DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF REMOVAL OF CONDITIONAL LICENSE

Electronic Delivery

December 19, 2022

Administrator
Warm Touch Home Care Inc
7548 Fremont Avenue North
Brooklyn Park, MN 55444

RE: Initial License Number 409103
Health Facility Identification Number (HFID) 36282
Project Number(s) SL36282015

Dear Administrator:

On December 8, 2022, The Minnesota Department of Health (MDH) completed a follow-up evaluation of your facility to determine correction of orders found on the licensing evaluation completed August 10, 2022. The follow-up evaluation found the facility to be in substantial compliance. **Based on these findings, the condition(s) on the license were removed effective December 08, 2022.**

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact Jonathan Hill, Evaluation Supervisor, at 651-201-3993.

Sincerely,

Maria King

Maria King, RN
Division Director

Minnesota Department of Health
Health Regulation Division

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF CONDITIONAL LICENSE

Electronically Delivered

October 6, 2022

Administrator
Warm Touch Home Care Inc
7548 Fremont Avenue North
Brooklyn Park, MN 55444

RE: Conditional License Number 409103
Health Facility Identification Number (HFID) 36282
Project Number(s) SL36282015

Dear Administrator:

The Minnesota Department of Health (MDH) completed a licensing evaluation on August 10, 2022 or the purpose of assessing compliance with state licensing statutes. Based on the licensing evaluation results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, MDH is issuing a 90 day conditional license due to expire on **January 4, 2023**.

LICENSING ORDERS
The enclosed State Form documents the state licensing orders. The Department of Health documents state licensing 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 . . ."

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

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

mechanism authorized in § 144G.20.

Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in §144G.20.

In accordance with Minn. Stat. § 144G.20, Subd. 4(a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572. Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4(a)(5)(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

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

St - 0 - 0110 - 144g.10 Subd. 1a - Assisted Living Director License Required - $3,000.00
St - 0 - 0340 - 144g.30 Subd. 5 - Correction Orders - $3,000.00
St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00
St - 0 - 1390 - 144g.62 Subd. 1 - Availability Of Contact Person To Staff - $3,000.00
St - 0 - 1690 - 144g.71 Subd. 1 - Medication Management Services - $3,000.00
St - 0 - 1710 - 144g.71 Subd. 3 - Individualized Medication Monitoring And - $3,000.00
St - 0 - 1730 - 144g.71 Subd. 5 - Individualized Medication Management Plan - $3,000.00
St - 0 - 1750 - 144g.71 Subd. 7 - Delegation Of Medication Administration - $3,000.00
St - 0 - 1760 - 144g.71 Subd. 8 - Documentation Of Administration Of Medication - $3,000.00
St - 0 - 1770 - 144g.71 Subd. 9 - Documentation Of Medication Setup - $3,000.00
St - 0 - 1820 - 144g.71 Subd. 13 - Prescriptions - $3,000.00

The total amount you are assessed is $30,500.00. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction for
approval.

The correction order documentation should include the following:

a. Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
b. Identify how the area(s) of noncompliance was corrected for all of the provider's residents/employees that may be affected by the noncompliance.
c. 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 licensing 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 general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing (but not both) under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15business days of the correction order.

Conditional License Issued:
MDH will issue Warm Touch Home Care Inc a conditional assisted living facility license for 90 calendar days from the date of this notice. At an unannounced point in time, within the 90 calendar days, MDH will conduct a follow-up evaluation, as defined in Minn. Stat. § 144G.30, Subd. 6. Based on the results of the follow-up evaluation, MDH will determine if Warm Touch Home Care Inc is in compliance.

