DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

July 3, 2023

Licensee
Second Home Healthcare LLC
2421 18th Avenue Northwest
Rochester, MN 55901

RE: Project Number(s) SL38165015

Dear Licensee:

On June 28, 2023, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the May 8, 2023, 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,

Paul Spencer, Supervisor
State Rapid Response Team
Email: paul.spencer@state.mn.us
Telephone: 651-587-4460 Fax: 651-215-6894

JMD

Electronically Delivered

May 31, 2023

Licensee
Second Home Healthcare, LLC
2421 18th Avenue Northwest
Rochester, MN 55901

RE: Project Number(s) SL38165015

Dear Licensee:

This is your **official notice** that you have been **granted your assisted living facility license.** Your license effective and expiration dates remain the same as on your provisional license. Your updated status will be listed on the license certificate at renewal and **this letter serves as proof** in the meantime. If you have not received a letter from us with information regarding renewing your license within 60 days prior to your expiration date, please contact us at (651) 201-5273 or by email at Health.assistedliving@state.mn.us.

The Minnesota Department of Health completed an initial survey on May 8, 2023, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

STATE CORRECTION ORDERS
The enclosed State Form documents the state correction orders. The Department of Health documents state correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Home Care 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 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 and enforcement actions 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
Per 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 residents/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 issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the Department of Health within 15 calendar days of the correction order receipt date.

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

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.

If you have any questions, please contact me.

Sincerely,

Paul T. Spencer

Paul Spencer, Supervisor
State Rapid Response Team
Email: paul.spencer@state.mn.us
Telephone: 651-201-4222 Fax: 651-215-6894
PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38165	A. BUILDING: _____ B. WING _____	05/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SECOND HOME HEALTHCARE LLC	2421 18TH AVENUE NORTHWEST ROCHESTER, MN 55901

(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****** ******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: SL38165015 On May 1st, 2023, through May 8th, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following immdiecate correction orders are issued. At the time of the survey, there was one active resident receiving 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.	
0 110 SS=F	144G.10 Subdivision 1a Assisted living director license required Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports.? This MN Requirement is not met as evidenced	0 110		

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0 110	Continued From page 1 by: Based on interview and record review, the licensee failed to ensure the licensed assisted living director (LALD) was listed as the Director of Record for the licensee. This had the potential to affect all 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: On May 2nd, 2023, at approximately 08:40 a.m., LALD-C stated she was the LALD for licensee. LALD-D obtained an assisted living director license on October 31, 2022. On May 2nd, 2023, at 10:00 a.m., the Board of Executives for Long-Term Services and Support (BELTSS) website indicated LALD-C held a current assisted living director license. The BELTSS website did not indicate LALD-C was listed as the Director of Record for the licensee. On May 2nd, 2023, at approximately 5:24 p.m., LALD-C acknowledged they were not listed as the Director of Record for licensee. LALD-C stated they were not aware of the requirement for the Director of Record. No further information provided.	0 110		

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0 110	Continued From page 2 TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
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 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 and interview, the licensee failed to develop and implement a staffing plan for determining its staffing level that:	0 470	Plan of correction provided by facility May 3, 2023 and immediacy removed.	

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0 470	Continued From page 3 - ensured 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 - ensured 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. - 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; It is potentially affecting all licensee's current 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 May 1st, 2023, at 9:07 a.m., resident (R)1 stated the night staff just left and he was home by himself waiting for the bus to pick him up for work. He stated he worked from 10 a.m. to 1:30 p.m. He said the night shift started from 7 p.m. to 9 a.m., and the evening shift started from 2 p.m. to 7 p.m. On May 1st, 2023, at 03:46 p.m., ULP-A stated the social worker told him he could leave the	0 470		

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0 470	Continued From page 4 resident by himself at home so he left early to run errands. He said the resident wanted to do everything himself and could do most personal care independently. He also said there was a staffing schedule available but did not know it needed to be posted. On May 1st, 2023, at 03:50 p.m.,ULP-D also stated she was not aware she needed to develop a staffing plan. She also said she did not know the schedule needed to be posted. The licensee lacked a policy to include the requirement to post a daily staffing schedule. TIME PERIOD FOR CORRECTION: Immediate.	0 470		
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	0 680		

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0 680	Continued From page 5 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 document review, the licensee failed to develop a written emergency disaster plan (EP) with all the required content. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On May 2nd, 2023, at 9:02 p.m. ULP-D provided a copy of the licensee's EP policy developed August 1, 2022. Review of Second Home Healthcare LLC Emergency Guide, dated August 1,2022, revealed that it lacked the following required content: - Conduct exercises at least twice a year including an annual full-scale exercise that is community based or individual based functional exercise or if facility experiences an actual emergency; and an additional annual exercise that may include a full scale exercise or mock	0 680		

