day, seven days a week. 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 September 9, 2024, at 10:27 a.m. during a tour of the assisted living facility (ALF), the surveyor observed a three-level home. The basement level of the ALF consisted of a common room, utility room, a bathroom and R1's bedroom. There was a call pendant located in the bathroom. There were no other call pendants or other means for residents to summon assisted in the remainder of the ALF. On September 10, 2024, at 1:58 p.m., R2 stated they did not receive a means to summon	0 460		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37076	A. BUILDING: _____ B. WING _____	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(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
0 460	Continued From page 8 assistance from the licensee when they moved in. On September 11, 2024, at 9:04 a.m., licensed assisted living director (LALD)-D stated they were aware the licensee was required to provide a means to summon staff and did not know why R2 was not given a means to summon assistance. LALD-D stated they may have forgotten to provide that to R2. The licensee's undated, 2.01 24-Hour Emergency Response policy indicated residents will have access to 24-hour emergency response by staff. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 460		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or	0 470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37076	A. BUILDING: _____ B. WING _____	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(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
0 470	Continued From page 9 safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a written staffing plan that included an evaluation completed by the clinical nurse supervisor (CNS) (as indicated in Minnesota Administrative Rule 4659.0180) at least twice a year. 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). The findings include: On June 24, 2024, at 9:43 a.m., during the entrance conference, licensed assisted living director (LALD)-D stated one unlicensed personnel (ULP) worked per shift and the shift schedule was 7:00 a.m., until 3:00 p.m., 3:00 p.m., until 11:00 p.m., and 11:00 p.m., until 7:00	0 470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37076	A. BUILDING: _____ B. WING _____	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(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
0 470	Continued From page 10 a.m. The clinical nurse supervisor (CNS) was available 24 hours per day, seven days per week. On September 24, 2024, at 10:19 a.m., during a facility tour of the three-level home, in the dining area of the main level, the surveyor observed a staffing plan dated August 1, 2021, posted on the wall. At the bottom of the document, there was a signature on the, "LALD signature" section and a date April 1, 2024. The staffing plan lacked a signature and date from a registered nurse (RN). On September 24, 2024, at 10:32 a.m., clinical nurse supervisor (CNS)-C stated they were aware the staffing plan had to be evaluated and signed by a RN, but CNS-C had only been employed by the licensee for three weeks. The licensee's undated, 4.06 Staffing & Schedule policy indicated the clinical nurse supervisor would develop and implement a staffing plan that provides an adequate number of qualified staff to meet the residents needs 24-hours a day, seven days a week. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and	0 480		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37076	A. BUILDING: _____ B. WING _____	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(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
0 480	Continued From page 11 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated September 10, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that 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	0 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37076	A. BUILDING: _____ B. WING _____	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(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
0 510	Continued From page 12 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 establish and maintain an effective infection control program to comply with accepted health care, medical, and nursing standards for infection control. This practice had the potential to affect the licensee's residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: HAND HYGIENE On September 10, 2024, at 7:45 a.m., the surveyor observed a three-level home. The main floor consisted of a common room, dining room, kitchen, and bathroom. Licensed assisted living director (LALD)-D was observed placing a pair of gloves on. LALD-D picked up a pair of shoes from the common area and moved them closer to the front door. LALD-D walked to the kitchen, removed gloves and placed them into a trash can. LALD-D did not perform hand hygiene after removing gloves.	0 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37076	A. BUILDING: _____ B. WING _____	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(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
0 510	Continued From page 13 On September 10, 2024, at 7:50 a.m., LALD-D stated all staff were required to wash their hands before placing gloves on. LALD-D further stated they were not required to wash their hands after glove removal, as hands should be washed prior to placing gloves on. On September 10, 2024, at 10:32 a.m., clinical nurse supervisor (CNS)-C stated they trained staff to wash hands for 20 seconds before gloves were placed on and 20 seconds after gloves were removed. CNS-C stated they did not train LALD-D and was unsure why LALD-D did not wash their hands after glove removal. The licensee's undated, 8.09 Hand Washing policy indicated hand hygiene should be performed before and after glove removal. SHARED MEDICAL EQUIPMENT On September 11, 2024, at 8:48 a.m., the surveyor observed R1 at the dining table. House manager (HM)-E was observed removing a blood pressure machine and pulse oximetry (a device that measured oxygen saturation levels) from a clear plastic container. Without wiping down the equipment, HM-E placed the blood pressure cuff onto R1's right forearm and recorded the reading. HM-E removed the blood pressure cuff. HM-E placed the pulse oximetry onto R1's right index finger, recorded the readings and removed the pulse oximetry device. Without wiping down the equipment, HM-E placed the blood pressure cuff and pulse oximetry device back into the plastic container. On September 11, 2024, at 8:56 a.m., HM-E stated the blood pressure machine and pulse	0 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37076	A. BUILDING: _____ B. WING _____	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(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
0 510	Continued From page 14 oximetry was used for all residents. HM-E stated they were trained to wipe down the equipment before use on residents, and was not sure if they were trained to wipe down the equipment after use on residents. On September 11, 2024, at 11:43 a.m., LALD-D stated CNS-C was absent from work today and to contact registered nurse (RN)-J for any nurse related questions. On September 11, 2024, at 12:01 p.m., RN-J stated staff were trained to wipe down vital sign equipment (blood pressure machine, pulse oximetry) immediately after use and not before. RN-J stated they were unsure why the equipment was not wiped down after it's use. The licensee's undated, 8.01 Infection Control Policy indicated the licensee's infection control program would be consistent with current guidelines form the center for Disease Control (CDC). The licensee's undated, 8.03 Cleaning Medical Equipment indicated all reusable resident care equipment is routinely cleaned, and when appropriate, disinfected, before and after reuse. The CDC Disinfection of Healthcare Equipment guidance dated November 23, 2023, indicated it was a requirement to clean equipment with appropriate disinfectant after contact with a blood or other potentially infectious materials. In addition, medical equipment surfaces should be disinfected with an environmental protection agency (EPA) registered low or intermediate level disinfectant. No further information was provided.	0 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37076	A. BUILDING: _____ B. WING _____	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(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
0 510	Continued From page 15 TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 620 SS=D	144G.42 Subd. 6 (a) / 626.557, Subd. 3 Compliance with requirements for reporting ma (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. The requirement in Minnesota Statute section 626.557, Subd. 3 is: (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above.	0 620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37076	A. BUILDING: _____ B. WING _____	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(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
0 620	Continued From page 16 (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to comply with the requirements for reporting suspected maltreatment for one of three residents (R1) but did not report it to the Minnesota Adult Abuse Reporting Center (MAARC). 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	0 620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37076	A. BUILDING: _____ B. WING _____	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(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
