Electronically Delivered

October 22, 2024

Licensee
Mercy Caregivers of Minnesota, Inc.
2942 Oliver Avenue North
Minneapolis, MN 55411

RE: Project Number(s) SL37390015

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.

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

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

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

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

The correction order documentation should include the following:

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

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

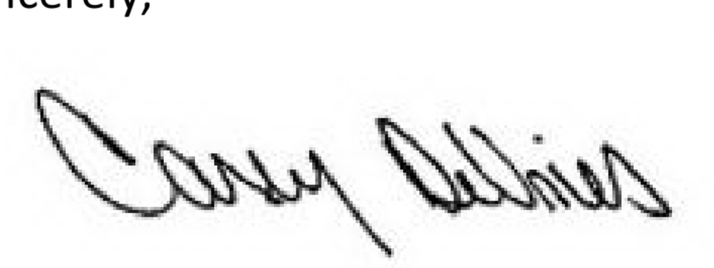
To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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

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

If you have any questions, please contact me.

Sincerely,



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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37390	A. BUILDING: _____ B. WING _____	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERCY CAREGIVERS OF MINNESOTA	2942 OLIVER AVENUE NORTH MINNEAPOLIS, MN 55411

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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: SL37390015-0 On September 9, 2024, through September 12, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were two residents, both of whom received services under the Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480		

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0 480	Continued From page 1 following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated, September 9, 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		
0 660 SS=F	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	0 660		

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0 660	Continued From page 2 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 interview and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) when the licensee failed to complete TB testing upon hire for two of five employees (unlicensed personnel (ULP)-B, ULP-D), failed to complete annual TB training for one of five employees (owner/ licensed assisted living director (O/LALD)-C), and failed to complete health history and symptom screening on hire for five of five employees (clinical nurse supervisor (CNS)-A, O/LALD-C, ULP-B, ULP-D, ULP-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 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 facility TB risk assessment was completed	0 660		

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0 660	Continued From page 3 by O/LALD-C on January 31, 2024, and indicated the facility was at a low risk for TB transmission. The TB risk assessment indicated the facility provided TB education for all employees at the time of hire and annually. Furthermore, the TB risk assessment indicated O/LALD-C was responsible for maintaining TB records and the records were to be stored in employee files. CNS-A CNS-A began employment with the licensee on June 17, 2022, to provide oversite to unlicensed personnel and direct services to residents. CNS-A's employee record included the negative result of a serum blood test for TB dated August 10, 2023, and record of TB training completed in 2021 and 2024. CNS-A's record lacked completed health history and symptom screening for the time of hire in 2022. O/LALD-C O/LALD-C opened facility and began employment June 1, 2020. O/LALD-C provided direct services to residents. O/LALD-C's employee record included a positive TB skin test result dated May 28, 2020, chest x-ray results dated May 28, 2020, that indicated no active TB, and TB training completed in 2020 and 2022. O/LALD-C's record lacked TB training for 2023 and 2024 and lacked a completed health history and symptom screening for the time of hire in 2020. ULP-B ULP-B had a hire date of November 5, 2022. ULP-B provided direct services to residents. ULP-B's record included a chest x-ray result,	0 660		

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0 660	Continued From page 4 dated December 10, 2018, that indicated no radiographic evidence of active TB and record of TB training completed in 2023. ULP-B's record did not include any historical positive TB testing results that would indicate appropriateness of chest x-rays for monitoring and lacked completed health history and symptom screening for the time of hire in 2022 and annually for 2023 and 2024. ULP-D ULP-D had a hire date of June 1, 2023. ULP-D provided direct services to residents. ULP-D's employee record included a chest x-ray result, dated October 25, 2020, that indicated no radiographic evidence of acute TB disease, and TB training completed in 2024. ULP-D's record lacked baseline TB testing completed on or within ninety days prior to their hire date with licensee. ULP-D's record did not include any historical positive TB testing results that would indicate appropriateness of chest x-rays for monitoring and lacked documentation of TB history and symptoms upon hire in 2023. ULP-E ULP-E had a hire date of August 4, 2023. ULP-E provided direct services to residents. ULP-E's employee record included positive TB blood test result dated July 20, 2023, chest x-ray results dated August 1, 2023, that indicated no evidence of acute cardiopulmonary disease, communicable disease, or active TB, and TB training completed in 2023. ULP-E's record lacked documentation of TB history and symptoms upon hire in 2023. TB TESTING UPON HIRE	0 660		