The following conditions apply on the conditional assisted living facility license:

a. **No new substantiated maltreatment allegations:** If any new investigations begin in the conditional license period, and the allegations are substantiated, MDH may pursue additional enforcement actions up to and including immediate temporary suspension and revocation of the license.

b. **No new admissions:** Warm Touch Home Care Inc will not admit any new residents under its conditional assisted living facility license until the MDH removes the "no new admissions" condition. Warm Touch Home Care Inc

must provide the Department:

i. A list of the names and birthdates of any individuals Warm Touch Home Care Inc is currently in the process of admitting. These individuals will be able to continue the admittance process.

ii. A list of all current residents by location including:
    1. Name and birthdate of each resident
    2. Physical location of each resident
    3. Current payment source for services
    4. If Elderly Waiver, the name and contact information of the care coordinator/case manager
    5. If the resident is not able to make informed decisions, the name of their representative and how to contact the representative

c. Consultant: Warm Touch Home Care Inc will contract with an RN to provide consultation concerning all resident(s) to whom Warm Touch Home Care Inc provides licensed assisted living services under the conditional license. The consultant must have access to all resident(s) receiving services from Warm Touch Home Care Inc. The consultant will conduct initial and ongoing evaluations of the provider. Direct resident observation may be required based on the consultant's judgement or at the discretion of MDH. The RN must not have any affiliation with Warm Touch Home Care Inc and MDH must review the RN's credentials and approve the selection. Warm Touch Home Care Inc is responsible for the expense of the contract with the RN. The main purpose of the consultant is to provide guidance to Warm Touch Home Care Inc in an effort to help Warm Touch Home Care Inc align their practices with the requirements of Minn. Stat. §§ 144G.01 – 144G.9999 and to provide oral and written reports to MDH noting progress toward compliance and/or concerns about observations. Warm Touch Home Care Inc will develop and implement policies, procedures, and processes specific to the offered services in accordance with the guidance provided by the consultant to ensure ongoing monitoring and compliance with statutory requirements.

d. Reports: The RN consultant will provide MDH with regular reports at intervals specified by MDH. Reports will begin on a weekly basis until MDH notifies Warm Touch Home Care Inc and the RN consultant about a change. Each report will be electronically submitted to Jonathan Hill, Evaluator Supervisor, State Evaluation Team, Health Regulation Division, at jonathan.hill@state.mn.us. Jonathan Hill can be reached at 651-592-5119 (office) with questions about reports. The content of the reports will include information such as:

i. Progress towards correction of licensing orders;
ii. Observations of staff delivering assisted living services and the level of

competency observed;
iii. Conversations with residents and family members about satisfaction with assisted living services;
iv. Conversations with staff about their level of knowledge about the tasks they perform, the people they serve and the health professionals who delegate to them;
v. Overall impressions about the quality of the assisted living services delivered;
vi. Overall impressions about the dignity with which the residents and their family members are treated;
vii. Concerns; and
viii. Any other information requested by the Department or considered important by the RN consultant(s).

e. Monitoring visits: MDH may make unannounced monitoring visits to assess the progress of Warm Touch Home Care Inc to correct the violations cited during the evaluation as well as to determine the overall practice of Warm Touch Home Care Inc in meeting the needs of the people it serves. In addition, the Office of Ombudsman for Long-Term Care (OOLTC) may also make unannounced monitoring visits to determine the level of satisfaction of those people who receive licensed assisted living services. The OOLTC will share their findings with MDH.

f. Follow-up Evaluation: At the time of the follow-up evaluation, MDH may pursue additional enforcement actions, up to and including immediate temporary suspension or revocation of the license if MDH identifies any level 3 or 4 violations or widespread care related violations.

g. Corrective Action Plan: Warm Touch Home Care Inc will develop and work within a corrective action plan (CAP). The CAP is a working document that includes at least the following information:
i. A statement of the concern
ii. A description of what will happen to correct the concern
iii. A target date for when each correction will be complete
iv. Who is responsible to make sure it happens
v. Current status of correction work
vi. Description of a plan to monitor and ensure ongoing compliance for each corrected order

Results of Follow-Up Survey During the Conditional License Period:
MDH will determine if Warm Touch Home Care Inc is in compliance based on the results of the follow up evaluation. MDH will make this determination within the 90-day conditional license period. If MDH determines Warm Touch Home Care Inc is in substantial compliance on the follow up evaluation, MDH will remove the conditions from Warm Touch Home Care Inc's assisted living facility license, and

Warm Touch Home Care Inc will correct violations identified during the evaluation to come into full compliance. If MDH determines Warm Touch Home Care Inc is not in substantial compliance, MDH may take additional enforcement action against Warm Touch Home Care Inc, including placement of additional conditions, issuing a second conditional license, or employ any of the enforcement tools listed in Minn. Stat. § 144G.20 up to and including immediate temporary suspension and revocation.