0 620	Continued From page 17 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 to the facility on August 18, 2023, and to receive assisted living services. R1 diagnoses included intervertebral disc degeneration, borderline personality disorder (unstable moods and behaviors), major depressive disorder, post-traumatic stress disorder, agoraphobia (fear of feeling trapped or feeling of panic), carpal tunnel (painful wrists), and fibromyalgia (generalized pain). R1 Service Plan (Waiver) - Addendum to Contract dated August 13, 2022, indicated R1 received assistance with ambulation, bathing assistance, dressing, grooming, incontinence care, behavior management, meal reminder, medication administration, vital signs, safety check socialization, and transfer assistance. R1's assessment dated August 16, 2024, indicated R1 was at risk to be abused with interventions of staff to monitor resident and report any signs of abuse to assisted living director (ALD) or registered nurse (RN). R1's progress note dated July 23, 2024, at 3:48 p.m., indicated R1 had communicated to a staff member, "[R1] told [licensee staff] that she thinks [(unlicensed personnel) ULP-M] touched her inappropriately both in the kitchen and dinner table area." R1's progress note dated July 25, 2024, at 12:45	0 620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37076	A. BUILDING: _____ B. WING _____	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(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
0 620	Continued From page 18 p.m., indicated the licensee reviewed recorded camera footage and did not show, "any foul play, inappropriate touching, or inappropriate language." The progress note indicated the licensee ended ULP-M's employment. The progress note did not include the date or times of the camera footage reviewed. On September 9, 2024, at 11:36 a.m. during resident interview, R1 stated they had reported to [licensee] ULP-M had touched their breast, and another time ULP-M had placed their arms around R1's waist. R1 stated after they reported this situation to [licensee], ULP-M was no longer employed at the assisted living facility (ALF). On September 9, 2024, at 11:59 a.m., clinical nurse supervisor (CNS)-C stated they were unaware of any recent MAARC reports. On September 10, 2024, at 1:58 p.m., case manager (CM)-I stated R1 informed them of the situation during a regular scheduled in person monthly meeting on August 9, 2024. CM-I stated R1 described the situation to them as, "groping." CM-I reported the information to [licensee] and filed the MAARC report on August 9, 2024. However, R1's record included notes of R1's report to the licensee on July 23, 2024. The licensee was required to file a MAARC report within 24 hours of receiving the complaint by R1. The licensee failed to file a MAARC report or update the case manager within the required 24-hour period. The MAARC report was filed 17 days later by the case manager, and not the licensee. On September 11, 2024, at 9:00 a.m., licensed assisted living director (LALD)-D stated a MAARC	0 620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37076	A. BUILDING: _____ B. WING _____	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(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
0 620	Continued From page 19 report was required to be completed by staff if there was suspected abuse or negligence. LALD-D stated they were unaware of the required timeframe for filing a MAARC report. LALD-D stated they believed house manager (HM)-E had filed the MAARC report and was unsure why the MAARC report had not been completed by the licensee. On September 11, 2024, at 10:20 a.m., owner/agent (O/A)-A stated staff were mandated reporters and MAARC reports should be completed, "right away." O/A-A stated they should had filed a MAARC report based on the stated situation and was unsure why the MAARC report was not filed. The licensee's undated, 2.44 Vulnerable Adult Maltreatment - Prevention and Reporting indicated all staff were mandated reporters and if there is suspected abuse or maltreatment, a report is required to be made to MAARC. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must 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;	0 650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37076	A. BUILDING: _____ B. WING _____	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(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
0 650	Continued From page 20 (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 included all required content for one of three employees (house manager (HM)-E). 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: HM-E began employment on May 1, 2021, and began to provide house manager services, direct care and services to residents. On September 10, 2024, at 7:52 a.m., the	0 650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37076	A. BUILDING: _____ B. WING _____	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(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
0 650	Continued From page 21 surveyor observed HM-E administer medications to R2. HM-E employee file lacked the following content: -annual performance reviews. On September 11, 2024, at 12:55 p.m., HM-E stated they had a performance review with the licensee in May 2024. On September 11, 2024, at 12:57 p.m., licensed assisted living director (LALD)-D stated they were aware a copy of the annual review was required to be in the employee file. LALD-D stated it was an error for the annual review not being available to the surveyor. The licensee's undated, 4.05 Employee Records policy indicated employee files would contain annual performance reviews. No other information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees,	0 660		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37076	A. BUILDING: _____ B. WING _____	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(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
0 660	Continued From page 22 contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included baseline testing and screening within the 90 days of hire for one of three employees (unlicensed personnel (ULP)-K). 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: ULP-K was hired on February 9, 2021, to provided direct cares for the residents of the facility. ULP-K's employee record included a QuantiFERON(R)-TB Gold Plus lab dated October 18, 2023, with a final result of negative. ULP-K employee record lacked a baseline TB screening tool completed within 90 days of hire.	0 660		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37076	A. BUILDING: _____ B. WING _____	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(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
0 660	Continued From page 23 On September 9, 2024, at 9:43 a.m., licensed assisted living director (LALD)-D stated they were providing coverage for the LALD who was on leave from the licensee. On September 12, 2024, at 9:04 a.m., registered nurse (RN)-J stated TB screening should be completed before employees start to provide direct cares to residents. RN-J stated they were unsure why ULP-K's employee file lacked the required TB screening. On September 12, 2024, at 9:14 a.m., LALD-D stated TB screening should be completed prior to employees providing direct care services, and was not the licensee's LALD at the time of ULP-K's hire. On September 12, 2024, at 9:20 a.m., owner/agent (O/A)-A stated the TB screening was required to be done prior to employees providing direct care services and it was an error for not completing the screening. The licensee's undated, 4.05 Employee Records policy indicated the licensee would keep a copy of TB screenings within the employee record. The licensee's undated 8.16 Tuberculosis Screening policy indicated staff will receive a TB screening upon hire. The CDC Clinical Testing Guidance for Tuberculosis: Health Care Personnel dated December 15, 2023, recommended all United States health care personnel should be screened for TB upon hire. No other information was provided.	0 660		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37076	A. BUILDING: _____ B. WING _____	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(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
0 660	Continued From page 24 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. This had the potential to affect all residents, staff, and visitors.	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37076	A. BUILDING: _____ B. WING _____	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(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