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0 660	Continued From page 5 On September 10, 2024, at 1:45 p.m., O/LALD-C stated they had, at some point, realized some of the employee records lacked required testing and had those employees' complete TB blood testing at that time. O/LALD-C stated they thought they had caught up on documentation of required testing but still had planned on updating TB screening and testing for all employees by the end of 2024 to make sure everyone had required screening and testing completed but had not done that yet. In addition, O/LALD-C stated they were aware they needed to have a positive test on record for employees and not just chest x-ray. O/LALD-C stated they were not aware they did not have positive results on record for ULP-B and ULP-D. ANNUAL TB TRAINING On September 10, 2024, at 1:45 p.m., O/LALD-C stated new employees received TB training in person from the RN at hire. Their annual training for TB is completed via Educare (online learning management system). O/LALD-C stated they were the one responsible to assign Educare modules and monitor to ensure completion of education for each employee. HEALTH HISTORY AND SYMPTOM SCREENING On September 9, 2024, at 2:00 p.m., CNS-A stated they were not sure if there was a form for baseline TB symptom review. On September 9, 2024, at 4:00 p.m., O/LALD-C stated they thought everything required for TB health history and symptom screening was completed at the clinic with skin and blood testing. O/LALD-C stated they had not realized this needed to be completed and retained in the employee record. O/LALD-C reviewed the blank	0 660		

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0 660	Continued From page 6 document binder received from working with a consultant in the past and found a blank document that met requirements for TB health history and screening and stated they planned to implement use of the document. The licensee's undated Tuberculosis Screening policy indicated all new employees would have documentation of baseline health symptom screening prior to providing direct care to residents. This screening would include, at minimum, the health symptom screening and TB skin or blood testing. Furthermore, all employee records would contain evidence of baseline TB screening consisting of a written assessment for current symptoms of active TB disease and testing for the presence of TB infection either by a two-step TB skin test or a single TB blood test. The policy indicated if the employee had proof of a TB blood test or negative Chest X-ray within 90 days of employment, it did not have to be repeated at the time of hire. The licensee's undated Tuberculosis Prevention and Control policy indicated the facility would establish a protocol for early identification of individuals with active tuberculosis. This included TB screening and training. The facility would provide training for all employees at the time of hire and annually to include: - the signs and symptoms of TB; - health screening and therapy; - facility specific protocols; and - use of respiratory protection equipment. Regulations for Tuberculosis Control in Minnesota Health Care Settings: A guide for implementing tuberculosis infection control regulations in your facility, dated July 2013, indicated before the health care worker (HCW) has direct patient	0 660		

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0 660	Continued From page 7 contact, the following should be documented in their record: 1. Test result, 2. Assessment for current TB symptoms, 3. Chest X-ray to rule out infectious TB disease. The chest X-ray should be done after the date of the positive TST or IGRA; however, a chest X-ray done within the three months prior to the TST/IGRA is acceptable, provided that the HCW has not been exposed to infectious TB disease since the chest X-ray was done. If infectious TB disease is ruled out, additional chest X-rays are not needed unless the HCW develops symptoms of active TB disease or a clinician recommends a repeat chest X-ray, and 4. If the chest X-ray is done at the time of hire because documentation of a previous film was not available, a medical evaluation to rule out infectious TB disease should be done. No medical evaluation is required if HCW already has a chest X-ray dated after documented positive TST or IGRA. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
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;	0 780		

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0 780	Continued From page 8 (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 keep the facility in compliance with the Minnesota Fire Code. The deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On facility tour with the licensed assisted living director (LALD) on September 9, 2024, between 11:45 a.m. and 12:45 p.m. the following deficient	0 780		

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0 780	Continued From page 9 condition was observed: LOCKS: The surveyor observed unapproved locks on the basement door. The surveyor explained to the LALD that the door from the basement shall always open with one motion and no special knowledge from the basement side of the door. This deficient condition was visually verified by the LALD accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property of a resident for two of two residents (R2, R3).	0 970		

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0 970	Continued From page 10 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: R2 R2 was admitted to the licensee and began receiving assisted living services on June 26, 2024. R3 R3 was admitted to the licensee and began receiving assisted living services on November 26, 2022. R2 and R3's Assisted Living Contracts, included on page four, a section titled Primary Services. Number six of this section, titled Emergency Services/Staff Availability indicated licensee would not be liable for resident safety once the resident had departed the premises. Number seven of this section, also on page four, indicated resident rooms had locks, and that if the resident chose not to lock their valuables, the resident assumed liability for those valuables. The contracts included, on page eleven and twelve, a section titled Miscellaneous Provisions. Part one of this section indicated the resident shall always maintain his or her own health, personal property, liability, automobile (if applicable), and other insurance coverages and shall provide evidence of same by copies of	0 970		

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0 970	Continued From page 11 binders or policies provided to licensee upon request. The section included resident acknowledgement that licensee was not an insurer of the resident's person or property. The resident agreed to release licensee from liability for any personal injury or property damage suffered by the resident or the resident's agents, guests, or invitees, unless caused by the negligence of licensee or its employees or agents. On September 12, 2024, at approximately 2:00 p.m., owner/ licensed assisted living director (O/LALD)-C stated they were not aware the contract did not meet requirements. The licensee's undated Assisted Living Contracts policy indicated the licensee would establish a contract with each resident at the time of admission. The contract would be inclusive of both the tenant-landlord relationship and the services to be provided. The contract would not include a waiver of facility liability for the health and safety or personal property of a resident. The contract would not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an	01440		