Request a Hearing:
Pursuant to Minn. Stat. §144G.20, Subd. 17 (c), the licensee may appeal an order immediately temporarily suspending a license or issuing a conditional license. The appeal must be made in writing by certified mail or personal service. If mailed, the appeal must be postmarked and sent to the commissioner within five calendar days after the license holder receives notice. If an appeal is made by personal service, it must be received by the commissioner within five calendar days after the license holder received the order. The request for hearing should be addressed to:

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

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this notice and the results of this visit with the President of your organization's Governing Body.

If you have any questions, please contact Jonathan Hill directly at: 651-592-5119.

Sincerely,

Maria King, RN
Division Director

Minnesota Department of Health
Health Regulation Division

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(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 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: SL36282015 On, August 8 through August 10, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were three (3) residents, all of whom received services under the provider's Assisted Living license. On August 8, 2022, August 9, 2022, immediate orders were issued for 0110, 1390 and 1750, respectively. The immediacy of 0110, 1390 and 1750 was not removed at the time of exit on August 10, 2022. Refer to 0340.	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 Home Care/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 144A.474 subd. 11 (b) (1) (2) -or- 144G.31 subd. 1, 2 and 3	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(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
0 110	Continued From page 1	0 110		
0 110 SS=I	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 by: Based on interview and record review, the licensee failed to ensure employment of a licensed assisted living director (LALD). This had the potential to affect all three (3) residents receiving Assisted Living services and staff. This resulted in an immediate correction order issued on August 8, 2022, at approximately 4:20 p.m., initially at 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) was issued. On August 9, 2022, at approximately 7:20 p.m. the level of this order was increased to a level three violation, but remained at widespread scope, due to the following two additional level three immediate orders: 1390 and 1750, both issued at widespread scope. The time period to correct 0110 remains immediate. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to	0 110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(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
0 110	Continued From page 2 serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee lacked evidence of a LALD as required, in general administrative charge of the facility. The licensee's Application for Assisted Living Licensure signed May 25, 2021, by assisted living director (ALD)-D, indicated ALD-D was applying for licensure as the Assisted Living Director for the Assisted Living facility. The application further indicated check marks attesting ALD-D understood Assisted Living Licensure laws, rules and statutes. The application further indicated ALD-D understood ALD-D was "legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract." The licensee's renewal application signed May 2, 2022, also indicated check marks attesting ALD-D understood Assisted Living Licensure laws, rules and statutes. The renewal application further indicated ALD-D understood ALD-D was "legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract." On August 8, 2022, at 10:25 a.m., during the entrance conference, the assistant director (AD)-B stated ALD-D was not yet licensed as assisted living director for the facility. AD-B	0 110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(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
0 110	Continued From page 3 further stated ALD-D was being mentored by LALD-E, who was the LALD for the facility. On August 8, 2022, at 1:30 p.m., the Board of Executives for Long-Term Services and Supports (BELTSS) website did not identify ALD-D held residency permit. Further, the BELTSS website failed to identify LALD-E as Director of Record for the facility. On August 8, 2022, at 1:40 p.m. a representative of BELTSS (R)-F stated, "[ALD-D] has not finished his director in residency permit application, so the permit has not been issued." R-F further stated, "[ALD-D] was sent the instructions initially, and again in March (2022), but [ALD-D] has not fully complied with the permit requirements." R-F was unable to verify LALD-E was acting director for the facility. On August 8, 2022, at approximately 4:15 p.m. an immediate correction order was issued. On August 9, 2022, at 11:08 a.m., consultant (C)-K verified she was serving as a mentor for ALD-D. C-K stated she is not the LALD of record for this facility, and further indicated she instructed ALD-D, approximately 3 weeks ago, he would need to complete the LALD in residency permit process. On August 10, 2022, at 1:03 p.m., ALD-D was asked via email to provide information, such as an email from BELTSS, to confirm who was the LALD for this facility. No confirmation was provided. The licensee's undated document titled, "Position Description - Director" indicated the facility director was responsible for day-to-day overall	0 110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(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