0 680	Continued From page 25 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's emergency disaster preparedness plan dated January 2024, lacked evidence of the following required content: - policies and procedures for medical documents; - policies and procedures for volunteers; - roles under a waiver declared by secretary, and; - methods for sharing information. On September 11, 2024, at 9:00 a.m., licensed assisted living director (LALD)-D stated a third-party vendor prepared the EPP for the licensee and was unsure why it was missing content. On September 11, 2024, at 10:20 a.m., owner/agent (O/A)-A stated the LALD and owner were responsible for the EPP and believed it contained all the required information. The licensee's undated, 9.01 Emergency Preparedness Plan - Appendix Z Compliance policy indicated the licensee EPP would align with Centers for Medicare and Medicaid Services State operational manual appendix Z. No other information was provided.	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37076	A. BUILDING: _____ B. WING _____	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(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
0 680	Continued From page 26 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 (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 comply with the current Minnesota Fire Code provisions. This had the potential to directly affect all residents, staff, and visitors.	0 780		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37076	A. BUILDING: _____ B. WING _____	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(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
0 780	Continued From page 27 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 a facility tour on September 9, 2024, from 12:15 p.m. to 1:45 p.m., with licensed assisted living director (LALD)-D, the surveyor made the following observations of non-compliance with current Minnesota Fire Code provisions: There was not a carbon monoxide alarm installed outside resident sleeping room 4 in the basement. Carbon monoxide alarms are required to be installed outside and within 10 feet of all resident sleeping rooms. The smoke alarms were not working when tested in resident sleeping rooms 1 and 2. The smoke alarms were not interconnected so activation of one alarm activates all alarms in resident sleeping rooms 3 and 4. The headboard of the bed was blocking half of the emergency escape and rescue opening in resident sleeping room 1. The emergency escape and rescue opening is required to be maintained free of obstructions that prevent its full and immediate use. There was an extra smoke alarm that did not work when tested inside resident sleeping room 3 and a smoke alarm in the dining room that was	0 780		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37076	A. BUILDING: _____ B. WING _____	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(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
0 780	Continued From page 28 not interconnected so activation of one alarm activates all alarms throughout the facility. Only one required smoke alarm placed in the required locations shall be installed and maintained. All existing smoke alarms that receive power from the building electrical system are required to continue to receive power from the building electrical system and be interconnected with additional required battery-operated smoke alarms. During the facility tour on September 9, 2024, at 1:45 p.m., LALD-D, verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Two (2) day.	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 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide or maintain fire extinguishers as	0 790		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37076	A. BUILDING: _____ B. WING _____	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(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
0 790	Continued From page 29 required throughout the facility. This deficient condition had the ability to affect all staff, visitors, 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 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 September 9, 2024, from 12:15 p.m. to 1:45 p.m., with licensed assisted living director (LALD)-D, it was observed that the fire extinguishers provided in the dining room and in the basement had a date of manufacture of 2022, and there was no documentation available for required annual service of the extinguishers. At least one fire extinguisher with minimum 2-A:10-B:C rating is required to be provided, mounted, maintained, and located within 75 feet of travel throughout the facility. Fire extinguishers are required to be mounted at least 4 inches off the floor and not higher than 60 inches from the floor to the top of the extinguisher. Documentation is required to demonstrate fire extinguishers have been inspected by facility personnel monthly, and annually replaced with a new extinguisher (of current year manufacture date) or serviced by a certified technician. During interview on September 9, 2024, at 1:50 p.m., LALD-D verified this deficient finding.	0 790		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37076	A. BUILDING: _____ B. WING _____	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(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
0 790	Continued From page 30 TIME PERIOD FOR CORRECTION: Two (2) days.	0 790		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 September 9, 2024, from 12:15 p.m. to 1:45 p.m., with licensed assisted living director (LALD)-D, the surveyor made the	0 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37076	A. BUILDING: _____ B. WING _____	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(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
0 800	Continued From page 31 following observations of facility hazard or disrepair: The emergency escape and rescue windows are hard to open and will not stay open without holding up in resident room 2 and 3. Several of the windows other than the emergency escape and rescue windows would not stay open without holding up in resident sleeping rooms 1, 2, and 3. Several of the windows other than the emergency escape and rescue windows were hard to open or would not open in resident sleeping rooms 1, 2, and 3. There was a missing light bulb with exposed electrical socket on the ceiling at the bottom of the stairs to the basement. Light bulbs are required to be maintained installed to prevent contact with live electrical connections in the light bulb socket. There was a missing toilet mount nut on the floor bolt of the toilet in the main floor bathroom. During the facility tour on September 9, 2024, at 1:55 p.m., LALD-D verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800		
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	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37076	A. BUILDING: _____ B. WING _____	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(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
0 810	Continued From page 32 plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop the fire safety and evacuation plan with required content, make the plan readily available, provide required training and drills. This had the potential to directly affect all residents, staff, and visitors.	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37076	A. BUILDING: _____ B. WING _____	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(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
0 810	Continued From page 33 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On September 9, 2024, at 11:30 a.m., licensed assisted living director (LALD)-D provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee provided FSEP dated August 1, 2021, failed to include the following: The location and number of resident sleeping rooms on the evacuation floor plan posted in the common areas of the facility. The evacuation floor plan was also not provided and available with the FSEP documentation. The available FSEP did not identify specific fire protection actions for residents as evident by not providing in writing in the FSEP, procedures for residents in the event of a fire or similar emergency in the building. The available FSEP included standard resident evacuation procedures, but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37076	A. BUILDING: _____ B. WING _____	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(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
0 810	Continued From page 34 of residents. The plan failed to include evacuation status and unique needs for each individual resident in a list and available for reference in the event of a fire or similar emergency. During an interview on September 9, 2024, at 11:50 a.m., LALD-D stated individual resident evacuation status and unique needs were not available and included with the FSEP. TRAINING Record review of the available documentation indicated the licensee provided general fire safety training but failed to provide training to employees based on the FSEP specific to this building upon hire and at least twice per year thereafter. Record review of the available documentation indicated the licensee failed to provided evacuation training to residents at least once per year as evident by not providing documentation the required training was completed. During an interview on September 9, 2024, at 11:55 a.m., LALD-D stated documentation was not available for required training of employees and residents. DRILLS Record review of the available documentation indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month as evident by providing documentation drills were completed every other month but not twice per year per shift. The documentation provided indicated all evacuation drills were completed on the day shift.	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37076	A. BUILDING: _____ B. WING _____	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(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