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01440	Continued From page 12 appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a registered nurse (RN) conducted direct supervision of staff performing a delegated task within 30 days of providing services for three of three employees (unlicensed personnel (ULP)-B, ULP-D, ULP-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).	01440		

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01440	Continued From page 13 The findings include: ULP-B ULP-B had a hire date of November 5, 2022. ULP-B provided direct services to residents. On September 10, 2024, at 10:30 a.m., the surveyor observed ULP-B prepare and administer medications for R3. ULP-B's employee record included a document titled 30-Day ULP Competency Verification, dated December 25, 2022, completed fifty-one days after the employee began providing direct services for residents. The document included the employee's name, date, RN signature, list of care areas, and a statement that the employee was proficient in all care areas listed. The 30-Day ULP Competency Verification lacked documentation to verify direct observation of staff administering medication or treatment and the staff interaction with the resident. ULP-D ULP-D had a hire date of June 1, 2023, ULP-D provided direct services to residents. R3's Medication Administration Record (MAR), dated September 2024, included ULP-D's initials on the corresponding lines for administration of 8:00 p.m., medications on September 8 and 12, which indicated ULP-D prepared and administered R3's medications on those dates. ULP-D's employee record included a 30-Day ULP Competency Verification, dated July 2, 2023, completed thirty-two days after the employee began providing direct services for residents. The document lacked documentation to verify direct observation of staff administering medication or	01440		

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01440	Continued From page 14 treatment and the staff interaction with the resident. ULP-E ULP-E had a hire date of August 4, 2023. ULP-E provided direct services to residents. R3's Medication Administration Record (MAR), dated September 2024, included ULP-E's initials on the corresponding lines for administration of 8:00 a.m., medications on September 1,6,8 and 12, which indicated ULP-E prepared and administered R3's medications on those dates. ULP-E's employee record included a 30-Day ULP Competency Verification, dated September 3, 2023. The document was completed within thirty days of ULP-E performing direct services for residents but lacked documentation to verify direct observation of staff administering medication or treatment and the staff interaction with the resident. On September 11, 2024, at 1:42 p.m., via telephone interview, clinical nurse supervisor (CNS)-A stated they meet with new employees at the facility when they have worked thirty days. CNS-A stated they review the 30-Day ULP Competency Verification form with the employee, provide additional information, and reiterate education on all topics listed under care areas on the document. CNS-A stated they do observe the new employee providing cares and administering medications but did not document any details of the observation and could not confirm it was completed on that same date based on documentation recorded. The licensee's undated Supervision of Unlicensed Personnel policy indicated the	01440		

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01440	Continued From page 15 registered nurse would provide direct supervision of employees performing delegated tasks including medication or treatment administration within thirty calendar days of the employee beginning work with licensee. Documentation of supervision would include direct observation of the staff administering the medication or treatment, the interaction with the resident, and would be retained in the employee's record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases;	01500		

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01500	Continued From page 16 (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure all employees that performed direct services completed all required training components for	01500		

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01500	Continued From page 17 each twelve months of employment for three of three employees (clinical nurse supervisor (CNS)-A, owner/ licensed assisted living director (O/LALD)-C, and unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: CNS-A CNS-A began employment with the licensee on June 17, 2022, to provide oversite to unlicensed personnel and direct services to residents. CNS-A's employee record lacked training for the following required topics: - review of provider policies and procedures for 2023 and 2024. O/LALD-C O/LALD-C opened the facility and began employment June 1, 2020. O/LALD-C provided direct services to residents. On September 9, 2024, at 10:45 a.m., during the entrance conference, O/LALD-C stated as part of their position they transport residents to medical appointments, go shopping with residents, and social do outings with residents on a regular basis. O/LALD-C stated when there is a scheduling need they worked full shifts with residents which included direct care and medication administration.	01500		

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01500	Continued From page 18 O/LALD-C's employee record lacked training for the following required topics: - reporting of maltreatment of vulnerable adults for 2023 and 2024; - review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights for 2022, 2023, and 2024; - review of infection control techniques for 2021, 2023, and 2024; - effective approaches to use in problem solving and communication for 2021, 2023, and 2024; - review of provider policies and procedures for 2021, 2022, 2023, and 2024; and - the principles of person-centered planning and service delivery for 2023 and 2024. ULP-B ULP-B had a hire date of November 5, 2022. ULP-B provided direct services to residents. On September 10, 2024, at 10:30 a.m., the surveyor observed ULP-B prepare and administer medications for R3. ULP-B's employee record lacked training for the following required topics: - review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights for 2023 and 2024; and - review of provider policies and procedures for 2023 and 2024. On September 10, 2024, at 1:45 p.m., O/LALD-C stated annual training was completed during the employee's anniversary month and expected to be completed by the end of that month each year. O/LALD-C stated annual training was completed	01500		