0 110	Continued From page 4 agency operations and assured adequate resources and efficient and effective use in meeting the agency goals and objectives. The position description further indicated the director was required to be a Licensed Assisted Living Director with Minnesota BELTSS, and had an in-depth working knowledge of the home health care industry, clinical practices and applicable federal, state and local health care regulations. No further information was provided Time Period to correct: IMMEDIATE	0 110		
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records,	0 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 250	Continued From page 5 files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required with records reviewed. This had the potential to affect all residents, staff, and visitors.	0 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 250	Continued From page 6 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on August 8, 2022, at approximately 10:25 a.m., assistant director (AD)-B stated the licensee's employees in charge of the facility were familiar with the assisted living regulations and the licensee provided medication and treatment management services. The licensee's Application for Assisted Living License, signed May 25, 2021, section titled Official Verification of Owner or Authorized Agent, (page four and five of the application), indicated, "I certify I have read and understand the following:" A check mark, indicating understanding, was placed before each of the following: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17. - I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th	0 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 250	Continued From page 7 Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G. - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659. - Reporting of Maltreatment of Vulnerable Adults. - Electronic Monitoring in Certain Facilities. - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all	0 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 250	Continued From page 8 data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license. - I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. - I have examined this application and all attachments and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required. - I attest to have all required policies and procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page five was electronically signed by owner, assisted living director (ALD)-D on May 25, 2021. The licensee's renewal application signed by owner, ALD-D on May 2, 2022, also indicated check marks attesting ALD-D understood Assisted Living Licensure laws, rules and statutes, as listed above. The renewal application further indicated ALD-D understood ALD-D was	0 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 250	Continued From page 9 "legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract." The licensee had an assisted living license issued on August 1, 2021, and renewal effective September 1, 2022, with an expiration date of July 31, 2024. The licensee failed to ensure the following policies and procedures were developed and/or implemented: - orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; - infection control practices; - conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis (TB) and COVID-19, consistent with current United States Centers for Disease Control and Prevention standards; - medication and treatment management; - delegation of tasks by registered nurses or licensed health professionals; and - supervision of unlicensed personnel performing delegated tasks. During the entrance conference on August 8, 2022, at 10:25 a.m., RN-A and AD-B verified the licensee provided the following: medication and treatment management, staff orientation and training, and delegation of tasks by the RN to ULPs, and infection control standards, but failed to implement the corresponding policies and procedures, as required. As a result of this survey, 41 correction orders were issued: 0110, 0250, 0340, 0460, 0470, 0480, 0490, 0510, 0550, 0640, 0650, 0660, 0680,	0 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 250	Continued From page 10 0730, 0780, 0790, 0800, 0810, 0920, 0930, 0950, 0970, 1370, 1390, 1440, 1470, 1530, 1620, 1650, 1690, 1710, 1730, 1750, 1760, 1770, 1820, 1880, 1910, 1940, 1960, 3090, indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250		
0 340 SS=I	144G.30 Subd. 5 Correction orders (a) A correction order may be issued whenever the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, or an employee of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction. (b) The commissioner shall mail or e-mail copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise	0 340		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(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
0 340	Continued From page 11 needed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide sufficient documentation with actions taken to comply with the following immediate correction orders identified during a survey: tag identification 0110, identified August 8, 2022, and tag indentification 1390 and 1750, identified August 9, 2022. This had the potential to affect all three (3) residents and staff in the facility. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On August 8, 2022, at 4:19 p.m., the Minnesota Department of Health issued an immediate correction order regarding citation identification number 0110 to the licensee via email. The email included a request for a reply to confirm receipt as well as to submit an immediate plan of correction. On August 8, 2022, at 4:55 p.m., the licensee, assisted living director (ALD)-D, emailed the survey supervisor, in reply to the previous message, and provided additional documentation related to the immediate correction order 0110. The licensee failed to provide an immediate plan	0 340		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(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