0 810	Continued From page 35 During an interview on September 9, 2024, at 12:05 p.m., LALD-D stated documentation was not available indicating drills were completed twice for each shift per year. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 820 SS=F	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide facilities that were not a distinct hazard to life. This had the potential to directly affect all residents, visitors, and staff. 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	0 820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37076	A. BUILDING: _____ B. WING _____	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 820	Continued From page 36 or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include: On a facility tour on September 9, 2024, from 12:15 p.m. to 1:45 p.m. with licensed assisted living director (LALD)-D, the following distinct hazards were observed: There was used cigarette butts discarded in a plastic combustible bucket next to the exterior wood front porch and on the ground around the front and sides of the front exterior wood porch. There were also used cigarette butts discarded on the surface of the exterior wood front porch. There was not an appropriate non-combustible dispenser provided for discarding used cigarette butts in the designated smoking area. There was a chain privacy lock on the inside of the basement exit door at the top of the stairs. Exit doors in the path of exit are required to be maintained openable from the inside in the direction of exit travel without obstructions that prevent immediate use. During the facility tour on September 9, 2024, at 1:55 p.m., LALD-D verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Two (2) days.	0 820		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility	0 970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37076	A. BUILDING: _____ B. WING _____	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(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
0 970	Continued From page 37 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 for three of three residents (R1, R2, R3). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted to the facility on August 18, 2023, and began receiving assisted living services. R1's [licensee] Assisted Living Contract dated August 18, 2023, page 12, section 1, included the following statement, "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	0 970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37076	A. BUILDING: _____ B. WING _____	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(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
0 970	Continued From page 38 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 [licensee] or its employees or agents." R2 R2 admitted to the licensee for services on May 21, 2024, and began receiving assisted living services. R2's [licensee] Assisted Living Contract dated August 18, 2023, page 12, section 1, included the following statement, "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,	0 970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37076	A. BUILDING: _____ B. WING _____	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(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
0 970	Continued From page 39 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 [licensee] or its employees or agents." R3 R3 admitted to the licensee for services on May 23, 2024, and began receiving assisted living services. R3's [licensee] Assisted Living Contract dated August 18, 2023, page 12, section 1, included the following statement, "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 [licensee] or its employees or agents." On September 11, 2024, at 9:00 a.m., licensed	0 970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37076	A. BUILDING: _____ B. WING _____	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(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
0 970	Continued From page 40 assisted living director (LALD)-D stated they were aware the liability clause could not be included in the assisted living contract. LALD-D stated the licensee should had removed that from each resident's contract. No other information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01290 SS=G	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study was current and eligible on NETStudy 2.0 (web-based system for submitting background study requests to the Department of Human Services (DHS)) and received in affiliation with the assisted living license for one of nine employees (unlicensed	01290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37076	A. BUILDING: _____ B. WING _____	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(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
01290	Continued From page 41 personnel/manager (ULP/M)-H). This resulted in an immediate correction order issued on September 10, 2024. 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: ULP/M-H was hired on February 10, 2021, to provide duties including office work, reviewing resident medical charts and other paperwork duties for the licensee. Licensee's document titled Employee Timesheet - ULP/M-H dated September 1, 2024, through September 30, 2024, indicated ULP/M-H worked on August 3, 2024, 9:00 a.m., until 4:00 p.m., August 15, 2024, 9:00 a.m., until 4:00 p.m. and September 9, 2024, from 9:00 a.m., until 4:00 p.m. On September 10, 2024, at 10:18 a.m., the surveyor observed house manager (HM)-E review the NETStudy 2.0 website. HM-E accessed rosters for two health facility identification number (HFID) numbers which were 35632 and 37076. ULP/M-H was listed under 35632. ULP/M-H's background study affiliated to HFID 35632, indicated "Eligible - COVID-19 Study - Expired" with an expiration date of December 31, 2022, on the NETStudy 2.0 website roster page. The background check was also not	01290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37076	A. BUILDING: _____ B. WING _____	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(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
01290	Continued From page 42 affiliated with the licensee's HFID 37076. On September 9, 2024, at 9:43 a.m., and at 10:41 a.m., during interviews, licensed assisted living director (LALD)-D stated they had been providing licensed assisted living director coverage for the licensee's regular LALD (LALD-B) who was on leave from the licensee since May 30, 2024. LALD-D stated they were unaware of the duties ULP/M-H performed the licensee, and they were unaware the COVID-19 NETStudy 2.0 expired, and all employees were required to have a cleared background check before performing duties at the facility. On September 10, 2024, at 10:21 a.m., owner/agent (O/A)-A stated they were responsible to ensure all employees had a cleared background check from NETStudy 2.0. O/A-A stated ULP/M-H accessed resident records and helped with paperwork for the facility. O/A-A stated HFID 35632 was the licensee's previous comprehensive home care license. O/A-A stated the eligible - COVID 19 study should have been resubmitted before it expired. On September 10, 2024, at 12:20 p.m., LALD-D stated they started employment with the licensee on May 30, 2024. LALD-D stated they were onsite once per week and had not met ULP/M-H and ULP/M-H only worked once per week for the licensee. The licensee's policy titled Recruitment and Hiring dated January 7, 2022, indicated all staff members would require a cleared background from NETStudy 2.0 before working for the licensee. On September 10, 2024, the Minnesota	01290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37076	A. BUILDING: _____ B. WING _____	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(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
01290	Continued From page 43 Department of Human Services website indicated the following: Emergency studies completed during the COVID-19 pandemic were no longer valid. Individuals who only had an emergency study must have a fully compliant, fingerprint-based background study. Roster maintenance - Individuals with a completed emergency study will remain on the entity's roster unless the entity removes the individual. Entities should remove individuals with emergency studies that are no longer affiliated; - If the individual should no longer be affiliated and has a new fully compliant background study, the entity should wait until the individual is separated and then remove both the emergency study and fully compliant study from their roster at the same time; - All entities are responsible for maintaining their rosters regularly and removing study subjects from their roster when they are no longer affiliated; and - Entities are responsible for identifying who needs to submit a new background study. For help identifying which study subjects still have an emergency study and need a fully compliant study, entities should refer to the instructional guide, "Identifying Emergency Studies" in the help section of NETStudy 2.0. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate Additionally, the licensee failed to ensure a background study was submitted and a clearance received in affiliation with the assisted living licensee's current health facility identification	01290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37076	A. BUILDING: _____ B. WING _____	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(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