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01500	Continued From page 19 via Educare (online learning management system). They were the one responsible to assign the Educare modules and monitor to ensure completion of education for each employee. O/LALD-C stated training on facility policies and procedures was completed by pulling a paper packet of policies, having employees review, and sign off that they had done that or having employees review the policies in an electronic format. O/LALD-C stated they did not have a set procedure or tracking method for annual training of provider policies and procedures. The licensee's undated Annual Training Requirements policy indicated all employees that provided direct care services would complete at least eight hours of annual training for each twelve months of employment. Evidence of training would be maintained in each individual's employee record. The annual training would include: - training on reporting of maltreatment of vulnerable adults; - review of the Assisted Living Bill of Rights and staff responsibilities related to ensuring the exercise and protection of those rights; - review of infection control techniques; - effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; - review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and - principles of person-centered planning and service delivery and how they apply to services provided by each employee.	01500		

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01500	Continued From page 20 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
01530 SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide employees	01530		

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01530	Continued From page 21 with the initial eight (8) hours of dementia training for two of five direct care employees (unlicensed personnel (ULP)-B, ULP-D). In addition, the licensee failed to provide employees with the required two hours of annual dementia care training for one of three direct care employees (owner/ licensed assisted living director (O/LALD)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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-B ULP-B had a hire date of November 5, 2022. ULP-B provided direct services to residents. On September 10, 2024, at 10:30 a.m., the surveyor observed ULP-B prepare and administer medications for R3. ULP-B's employee record included 7.5 hours of dementia training in 2023, however lacked the required full eight hours of initial training within 160 hours of the start date for providing direct care to assisted living residents. ULP-D ULP-D had a hire date of June 1, 2023. ULP-D provided direct services to residents. ULP-D's employee record included 4 hours of dementia training in August of 2024, however	01530		

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01530	Continued From page 22 lacked the required full eight hours of initial training within 120 hours of the start date for providing direct care to assisted living residents. O/LALD-C O/LALD-C opened the facility and began employment June 1, 2020. O/LALD-C provided direct services to residents. O/LALD-C's employee record lacked the required two hours of annual dementia training for 2021, 2023, and 2024. On September 10, 2024, at 1:45 p.m., O/LALD-C stated dementia training was assigned at hire and annually for all employees. Annual training was completed during the employee's anniversary month and expected to be completed by the end of that month each year. O/LALD-C stated they were the one responsible to assign the training and monitor to ensure the training was completed. The licensee's undated Dementia Care Training policy indicated licensee provided dementia training to all direct care staff and their supervisors. Supervisors of direct-care staff would have at least eight hours of initial training within 120 working hours of employment start date. Direct care employees would have completed at least eight hours of initial training on required topics in the first 160 hours from employment. All employees would have at least two hours of dementia related education for every twelve months of employment. In addition, the policy indicated until the employee's initial eight hours of training was complete, the employee must not provide direct care unless there was another employee on site	01530		

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01530	Continued From page 23 who had completed the initial eight hours of training related to dementia care and who can act as a resource and assist as needed. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
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 interview and record review, the licensee failed to execute a signed service plan to	01640		

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01640	Continued From page 24 include services being provided by the licensee for two of two 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) 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: R2 R2 was admitted to the licensee and began receiving assisted living services on June 26, 2024. R2's diagnoses included major depressive disorder, anxiety, post-traumatic stress disorder, alcohol dependence, and anti-social personality disorder. R2's Service Plan, dated June 26, 2024, was signed by R2 and owner/ licensed assisted living director (O/LALD)-C and indicated R2 received services for medication reminders and administration daily, hygiene/grooming assistance weekly, housekeeping daily, linen change weekly, and meal preparation daily. R2's service sign off record dated September 1-10, 2024, indicated R2 received the following services which were not included on R2's service plan: - assistance with self-administration of medications twice daily; - assistance making appointments; - laundry without frequency specified;	01640		

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01640	Continued From page 25 - manage orientation issues three times daily; - manage anxiety three times daily; - manage agitation three times daily; - manage self-injurious behavior three times daily; and - "Meet other cognitive/mental health need" with space to enter a specific for monitoring was included three times without anything listed with staff signing off that it was completed three times daily. R2's Evaluation/ Baseline/ Post-Hospital Assessment, dated June 26, 2024, indicated R2 required supervision/ oversight with dressing, bathing, hair care, and shaving. The assessment indicated R2 required assistance with finances, shopping, laundry, housekeeping, food preparation, appointments, and transportation. The assessment specified staff would work with R2 weekly for budgeting needs and that staff would administer all of R2's medications. On September 12, 2024, at 12:30 p.m., unlicensed personnel (ULP)-E stated they assist R2 with picking out clean clothes, do laundry when needed, administer medications, prepare meals and snacks, make sure R2 wears their compression stockings at night, encourage R2 to take showers, and cleans up after them. On September 11, 2024, at 1:42 p.m., via telephone interview, clinical nurse supervisor (CNS)-A verified R2 received the following services that should be on the service plan and service sign off record: -medication administration twice daily with no medication reminders and no self-administration of medications; - laundry weekly; - check if wearing compression stockings daily;	01640		