0 340	Continued From page 12 of correction. On August 9, 2022, at 9:42 a.m., the survey supervisor replied to ALD-D via email, acknowledging receipt of the provided document, and indicating the immediacy would not be lifted. Further, the survey supervisor again requested the licensee's plan to address the immediate order 0110. On August 9, 2022, at 10:52 a.m., ALD-D submitted a correction plan, via email, for the immediate order 0110. On August 9, 2022, at 11:26 a.m., the survey supervisor indicated via email, the immediacy of the order 0110 would not be removed, and requested additional information. On August 9, 2022, at 2:13 p.m. and 2:21 p.m., respectively, ALD-D submitted to the survey supervisor, via email, additional documentation followed by a list of the documents sent and a request to notify the licensee if the supervisor needed anything further. On August 9, 2022, at 7:22 p.m., the Minnesota Department of Health issued immediate correction orders regarding citation identification numbers 1390 and 1750 to the licensee, via email. The correction order included the previously identified immediate order 0110, and indicated the order had been revised (the severity was increased to level 3). The email included a request for a reply to confirm receipt as well as to submit an immediate plan of correction. On August 9, 2022, at 8:13 p.m., ALD-D replied to the correction order notification via email, but failed to acknowledge receipt or include an	0 340		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(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
0 340	Continued From page 13 immediate plan of correction. On August 10, 2022, at 11:19 a.m., ALD-D submitted a correction plan in regards to immediate orders 0110, 1390, and 1750. On August 10, 2022, at 1:03 p.m., the plan was found to be insufficient, and the survey supervisor replied via email requesting additional information. The supervisor indicated in the email that no immediacy had been removed. On August 10, at 2:26 p.m., assistant director (AD)-B stated as of that time, three ULPs that were scheduled for work that day had received medication administration training and competency evaluation. AD-B further stated RN-A would be performing further training for each remaining ULP at the start of their next scheduled shift. Medication administration training documents were provided for ULP-H, ULP-I, and ULP-M, all dated August 10, 2022. No further documentation of ULP training was provided. ALD-D failed to acknowledge the request for additional information and failed to submit further information. The immediacy of correction order tag identification 0110, 1390, and 1750 was not lifted. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 340		
0 460 SS=F	144G.41 Subdivision 1 Minimum requirements	0 460		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 460	Continued From page 14 (5) provide a means for residents to request assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide a means for residents to request assistance for health and safety needs 24 hours a day, seven days a week. This had the potential to affect all three (3) residents and staff in the facility. This practice resulted in a level two violation (a violation that did not harm a client'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 the residents).	0 460		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 460	Continued From page 15 The findings include: On August 8, 2022, at 10:25 a.m., during the entrance conference, assistant director (AD)-B indicated the facility did not have a system in place for residents to request assistance of staff. AD-B stated residents verbally request assistance of staff. -at 10:46 a.m., registered nurse (RN)-A stated residents were able to come out and get staff if they needed assistance. RN-A further stated staff would check on residents every hour if they had not seen them. On August 9, 2022, at 9:20 a.m., R1 stated he had to yell for staff assistance. R1 stated he sometimes had to wait for staff to respond, especially at night. On August 9, 2022, at 5:40 p.m., R1 was observed in his room, on the main floor of the facility, loudly calling for unlicensed personnel (ULP)-I by name. ULP-I responded five minutes later, at 5:45 p.m. The licensee's Scope of Service policy, dated August 1, 2022, indicated residents were provided with a system for accessing staff when needed. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 460		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that:	0 470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 470	Continued From page 16 (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 interview and record review, the licensee failed to develop and implement a staffing plan to determine staffing levels to meet the needs of all residents. This had the potential to affect all three (3) residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive	0 470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 470	Continued From page 17 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 August 8, 2022, at approximately 10:45 a.m., during the entrance conference, the licensee's staffing plan was requested. Assistant director (AD)-B stated they did not have a staffing plan. The licensee's Administrator position description indicated the Administrator would be responsible to, "Evaluate, make recommendations and establish appropriate staffing levels necessary to provide an efficient and effective operation; monitor staff performance to ensure all work functions are accomplished in a timely, accurate and productive manner." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply:	0 480		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 480	Continued From page 18 (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 had the potential to affect all three (3) residents of the assisted living facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive 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 August 8, 2022, at approximately 10:15 a.m., the kitchen area of the facility was observed to lack a posted meal menu for the week. On August 8, 2022, at 10:25 a.m., during the entrance conference, assistant director (AD)-B stated three meals per day are served to residents, but acknowledged there was no menu posted in the facility. AD-B indicated the licensee used a "catering service" to provide meals, and residents were able to choose their meals from a weekly list of available meals. A print out of the meal menu was requested, but not provided.	0 480		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 480	Continued From page 19 On August 8, 2022, at 1:29 p.m., AD-B stated residents would be ordering out for lunch on that day, and again for the evening meal, as there was no food located in the freezer from the catering service. -at 1:53 p.m., AD-B stated the food delivery service was started in February 2022. AD-B indicated there was an oven provided by the catering service that was used to prepare pre-packaged meals delivered for the residents. When asked to show the oven, AD-B stated the oven was not in the facility, and was currently in the office because it needed to be cleaned. On August 9, 2022, during a 9:20 a.m. interview, R1 stated he had not seen a meal menu posted. R1 further stated staff would ask residents what they wanted to eat or where they wanted to order food from, but it was not planned in advance. On August 9, 2022, at 9:42 a.m., unlicensed personnel (ULP)-H stated she made breakfast that morning and R1 ate eggs, french toast and sausage for breakfast. ULP-H stated she would usually make residents lunch that would typically be "something simple" such as a grilled cheese or bologna sandwich, egg rolls or maybe a frozen pizza. ULP-H stated they had not ordered food while she was working. On August 9, 2022, at 11:32 a.m., registered nurse (RN)-A stated she had not heard of the meal catering service or seen the oven associated with it. RN-A acknowledged there had been discussions with R1 and another resident who requested better food. RN-A stated she would like staff to provide more home cooked meals rather than providing frozen meals or ordering out.	0 480		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 480	Continued From page 20 On August 9, 2022, at 3:05 p.m., ULP-H was observed to answer the door to receive a carry-out food delivery for the residents. On August 10, 2022, at approximately 10:45 a.m., carry-out food was again delivered to the facility, and ULP-H was observed to deliver the food to R1. -at 11:28 a.m., ULP-H verified food was ordered in for the residents for breakfast that day. R1's Assisted Living Contract, signed July 16, 2021, indicated, "A menu is posted weekly, and you will be informed in advance of any changes to the menu." Please also refer to the included document titled, Food and Beverage Establishment Inspection Report, dated August 8, 2022, for the specific Minnesota Food Code deficiencies. The licensee's Scope of Service policy, dated August 1, 2021, indicated the licensee would provide assisted living services to include meal preparation (3 nutritious meals per day plus snacks), including modified diets ordered by a licensed professional. The licensee's Home Health Aide position description, undated, indicated job duties for unlicensed personnel included, "prepare meals, including modified diets and food safety". No further information provided TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(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
0 490	Continued From page 21	0 490		
0 490 SS=F	144G.41 Subd 1 (13) (ii)-(vii) Minimum requirements (ii) weekly housekeeping; (iii) weekly laundry service; (iv) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for providing this assistance; (v) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance; (vi) provide culturally sensitive programs; and (vii) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide a daily program of social and recreational activities that were based upon individual and group interests or physical, mental, and psychosocial needs. This had the potential to affect all three (3)residents of 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	0 490		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(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
0 490	Continued From page 22 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: During the entrance conference on August 8, 2022, at 10:25 a.m., assistant director (AD)-B indicated the licensee had a membership for the YMCA for the residents to use. AD-B stated staff offered to take residents to the YMCA or other activities such as bowling twice a week, every Tuesday and Friday. AD-B stated other activities would be provided as requested. AD-B stated an activity schedule was available online. The schedule was not provided. During a facility tour on August 8, 2022, at 11:39 a.m., surveyors observed the facility lacked an activity schedule posted in the common areas of the facility. On August 9, 2022, during a 9:20 a.m. interview, R1 stated, "it is very boring here", adding he had never heard of Tuesday and Friday activities. -at 9:50 a.m., R1 stated he had lived in the facility about a year, and had never been taken to the YMCA. R1 stated, "we keep asking and asking, but never get to go." On August 10, 2022, at 11:25 a.m., unlicensed personnel (ULP)-H stated she had not seen or heard of an activities schedule posted anywhere. ULP-H further stated she was not aware of residents ever going to the YMCA since she started working there (approximately one month). The licensee's Scope of Service policy, dated	0 490		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(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