01290	Continued From page 44 (HFID) for one of three employees (unlicensed personnel (ULP)-K). The findings include: ULP-K began employment on February 9, 2021, and began to provide direct care and services to residents. ULP-K's employee file included a background study clearance dated February 9, 2021, which was affiliated with the licensee's previous comprehensive home care license (HFID 35632). The licensee failed to have a background study clearance for ULP-K affiliated with their assisted living facility (HFID 37076). On September 12, 2024, at 9:14 a.m., licensed assisted living director (LALD)-D stated staff members background study clearance should be affiliated with the facility they are employed at, and it was an error for not having it completed. On September 12, 2024, at 9:15 a.m., owner/agent (O/A)-A stated they were aware the background check should be affiliated with the facility staff member's work site, and it was an error for not having ULP-K background affiliated with HFID 37076. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01370 SS=F	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all	01370		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37076	A. BUILDING: _____ B. WING _____	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(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
01370	Continued From page 45 unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by:	01370		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37076	A. BUILDING: _____ B. WING _____	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(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
01370	Continued From page 46 Based on interview and record review, the licensee failed to ensure training and competency evaluations were completed for all required skill areas prior to providing services, for three of three unlicensed personnel (ULP-K, ULP-L and house manager (HM)-E). 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: ULP-K ULP-K began employment on February 9, 2021, and began to provide direct care and services to residents. ULP-K's employee record lacked the following: Training: -basic nutrition, meal preparation, food safety, and assistance with eating; -preparation of modified diets as ordered by a licensed health professional, and; -awareness of commonly used health technology equipment and assistive devices. Competency evaluations: -standby assistance techniques and how to perform them. ULP-L ULP-L began employment on July 30, 2024, and began to provide direct care and services to residents.	01370		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37076	A. BUILDING: _____ B. WING _____	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(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
01370	Continued From page 47 ULP-L's employee record lacked the following: Training: -basic nutrition, meal preparation, food safety, and assistance with eating; -preparation of modified diets as ordered by a licensed health professional, and; -awareness of commonly used health technology equipment and assistive devices. Competency evaluations: -standby assistance techniques and how to perform them. HM-E HM-E began employment on May 1, 2021, and began to provide house manager services, direct care and services to residents. HM-E's employee record lacked the following: Training: -basic nutrition, meal preparation, food safety, and assistance with eating; -preparation of modified diets as ordered by a licensed health professional, and; -awareness of commonly used health technology equipment and assistive devices. Competency evaluations: -standby assistance techniques and how to perform them. On September 12, 2024, at 9:07 a.m., registered nurse (RN)-J stated the RN would complete the trainings and evaluations for staff members that provide direct care services. The RN would sign paperwork as proof staff members were observed as competent at providing direct care services. RN-J stated the licensed assisted living director (LALD) was responsible for maintaining	01370		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37076	A. BUILDING: _____ B. WING _____	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(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
01370	Continued From page 48 employee records. On September 12, 2024, at 9:51 a.m., LALD-D stated the clinical nurse supervisor (CNS) was responsible for completing all trainings and completing the required paperwork for the licensee. The licensee's undated, 5.02 Competency Training evaluations policy indicated a registered nurse would ensure staff were competent at performing each tasks or procedures. The licensee's undated, 5.10 Training Records indicated the licensee would maintain a record of staffing training and required competencies. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01380 SS=F	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation;	01380		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37076	A. BUILDING: _____ B. WING _____	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(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
01380	Continued From page 49 (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency evaluations were completed for all required skill areas prior to providing services for three of three unlicensed personnel (ULP-K, ULP-L, and house manager (HM)-E). 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: ULP-K ULP-K began employment on February 9, 2021, and began to provide direct care and services to residents. ULP-K's employee record lacked the following: Competency evaluations: -reading and recording temperature, pulse, and respirations of the resident. ULP-L ULP-L began employment on July 30, 2024, and began to provide direct care and services to residents. ULP-L's employee record lacked the following:	01380		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37076	A. BUILDING: _____ B. WING _____	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(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
01380	Continued From page 50 Competency evaluations: -safe transfer techniques and ambulation; -range of motioning and positioning, and; -administering medications or treatments as required. HM-E HM-E began employment on May 1, 2021, and began to provide house manager services, direct care and services to residents. HM-E's employee record lacked the following: Competency evaluations: -reading and recording temperature, pulse, and respirations of the resident; -safe transfer techniques and ambulation, and; -range of motioning and positioning. On September 12, 2024, at 9:07 a.m., registered nurse (RN)-J stated the RN would complete the trainings and evaluations for staff members that provide direct care services. The RN would sign paperwork as proof staff members were observed as competent at providing direct care services. RN-J stated the licensed assisted living director (LALD) was responsible for maintaining employee records. On September 12, 2024, at 9:51 a.m., LALD-D stated the clinical nurse supervisor (CNS) was responsible for all trainings and completing the required paperwork for the licensee. The licensee's undated, 5.02 Competency Training evaluations policy indicated a registered nurse would ensure staff were competent at performing each tasks or procedures. The licensee's undated, 5.10 Training Records indicated the licensee would maintain a record of	01380		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37076	A. BUILDING: _____ B. WING _____	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(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
01380	Continued From page 51 staffing training and required competencies. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plan included a signature or other authentication by the resident or resident's designated	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37076	A. BUILDING: _____ B. WING _____	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(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
01640	Continued From page 52 representative to document agreement on the services to be provided for three of three residents (R1, R2, 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: R1 R1 was admitted to the facility on August 18, 2023, and began receiving assisted living services. R1 diagnoses included intervertebral disc degeneration, borderline personality disorder (unstable moods and behaviors), major depressive disorder, post-traumatic stress disorder, agoraphobia (fear of feeling trapped or feeling of panic), carpal tunnel (painful wrists), and fibromyalgia (generalized pain). R1 Service Plan (Waiver) - Addendum to Contract dated August 13, 2022, indicated R1 received assistance with ambulation, bathing assistance, dressing, grooming, incontinence care, behavior management, meal reminder, medication administration, vital signs, safety check socialization, and transfer assistance. On September 11, 2024, at 8:15 a.m., the surveyor observed house manager (HM)-E administer medications to R1.	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37076	A. BUILDING: _____ B. WING _____	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(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