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01640	Continued From page 26 - grooming, hair care, dressing, shaving reminders daily; - shower reminder weekly; - assistance with shopping, appointments, and transportation as needed; and - vital signs weekly. R3 R3 was admitted to the licensee and began receiving assisted living services on November 26, 2022. R3's diagnoses included paranoid schizophrenia, anxiety, antisocial personality disorder, and marijuana abuse. R3's Service Plan, dated November 26, 2022, was signed by R3 and O/LALD-C and indicated R3 received medication administration, grooming, dressing, laundry, housekeeping, and meal preparation. There was not a frequency listed for any of the services. R3's service sign off record dated September 1-10, 2024, indicated R3 received the following services which were not included on R3's service plan: - assistance with self-administration of medications twice daily; - verbal/ visual medication reminders twice daily; - assistance making appointments; - laundry without frequency specified; - manage orientation issues three times daily; - manage anxiety three times daily; - manage agitation three times daily; - manage self-injurious behavior three times daily; and - "Meet other cognitive/mental health need" with space to enter a specific for monitoring was included three times without anything listed with	01640		

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01640	Continued From page 27 staff signing off that it was completed three times daily. R3's Baseline Assessment, dated June 26, 2024, indicated R3 required minor assistance with dressing; supervision with shaving, eating, and self-preservation; and assistance with hair care. The assessment indicated R3 required assistance with finances, shopping, laundry, housekeeping, food preparation, appointments, and transportation. On September 12, 2024, at 12:30 p.m., ULP-E stated they assist R3 with picking out clean clothes, do laundry when needed, administer medications, prepare meals and snacks, encourage R3 to take showers, and cleans up after them. On September 11, 2024, at 1:42 p.m., via telephone interview, CNS-A verified R3 received the following services that should be on the service plan and service sign off record: - medication administration twice daily with no medication reminders and no self-administration of medications; - laundry weekly; - grooming, hair care, dressing, shaving reminders daily; - shower reminder weekly; - assistance with shopping, appointments, and transportation as needed; and - vital signs weekly. On September 9, 2024, at 2:05 p.m., CNS-A stated they collaborated with O/LALD-C to complete the service plan based on the resident's needs identified during their assessment. On September 12, 2024, at 2:00 p.m., O/LALD-C	01640		

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01640	Continued From page 28 reviewed the service plan and staff documentation with the surveyor. O/LALD-C agreed services provided were not consistent or accurate from assessment to the service plan to the staff documentation. The licensee's undated Service Plan policy indicated assisted living services would be provided according to the current written service plan. The service plan would be based on nursing assessment, resident needs, preferences, and accepted standards of practice for professional nursing or other relevant standards. All services provided would be agreed upon and included on the service plan. The service plan and any revisions would include a signature or other authentication by the assisted living provider and by the resident or resident's representative documenting agreement on the services to be provided. The service plan would be revised as needed based on resident assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01710 SS=F	144G.71 Subd. 3 Individualized medication monitoring and reas The assisted living facility must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. This MN Requirement is not met as evidenced by:	01710		

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01710	Continued From page 29 Based on observation, interview, and record review, the licensee failed to monitor and reassess the resident's medication management services at least annually for one of one resident (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: R3 was admitted to the licensee and began receiving assisted living services on November 26, 2022. R3's diagnoses included paranoid schizophrenia, anxiety, antisocial personality disorder, and marijuana abuse. R3's Service Plan, dated November 26, 2022, indicated R3 received medication administration, grooming, dressing, laundry, housekeeping, and meal preparation. R3's medication administration record (MAR) dated September 2024, indicated R3 was receiving amlodipine 10 mg one tablet by mouth daily, tab-a-vite (multivitamin) one tablet by mouth daily, carvedilol 25 mg one tablet by mouth twice daily, Eliquis 5 mg one tablet by mouth twice daily, risperidone 3 mg one tablet by mouth every night at bedtime, rosuvastatin 5 mg one-half tablet totaling 2.5 mg every night at bedtime,	01710		