0 490	Continued From page 23 August 1, 2021, indicated the licensee would provide assisted living services to include daily socialization and recreation. The licensee's Home Health Aide position description, undated, indicated job duties for unlicensed personnel included, "plans and facilitates activities for residents to enhance socialization". No further information was provided. TIME PERIOD TO CORRECT: Twenty-one (21) Days	0 490		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to establish and maintain an effective infection control program to comply with accepted health care, medical, and nursing standards for infection control and current recommendations for COVID-19. The licensee failed to ensure proper	0 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 510	Continued From page 24 screening of staff and visitors for COVID symptoms was completed, and failed to ensure appropriate personal protective equipment (PPE) was worn in the facility and while providing cares. This had the potential to affect all three (3) residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: COVID PPE Unlicensed personnel (ULP)-H was hired July 10, 2022, and provided direct care services to the residents of the facility. On August 9, 2022, at 9:50 a.m., unlicensed personnel (ULP)-H was observed to administer medications to R1. ULP-H wore a face mask improperly positioned, exposing her nose. ULP-H lacked eye protection while administering medications to R1. On August 9, 2022, at 10:05 a.m., ULP-H was observed to assist R1 with activities of daily living (ADLs). ULP-H wore a face mask improperly positioned, exposing her nose. ULP-H lacked eye protection while providing cares. On August 9, 2022, at 10:28 a.m., ULP-H stated she wore a face mask when in the house but never wore eye protection.	0 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 510	Continued From page 25 On August 9, 2022, at 3:05 p.m., ULP-H was observed in living room on her cell phone, wearing a face mask improperly positioned on her chin, exposing both her mouth and nose. ULP-H was observed to go to the front door to accept a carry out food delivery with the mask continuing to be positioned on her chin, exposing both her mouth and nose. -at 3:17 p.m., ULP-H was observed delivering food to R1 wearing a facemask positioned on her chin, exposing both her mouth and nose. On August 10, 2022, at 10:44 a.m., ULP-H was observed to enter R1's room wearing a face mask improperly positioned, exposing her nose. ULP-H was observed to exit R1's room, retrieved an item from the refrigerator and then returned to R1's room, continuing to wear her face mask positioned below her nose. On August 9, 2022, at 10:22 a.m., ULP-H stated she had not been provided infection control training. On August 10, 2022, at 10:33 a.m., registered nurse (RN)-A stated staff were not wearing eye protection anymore and was unaware they were supposed to be. RN-A acknowledged understanding of the MDH COVID PPE grid and how to find community transmission levels on the CDC data tracker. The licensee's Infection Control policy, dated August 1, 2021, indicated, "[Licensee] will observe the recommended precautions for home care as identified by the Centers for Disease Control and Prevention (CDC). COVID Screening	0 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 510	Continued From page 26 The licensee's "Visitor Log Temp Check" was observed by the front door. The log indicated one visitor signed February 26, 2022, with no temperature documented. The log further included undated temperature readings for the nursing surveyors who entered on August 8, 2022, the surveyor from the state Fire Marshall's office who entered August 8, 2022, and again listed the nursing surveyors' temperatures taken upon entrance to the facility August 9, 2022. The log did not indicate staff screening or screening of the environmental health sanitarian (EHS)-G, who also entered the facility August 8, 2022. On August 9, 2022, at 9:25 a.m., ULP-H stated she self-screened for COVID symptoms upon entering the facility, but did not document it anywhere. On August 9, 2022, at 9:35 a.m., RN-A stated employees self-screened for COVID symptoms upon entering the facility. RN-A stated they were supposed to document the screening on a log. RN-A further stated she was screened when she came in that morning. When asked where the screening was documented, RN-A stated she did not document the screening, but told assistant director (AD)-B who documented the screening. On August 9, 2022, at 9:47 a.m., EHS-G stated she was not screened for COVID symptoms when she entered the facility on August 8, 2022. EHS-G further stated staff acknowledged they forgot to screen her, but told her they normally would screen all visitors. On August 9, 2022, at 9:55 a.m., an untitled employee COVID screening log was provided. The log indicated screening for AD-B and RN-A done that morning (August 9, 2022), but did not	0 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 510	Continued From page 27	0 510		