01640	Continued From page 53 R1's service plan lacked a signature or other authentication by the resident or resident's designated representative indicating agreement on services to be provided when revisions occurred. R2 R2 admitted to the licensee for services on May 21, 2024, and began receiving assisted living services. R2 Service Plan (Waiver) - Addendum to Contract dated May 21, 2024, indicated R2 received assistance with deep room cleaning, housekeeping, laundry, linen exchange, behavior management, meal reminder, medication setup and administration, garage removal, safety check, and shopping assistance. On September 10, 2024, at 7:52 a.m., the surveyor observed HM-E administer medications to R2. R2's service plan lacked a signature or other authentication by the resident or resident's designated representative indicating agreement on services to be provided when revisions occurred. R3 R3 admitted to the licensee for services on May 23, 2024, and began receiving assisted living services. R3 Service Plan (Waiver) - Addendum to Contract dated May 23, 2024, indicated R3 received assistance with activity assistance, bed making, deep room cleaning, housekeeping, laundry, linen exchange, behavior management,	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37076	A. BUILDING: _____ B. WING _____	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(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
01640	Continued From page 54 meal reminder, medication setup and administration, garage removal, safety checks, shopping assistance, and transportation assistance. R3's service plan lacked a signature or other authentication by the resident or resident's designated representative indicating agreement on services to be provided when revisions occurred. On September 11, 2024, at 10:43 a.m., licensed assisted living director (LALD)-D stated they were aware the service plan had to be signed by the resident and the licensee. LALD-D stated it was an error for not having the service plan signed. The licensee Service Plan policy dated January 7, 2022, indicated an individualized service plan is implemented for all residents and will be signed by [licensee] and the resident or resident representative. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37076	A. BUILDING: _____ B. WING _____	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(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
01730	Continued From page 55 assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and maintain a current individualized medication management record to include all required content for one of three residents (R1).	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37076	A. BUILDING: _____ B. WING _____	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(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
01730	Continued From page 56 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted to the facility on August 18, 2023, and began receiving assisted living services. R1 diagnoses included intervertebral disc degeneration, borderline personality disorder (unstable moods and behaviors), major depressive disorder, post-traumatic stress disorder, agoraphobia (fear of feeling trapped or feeling of panic), carpal tunnel (painful wrists), and fibromyalgia (generalized pain). R1 Service Plan (Waiver) - Addendum to Contract dated August 13, 2022, indicated R1 received assistance with medication administration. R1 medication administration record (MAR) dated September 1, 2024, through September 31, 2024, indicated R1 received the following medications; omeprazole 40 milligrams (mg) 1 capsule daily, nystatin 100,000 apply topically (on the skin) twice daily, buspirone 10 mg 1 tablet three times daily, dicyclomine 20 mg 1 table four times daily, fluoxetine 20 mg 3 capsule three daily, gabapentin 400 mg 1 capsule twice daily, lamotrigine 100 mg 1 tablet once daily,	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37076	A. BUILDING: _____ B. WING _____	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(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
01730	Continued From page 57 miconazole 2 percent (%) apply 2 grams (gm) topically to affected areas twice daily, penicillin 250 mg 1 tablet twice daily, pravastatin 80 mg 1 tablet once daily, propranolol 20 mg 1 tablet three times daily, Stress Formula 1 tablet once daily, suboxone 4mg/1mg 1 film inside of check three times daily, tizanidine 2 mg 1-2 tablets three times daily, triamcinolone 0.1 % ointment 80 mg apply thin layer to rash area on the legs twice daily, buspirone 10 mg 2 tablets three times daily, Wegovy injection 0.25 mg inject 0.25 mg subcutaneously (into the subcutaneous section of skin) once a week, topiramate 1 tablet at bedtime, vitamin D3 25 micrograms (mcg) 1 tablet once daily, Gavilax powder mix 17 gm in liquid with a drink once daily as needed, quetiapine 200 mg 1 tablet at bedtime as needed, Senexon-S tablet 8.6-50 mg 1 tablet twice daily as needed, acetaminophen 1-2 tablets four times a day as needed, albuterol 0.5 nebulizer solution 20 mg every six hours as needed, albuterol inhaler inhale 2 puffs four times as needed, Eucerin cream apply topically as needed for dry skin, furosemide 20 mg tablet 1 tablet as needed for edema (fluid swelling), ibuprofen 800 mg 1 tablet three times daily as needed, lidocaine cream 5 % apply to affected areas on lower legs twice needed, loperamide 2 mg 1-2 capsules as needed, mirtazapine 15 mg 1 tablet by mouth at bedtime as needed, ondansetron 8 mg 1 table three times daily as needed, and Rozerem 8 mg 1 tablet at bedtime as needed. Pepto Bismol was not included on the MAR. On September 9, 2024, at 10:27 a.m. during a tour of the assisted living facility (ALF), the surveyor observed a three-level home. The basement level of the ALF consisted of a common room, utility room, a bathroom and R1's bedroom. Located on the nightstand in R1's	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37076	A. BUILDING: _____ B. WING _____	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(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
01730	Continued From page 58 room, was a bottle of liquid Pepto Bismol. R1's 90-day assessment dated August 16, 2024, indicated the licensee would store all medications for R1 and only staff members would have access to R1's medications. R1's assessment lacked documentation the resident could self-administer medications. On September 11, 2024, at 10:18 a.m., house manager (HM)-E stated they were unaware of the medications stored in R1's room. HM-E stated they were trained to contact the registered nurse if they find medications in resident rooms and was unsure if R1 was allowed to store medications in their room. On September 11, 2024, at 11:49 a.m., registered nurse (RN)-J stated residents were not allowed to store medications in their rooms and the licensee was required to store all medications. RN-J stated if staff observed medications in resident rooms, they were trained to contact the RN. RN-J stated they were unaware R1 had medications stored in their room. The licensee's undated, 7.11 Medication Storage policy indicated the licensee would store medications consistent with each resident's medicaion management plan. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01820 SS=E	144G.71 Subd. 13 Prescriptions There must be a current written or electronically	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37076	A. BUILDING: _____ B. WING _____	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(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
01820	Continued From page 59 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 three residents (R2, 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, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R2 R2 admitted to the licensee for services on May 21, 2024, and began receiving assisted living services. R2 Service Plan (Waiver) - Addendum to Contract dated May 21, 2024, indicated R2 received medication setup and administration. On September 10, 2024, at 7:52 a.m., the surveyor observed house manager (HM)-E administer medications to R2. R2's medication administration record (MAR) dated September 1, 2024, through September 31,	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37076	A. BUILDING: _____ B. WING _____	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(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
01820	Continued From page 60 2024, included the following medications: clozapine 100 milligram (mg) 1 tablet daily, polyethylene glycol 17 grams mixed with water as needed, clozapine 3.5 mg 1 tablet daily at bedtime, olanzapine 5 mg 1 tablet at bedtime, clonidine 0.1 mg 1 tablet once daily as needed, topiramate (no dose listed on MAR) 1 tablet once daily as needed, and Trazodone 100 mg 1 tablet once daily as need. The licensee lacked signed provider orders for the following medications: -topiramate R3 R3 admitted to the licensee for services on May 23, 2024, and began receiving assisted living services. R3 Service Plan (Waiver) - Addendum to Contract dated May 23, 2024, indicated R3 received assistance with medication setup and administration. R3's MAR dated September 1, 2024, through September 31, 2024, included the following medications: olanzapine 20 mg 1 tablet by mouth daily, bisacodyl rectal suppository (medication inserted into the rectum) once daily, hydroxyzine pamoate 25 mg 1 capsule three times as needed, magnesium drink contents of the bottle, nicotine chew 1 piece as needed, olanzapine 5 mg 1 tablet three times daily as needed, and polyethylene glycol 17 grams mixed with water as needed. The licensee lacked signed provider orders for the following medications: -bisacodyl rectal suppository once daily, -hydroxyzine pamoate 25 mg 1 capsule three	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37076	A. BUILDING: _____ B. WING _____	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(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