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01710	Continued From page 30 Risperdal Consta 50 mg injection inject 50 mg intramuscular (IM) every two weeks, and Senna 8.6 mg one tablet by mouth twice daily as needed for constipation. On September 10, 2024, at 10:30 a.m., the surveyor observed ULP-B prepare and administer R3's medications. On September 11, 2024, at 1:42 p.m., via telephone interview, clinical nurse supervisor (CNS)-A stated the medication management assessment was part of the admission assessment document and completed when a new resident moved into the facility. CNS-A stated they updated the plan with changes as needed but have not updated or repeated the medication management assessments. CNS-A verified R3's record lacked monitoring and reassessment of medication management services annually as required for the above content. The licensee's undated Nursing Assessment and Reassessment of Residents policy indicated an assessment for the need of medication management services would be completed on or before a new resident moved in and ongoing to meet state requirements. The assessment for medication management would be face to face with the resident and include: - full review of all medications the resident is known to be taking including over the counter medications, prescription medications, and supplements: - identification of all medications and providing indications, potential side effects and contraindications; - identification of allergies and sensitivities to medications;	01710		

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01710	Continued From page 31 - identification of potential adverse reactions and how to address those issues; and - interventions to prevent diversion of the medications by the resident or by others who have access to the medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01710		
01870 SS=D	144G.71 Subd. 18 Medications provided by resident or family me When the assisted living facility is aware of any medications or dietary supplements that are being used by the resident and are not included in the assessment for medication management services, the staff must advise the registered nurse and document that in the resident record. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have awareness of over-the-counter medications in possession of one of two residents (R2). 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:	01870		

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01870	Continued From page 32 R2 was admitted to the licensee and began receiving assisted living services on June 26, 2024. R2's diagnoses included major depressive disorder, anxiety, post-traumatic stress disorder, alcohol dependence and anti-social personality disorder. R2's Service Plan, dated June 26, 2024, indicated R2 received medication administration, grooming, housekeeping, and meal preparation. R2's Medication Management Assessment, dated June 26, 2024, indicated R2 required assistance with medication administration and that all R2's medications would be stored in the secure locked cabinet in the living room. On September 9, 2024, at 11:59 a.m., the surveyor observed one bottle of miconazole nitrate 2 percent (%) antifungal powder (common over the counter powder for Athlete's Foot) on the nightstand in R2's room. On September 9, 2024, at 2:05 p.m., clinical nurse supervisor (CNS)-A stated they were not aware R2 had antifungal powder in their room. CNS-A stated they would not usually have residents store medications in their rooms. CNS-A stated R2 might be able to use the powder themselves and it would be okay. However, CNS-A had not assessed this as they were not aware of the powder. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01870		

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01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to monitor the medication refrigerator temperature. This had the potential to affect all residents with refrigerated medications. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R3 was admitted to the licensee and began receiving assisted living services on November 26, 2022. R3's Service Plan, dated November 26, 2022, indicated R3 received medication administration, grooming, dressing, laundry, housekeeping, and meal preparation. R3's Medication Management Plan, dated November 26, 2022, indicated R3 required assistance with medication administration and storage.	01880		

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01880	Continued From page 34 On September 9, 2024, at 2:54 p.m., the surveyor observed the medication storage refrigerator. The medication refrigerator lacked the presence of a thermometer. No temperature log was observed to be on or near the medication refrigerator. The medication refrigerator contained one Risperdal Consta 50 milligram (mg) single use dose pack prescribed to R3. The manufacturer's instructions on the package label indicated the medication should be stored in refrigerator between thirty-six- and forty-six-degrees Fahrenheit. On September 9, 2024, at 2:54 p.m., when asked about a method of checking the temperature of the medication refrigerator and a record of the temperature history, CNS-A stated they had not been checking the temperature of the refrigerator. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service	01910		

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01910	Continued From page 35 contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to dispose of medications remaining with the facility that were expired upon termination of the service contract for two of two residents (R1, R4). 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 September 9, 2024, at 2:50 p.m., when reviewing the current resident medication storage area with clinical nurse supervisor (CNS)-A, the surveyor observed medications in the facility medication storage area that were prescribed to R1 and R4. R1 R1 was admitted to the licensee and began receiving assisted living services on December 3,	01910		

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01910	Continued From page 36 2021. R1's diagnoses included schizoaffective disorder, bipolar disorder, and cocaine use disorder. R1 was discharged from licensee on June 28, 2024. R1's ammonium lactate 12 percent (%) cream was in the facility medication storage on September 9, 2024. R4 R4 was admitted to the licensee and began receiving assisted living services on July 21, 2021. R4's diagnoses included major depressive disorder, anxiety, post-traumatic stress disorder, alcohol dependency, and stimulant dependency. R4 was discharged from licensee to another facility on April 7, 2023. R4's nicotine 4 milligram (mg) lozenges box of 72 and polyethylene glycol 3350 bottle of powder were in the facility medication storage on September 9, 2024. On September 9, 2024, at 3:00 p.m., clinical nurse supervisor (CNS)-A stated they had sent all R1 and R4's current medications with them when they discharged but did not include the medications remaining because they were expired. CNS-A stated they had planned to destroy them but had not done that yet. CNS-A stated there was not a clear area for medications to be destroyed so they were in with the current resident's medication overflow area. CNS-A put them in a separate bag marked to be destroyed.	01910		