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0 680	Continued From page 6 disaster drill or table-top exercise. - A communication plan that includes arrangements with other facilities and names and contact information for staff, resident physicians, and other facilities. Additionally, the licensee did not do the following: -Post the plan in a prominent area. -Provide residents with exit diagrams. -Post emergency exit diagrams on each floor. -Make emergency and disaster training annually available to the residents TIME PERIOD FOR CORRECTION: Seven (7) days	0 680		
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 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. This deficient condition had the potential to affect all staff, residents, and visitors.	0 800		

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0 800	Continued From page 7 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). Findings include: On May 8, 2023, between 9:00 a.m. and 9:30 a.m., survey staff toured the facility with the licensed assisted living director (LALD)-C and administrative staff (ULP)-D. During the facility tour, survey staff observed that a key-only lock was installed on the door for a vacant resident bedroom. A key was not available to unlock the door during the facility tour. Locks controlled only by key could delay the occupant's ability to exit the room and the building in a timely and efficient manner in the event of an emergency. On May 8, 2023, at approximately 10:15 a.m., the LALD-C and ULP-D verified this deficient condition. TIME PERIOD FOR CORRECTION: Two (2) 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 plans shall include but are not limited to: (1) location and number of resident sleeping rooms;	0 810		

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0 810	Continued From page 8 (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, record review, and interview, the licensee failed to develop the fire safety and evacuation plans with the required elements and failed to meet the evacuation drill frequency requirements. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a	0 810		

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0 810	Continued From page 9 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). Findings include: On May 8, 2023, between 9:00 a.m. and 9:30 a.m., survey staff toured the facility with the licensed assisted living director (LALD)-C and administrative staff (ULP)-D. During the facility tour, survey staff observed that a room labeled as a bedroom on the evacuation map was being used as an office. The LALD-C and ULP-D explained during the tour that this room was only used as an office because the windows did not meet the minimum size requirements for egress. Record review of available documentation was completed on May 8, 2023, between 9:30 a.m. and 10:00 a.m. Record review of the available documentation indicated that the office was labeled as a bedroom in the evacuation plans. Record review of the available documentation did not indicate that evacuation drills were conducted twice per year per shift with at least one evacuation drill every other month as required. The fire drill log had an evacuation drill recorded on 09/28/2022. No additional evacuation drills had been recorded. No further information was provided. On May 8, 2023, at approximately 10:15 a.m., the LALD-C and ULP-D verified these deficient	0 810		

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0 810	Continued From page 10 conditions.	0 810		
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 ensure medications were properly stored and secured. This had the potential to affect all residents in 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, 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). Findings include: During an observation on May 1st, 2023, at 9:07 a.m., the investigator observed the doorknob of the closet labeled 'medication' had a key hanging on it. The resident was at home alone, and no staff members were present. On May 1st, 2023, at 03:46 p.m., when asked about the medication closet, ULP-A stated that it was supposed to be locked, but when asked where the key was, he said the key attached to	01880		

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01880	Continued From page 11 the doorknob of the closet. The licensee's "Storage/Control of Medications" policy dated August 1 , 2022, indicated all prescription drugs would be securely locked in substantially constructed compartments and only authorized personnel would have access to the stored medications. TIME PERIOD FOR CORRECTION: Seven (7) days.	01880		

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

Type: Full
Date: *05/03/23*
Time: 08:55:43
Report: 8044231149

Food and Beverage Establishment Inspection Report

Location:
Second Home Health Care LLC
2421 18th Ave NW
Rochester, MN55901
Olmsted County, 55

Establishment Info:
ID #: 0041241
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/23

Operator:

Phone #:
ID #:

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

The following orders were issued during this inspection.

2-200 Employee Health

2-201.11C ** Priority 1 **

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

No illness log.

Illness log provided by inspector.
Comply By: 05/03/23

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 40.4 Degrees Fahrenheit - Location: Chicken in refrigerator
Violation Issued: No

Process/Item: Cold Holding
Temperature: 38.0 Degrees Fahrenheit - Location: Refrigerator
Violation Issued: No

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

HRD inspection conducted with Lena Gangestad and Rob Davis.

Inspection report reviewed on site with owner, Makena.

Type: Full
Date: *05/03/23*
Time: 08:55:43
Report: 8044231149
Second Home Health Care LLC

Food and Beverage Establishment Inspection Report

Establishment Info: athieei116@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 8044231149 of 05/03/23.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Signed:_____
Inspector signed for Makenna

Signed:_____
Michael DeMars, RS
Public Health Sanitarian III
Rochester District Office
507-206-4715
michael.demars@state.mn.us