01820	Continued From page 61 times as needed, -magnesium drink contents of the bottle, -nicotine chew 1 piece as needed, -olanzapine 5 mg 1 tablet three times daily as needed, and -polyethylene glycol 17 grams mixed with water as needed On September 10, 2024, at 12:43 p.m., clinical nurse supervisor (CNS)-C stated these were the only provider orders the licensee had available for R2 and R3. On September 11, 2024, at 9:20 a.m., CNS-C stated there should be current signed orders in the resident file. CNS-C stated any changes to a medication required a signed order from a medical prescriber and a copy should be in the resident file. CNS-C stated they were a new employee to the licensee and believed the lack of signed orders was an error. On September 12, 2024, at 9:51 a.m., licensed assisted living director (LALD)-D stated the CNS was responsible for ensuring residents had signed orders from a medical prescriber for medications in the resident file. The licensee's undated, 7.12 Medications - Prescribed, Not Prescribed & OTC (over the counter) policy indicated [licensee] will determine whether the facility shall require a prescription for all medications the provider manages. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37076	A. BUILDING: _____ B. WING _____	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(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
01890	Continued From page 62	01890		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to discard expired medication for one of three residents (R1). The licensee also failed to store medications correctly for one of three residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: EXPIRED MEDICATIONS R1 was admitted to the facility on August 18, 2023, and began receiving assisted living services. R1 diagnoses included intervertebral disc degeneration, borderline personality disorder (unstable moods and behaviors), major depressive disorder, post-traumatic stress	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37076	A. BUILDING: _____ B. WING _____	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(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
01890	Continued From page 63 disorder, agoraphobia (fear of feeling trapped or feeling of panic), carpal tunnel (painful wrists), and fibromyalgia (generalized pain). R1 Service Plan (Waiver) - Addendum to Contract dated August 13, 2022, indicated R1 was receiving assistance with medication administration. R1's Assessment dated August 16, 2024, indicated the licensee would store medications for R1. On September 10, 2024, at 8:11 a.m., the surveyor observed a plastic container with R1 identifiers. The plastic container contained three acetaminophen 500 milligram (mg) medication cards expired March 30, 2024, one albuterol inhaler (a device that delivers medications to the lungs via the mouth) expired July 2020, and five loperamide 2 mg medication cards expired August 28, 2024. On September 10, 2024, at 10:34 a.m., clinical nurse supervisor (CNS)-C stated R1 had requested the licensee not to destroy the medications. CNS-C stated they were unaware there were expired medications in the plastic container. CNS-C further stated there should not be expired medications. On September 11, 2024, at 9:15 a.m., licensed assisted living director (LALD)-D stated the CNS was responsible for ensuring there were no expired medications. LALD-D stated they were aware of R1's expired medications; however, R1 requested the licensee continue to store the medications. The licensee's undated, 7.23 Medication Disposal	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37076	A. BUILDING: _____ B. WING _____	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(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
01890	Continued From page 64 policy indicated the licensee would dispose of expired medications according to the accepted practices of the Minnesota board of Pharmacy. MEDICATIONS NOT STORED CORRECTLY. On September 10, 2024, at 10:29 a.m., the surveyor observed a zip lock bag inside of a large plastic container labeled with R1 identifier. The zip lock bag had a printed pharmacy label that read, "[R1] Suboxone Sublingual (under the tongue) film 4 milligrams/1 milligram." On the same printed pharmacy label, there was a line drawn in ink pen through the identifier for R1, and a line drawn in ink pen through the words "Suboxone Sublingual." In ink pen the words, "tiazanadine 1, Buspion 5, and Ibprofen" had been handwritten onto the printed pharmacy label. In the zip lock bag, there were a total of five pills; 4 pills with the markings, "ZC80", which WebMD website identified as the medication lamotrigine, and 1 pill with the markings "L8," which WebMD website identified as the medication clobazam. The medications were not stored in the original medication container. The pharmacy label and the words written in ink pen did not match the medications contained in the zip lock bag. On September 10, 2024, at 10:33 a.m., CNS-C stated medications were required to be stored in their original dispensed container and not in a zip lock bag. CNS-C stated there should not be ink handwriting on the pharmacy label. CNS-C stated they were unsure why the medications were stored in the zip lock bag, as it was their third week of employment with the licensee. On September 11, 2024, at 9:13 a.m., LALD-D stated medications should not be stored in the zip	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37076	A. BUILDING: _____ B. WING _____	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(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
01890	Continued From page 65 lock bag. LALD-D stated medications should be stored in their original pharmacy container. The licensee undated, 7.11 Medication Storage policy indicated medications will be kept securely locked and stored per manufacturer directions. The Center for Disease Control (CDC) Tips for Safe Storage and Disposal dated August 5, 2022, recommends prescription medication is stored in the original packaging with the safety lock tightened and secured. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
02290 SS=F	144G.91 Subd. 2 Legislative intent The rights established under this section for the benefit of residents do not limit any other rights available under law. No facility may request or require that any resident waive any of these rights at any time for any reason, including as a condition of admission to the facility. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee posted signage that used language which limited the rights of all residents residing within 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	02290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37076	A. BUILDING: _____ B. WING _____	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(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
02290	Continued From page 66 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 September 9, 2024, at 10:27 a.m. during a facility tour, the surveyor observed a three-level home. The main floor consisted of a common room, dining room, kitchen, and bathroom. On a wall between the kitchen and common area was signage that read, "[licensee] February 19, 2022, curfew is at 11 PM everyday week day holiday weekend." On September 10, 2024, at 8:46 a.m., licensed assisted living director (LALD)-D stated the curfew for residents was 11:00 p.m. LALD-D stated curfew was enforced by staff as residents were vulnerable adults. LALD-D stated they were aware [licensee] cannot limit freedoms, and the purpose of displaying the signage was to make sure residents would inform staff if they wanted to leave the facility after 11:00 p.m. LALD-D stated it was an error for stating there was a curfew time. On September 10, 2024, at 8:51 a.m., owner/agent (O/A)-A stated the house rules included a curfew. O/A-A stated they were unaware the licensee could not impose a curfew. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02290		
02410 SS=F	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
	37076	A. BUILDING: _____ B. WING _____	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(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 67 (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 and interview, the licensee failed to provide a working locking mechanism on a communal bathroom used by all residents (R1, R2, 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).	02410		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37076	A. BUILDING: _____ B. WING _____	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CC GROUP HOME CARE INC	3633 COLUMBUS AVENUE MINNEAPOLIS, MN 55407