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01910	Continued From page 37 The licensee's undated Medication Disposition or Disposal policy indicated all prescription drugs managed and secured by the facility that are left with after the death or termination of services for a resident for whom the drug was prescribed, or any prescription drug permanently discontinued, must be destroyed by the nurse or pharmacist with one other person as a witness. The policy specified that discontinued or unused medications would be destroyed within one month or less of the time they are discontinued or the day of death or discharge of the resident. In addition, staff would document the disposition or disposal of medications in the resident record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
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, interview, and record review, the licensee established written house rules and regulations that used language which limited the rights for one of one resident (R2). This had the potential to affect all residents residing within the facility.	02290		

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02290	Continued From page 38 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 September 9, 2024, at approximately 12:00 p.m., during a tour of the facility, the surveyor observed a sign titled House Rules- Reminder, near the front door of the facility. The sign indicated resident guests were not allowed in the facility before 8:00 a.m., after 8:00 p.m., and were not allowed to spend the night. In addition, resident's guests were not allowed to open the refrigerator, use the facility stove, go into the basement, use the bathroom to shower, or sit unnecessarily long in the bathroom. R2's Service Plan, dated June 26, 2024, indicated R2 received medication administration, grooming, housekeeping, and meal preparation. R2's Assisted Living Contract was signed on June 26, 2024. R2's record included Rules & Regulation- Addendum to Lease, signed by R2 on June 26, 2024. The Rules & Regulation- Addendum to Lease included: - "resident can have guest(s) at his/her room for a visit daytime. No overnight guest is allowed in the facility; - guests are free to enter the facility daily from 8:00AM and MUST leave the facility no later than 8:00PM;	02290		

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MERCY CAREGIVERS OF MINNESOTA	2942 OLIVER AVENUE NORTH MINNEAPOLIS, MN 55411

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02290	Continued From page 39 - no cooking or use of stove after 10:00PM. Clients are free to use the microwave after 10:00PM; - zero tolerance for Marijuana, Alcohol, Drugs or any Drug paraphernalia at the facility; - absolutely, no smoking or vaping in your room or at any of the common areas inside the facility. We have a designated smoking area outside the front door by the garage; - no resident should share, give or distribute alcohol, marijuana, drugs or any vape materials with drug content to any other resident; - resident must not threaten or endanger his/her own life or that of any other client or staff; - no physical or verbal aggression towards other clients or staff of the facility; - resident must sign a Leave of Absence (LOA) if you are leaving the facility and passing the night somewhere. Staff will pack your medications for you; - no resident is permitted to stay or sleep overnight in the room of another resident; - no resident must stay longer than 10:00PM in the room of another resident; - facility reserved the right to check the room of any resident without an advance notice for drugs, alcohol or any drug paraphernalia; - facility will declare a resident missing after 24 hours of leaving the facility, if management cannot determine the precise location of the resident or if the resident is not reachable by phone or text message. We will start the discharge process from the facility immediately thereafter; - facility will start the discharge process of any resident that violate any of these rules". Following the rules and regulations above the document indicated "Signed Management" of the facility. There was a space for the resident name,	02290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37390	A. BUILDING: _____ B. WING _____	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERCY CAREGIVERS OF MINNESOTA	2942 OLIVER AVENUE NORTH MINNEAPOLIS, MN 55411

(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 40 signature, and date after the following statement, "I HAVE READ, UNDERSTOOD AND IN AGREEMENT WITH THIS ADDENDUM TO THE LEASE". On September 12, 2024, at 2:00 p.m., owner/ licensed assisted living director (O/LALD)-C stated they had developed the house rules to help protect the residents. O/LALD-C stated they are vulnerable adults under their responsibility and don't always make good decisions, and the house rules help guide them in the best direction. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02290		

Minnesota Department of Health
Food, Pools, and Lodging Services
625 Robert Street North
St. Paul
6512014500

Type: Full
Date: *09/09/24*
Time: 11:08:14
Report: 1029241301

Food and Beverage Establishment Inspection Report

Location:

Mercy Caregivers Of Minnesota
2942 Oliver Avenue North
Minneapolis, MN55411
Hennepin County, 27

Establishment Info:

ID #: 0038611
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 6122221829
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.

4-300 Equipment Numbers and Capacities

4-302.12B ***** Priority 2 *****

MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.

NO SMALL DIAMETER PROBE THERMOMETER. OPERATOR INSTRUCTED TO OBTAIN AND USE SMALL DIAMETER PROBE THERMOMETER.

Comply By: 09/27/24

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.11

MN Rule 4626.1515 Maintain the physical facilities in good repair.

SLIGHT CHIPPING TO PAINT ON CABINETRY AND DRAWERS. MDF EXPOSED IN ONE CABINET. OPERATOR INSTRUCTED TO MAKE SURFACES SMOOTH, DURABLE, EASILY CLEANABLE, AND NON-ABSORBENT.