(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 68 The findings include: On September 9, 2024, at 10:27 a.m. during a facility tour, the surveyor observed a three-level home. The main level consisted of a common room, dining room, kitchen, and bathroom. The bathroom lock could not be secured in the lock position, preventing privacy for residents while using the bathroom. On September 10, 2024, at 7:16 a.m., owner/agent (O/A)-A stated the bathroom was used by staff and residents and was unaware the lock on the bathroom did not work. On September 10, 2024, at 7:38 a.m., licensed assisted living director (LALD)-D stated they were aware the bathroom was required to have a working locking mechanism and was unaware the lock on the bathroom did not work. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02410		

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

Type: Full
Date: *09/10/24*
Time: 11:05:20
Report: 8044241278

Food and Beverage Establishment Inspection Report

Location:
Cc Group Home Care Inc
3633 Columbus Avenue
Minneapolis, MN55407
Hennepin County, 27

Establishment Info:
ID #: 0037816
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6123873039
ID #:

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

The following orders were issued during this inspection.

4-200 Equipment Design and Construction

4-203.11 ***** Priority 2 *****

MN Rule 4626.0555 Replace food temperature measuring devices that are not accurate to plus or minus 2 degrees F.

Stem thermometer not working.
Comply By: 09/11/24

Surface and Equipment Sanitizers

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

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 39.0 Degrees Fahrenheit - Location: Milk in fridge
Violation Issued: No

Process/Item: Cold Holding
Temperature: 35 Degrees Fahrenheit - Location: Fridge
Violation Issued: No

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

HRD inspection conducted with Nurse Evaluator Keith Langley. Inspection report reviewed on site with Mohamed Jama.

Type: Full
Date: *09/10/24*
Time: 11:05:20
Report: 8044241278
Cc Group Home Care Inc

Food and Beverage Establishment Inspection Report

Domestic kitchen consists of tile floors, wooden hollow-base cabinets, painted gypsum walls & ceilings, and domestic equipment, including a dishwasher.

Establishment Info: cicigrouphome@gmail.com

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 8044241278 of 09/10/24.

Certified Food Protection Manager: Zamzam Elmi

Certification Number: FM87670 Expires: 12/18/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
Inspector signed for Mohamed

Signed: _____

Michael DeMars, RS
Public Health Sanitarian III
Rochester District Office
507-216-1096
michael.demars@state.mn.us