Comply By: 12/13/24

Surface and Equipment Sanitizers

HOT WATER: = at 160 Degrees Fahrenheit
Location: DISHWASHER (THERMAL STICKER)
Violation Issued: No

Food and Equipment Temperatures

Process/Item: COLD HOLD/MILK
Temperature: 39 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: No

Type: Full
Date: *09/09/24*
Time: 11:08:14
Report: 1029241301
Mercy Caregivers Of Minnesota

Food and Beverage Establishment Inspection Report

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

Kitchen is residential in nature. Establishment uses a Maytag dishwasher with a sanitize option that purportedly raises the water temperature in the final rinse to approximately 154°F which sanitizes the dishes and glassware in accordance with NSF/ANSI Standard 184 for Residential Dishwashers. Operator used a TempRite thermal sticker to verify a utensil surface temperature of at least160°F. Establishment does not currently serve a high susceptible population.

Foodborne illness risk factors, employee illness logging and exclusion protocol, temperature control, sanitizing, date marking, and other food safety topics discussed. Issues identified during the inspection were addressed with the operator.

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 1029241301 of 09/09/24.

Certified Food Protection Manager: ADELEKE T. IJIYODE

Certification Number: FM110890 Expires: 04/14/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
ADELEKE T. IJIYODE
LALD

Signed: Trevor McCliment
Trevor McCliment
Public Health Sanitarian
Metro District Office
651-201-3957
trevor.mccliment@state.mn.us

Report #: 1029241301

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Food, Pools, and Lodging Services
625 Robert Street North
St. Paul

No. of RF/PHI Categories Out	0	Date	09/09/24
No. of Repeat RF/PHI Categories Out	0	Time In	11:08:14
Legal Authority MN Rules Chapter 4626		Time Out	

Mercy Caregivers Of Minnesota	**Address** 2942 Oliver Avenue North	**City/State** Minneapolis, MN	**Zip Code** 55411	**Telephone** 6122221829
License/Permit # 0038611	**Permit Holder**	**Purpose of Inspection** Full	**Est Type**	**Risk Category**

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item — Mark "X" in appropriate box for COS and/or R

IN= in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

	Compliance Status		COS	R
	Supervision			
1	(IN) OUT	PIC knowledgeable; duties & oversight		
2	(IN) OUT N/A	Certified food protection manager, duties		
	Employee Health			
3	(IN) OUT	Mgmt/Staff;knowledge,responsibilities&reporting		
4	(IN) OUT	Proper use of reporting, restriction & exclusion		
5	(IN) OUT	Procedures for responding to vomiting & diarrheal events		
	Good Hygenic Practices			
6	IN OUT (N/O)	Proper eating, tasting, drinking, or tobacco use		
7	(IN) OUT N/O	No discharge from eyes, nose, & mouth		
	Preventing Contamination by Hands			
8	IN OUT (N/O)	Hands clean & properly washed		
9	IN OUT N/A (N/O)	No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10	(IN) OUT	Adequate handwashing sinks supplied/accessible		
	Approved Source			
11	(IN) OUT	Food obtained from approved source		
12	IN OUT N/A (N/O)	Food received at proper temperature		
13	(IN) OUT	Food in good condition, safe, & unadulterated		
14	IN OUT (N/A) N/O	Required records available; shellstock tags, parasite destruction		
	Protection from Contamination			
15	(IN) OUT N/A N/O	Food separated and protected		
16	(IN) OUT N/A	Food contact surfaces: cleaned & sanitized		
17	(IN) OUT	Proper disposition of returned, previously served, reconditioned, & unsafe food		

	Compliance Status		COS	R
	Time/Temperature Control for Safety			
18	IN OUT N/A (N/O)	Proper cooking time & temperature		
19	IN OUT N/A (N/O)	Proper reheating procedures for hot holding		
20	IN OUT N/A (N/O)	Proper cooling time & temperature		
21	IN OUT (N/A) N/O	Proper hot holding temperatures		
22	(IN) OUT N/A	Proper cold holding temperatures		
23	IN OUT N/A (N/O)	Proper date marking & disposition		
24	IN OUT (N/A) N/O	Time as a public health control: procedures & records		
	Consumer Advisory			
25	IN OUT (N/A)	Consumer advisory provided for raw/undercooked food		
	Highly Susceptible Populations			
26	(IN) OUT N/A	Pasteurized foods used; prohibited foods not offered		
	Food and Color Additives and Toxic Substances			
27	IN OUT (N/A)	Food additives: approved & properly used		
28	(IN) OUT	Toxic substances properly identified, stored, & used		
	Conformance with Approved Procedures			
29	IN OUT (N/A)	Compliance with variance/specialized process/HACCP		

Risk factors (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is **not** in compliance — Mark "X" in appropriate box for COS and/or R — **COS=** corrected on-site during inspection **R=** repeat violation

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

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

Food Recalls: _____

Person in Charge (Signature) **Date:** 09/09/24

Inspector (Signature) Trevor McCliment