include ULP-H. RN-A stated they had a folder with all the screening documented. RN-A further stated they could not find the additional screening logs, but would continue looking.

Assistant director (AD)-B provided the licensee's "[Licensee] Visitors and Employee COVID-19 Log," which indicated, "All the individuals we serve are at serious health risk associated with COVID-19, to protect these individuals, anyone entering this building must acknowledge if whether they have any symptoms associated with the COVID virus. If you have any of these symptoms you will not be permitted to enter the building and will reach out to your supervisor, manager, or HR guidance."

The screening log contained two pages with screenings documented on the following dates from May 9, 2022, through August 10, 2022: May 9, 23, 30, June 4, 9, 13, July 5, 18, 19, 20, 28, 30, 31, August 1, 2, 5, 8, 9, and 19, 2022.

On August 10, 2022, at 10:51 a.m., RN-A confirmed the screening log was lacking documentation of screenings for several days.

The licensee's undated Screening and Testing policy, which addressed COVID-19, indicated, "all staff should be screened when reporting for work for a fever equal to or over 100 Fahrenheit (F), acute respiratory symptoms, including cough, shortness of breath (SOB), sore throat, loss of taste or smell, muscle aches and chills."

The Minnesota Department of Health COVID-19 Personal Protective Equipment (PPE) Grid for Congregate Care Settings, dated April 7, 2022, instructed health care workers (HCW) with face-to-face contact with COVID-19 negative

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 510	Continued From page 28 residents to wear a medical grade well-fitting facemask and eye protection. In addition, it instructed HCW with no face-to-face contact with residents to wear a medical-grade well-fitting facemask. The Minnesota Department of Health (MDH) guidance titled, "COVID-19 PPE and Source Control Grids - for congregate care settings, by community transmission level", dated April 7, 2022, indicated during "substantial" or "high" levels of community transmission (based on the Centers for Disease Control and Prevention (CDC) online data tracking system), caregivers must wear a face mask (source control) and eye protection while working with residents without suspected or confirmed SARS-CoV-2 infection. The CDC COVID Data Tracker on August 8, August 9, 2022, and August 10, 2022, indicated Hennepin County, MN (the county of the assisted living facility) was at a "high" level of community transmission, which indicated the use of a face mask and eye protection while working with residents. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 510		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances.	0 550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(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
0 550	Continued From page 29 The notice must also have the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post the required information related to the grievance procedure and contact information for the Office of Ombudsman for Long-Term Care (OOLTC) and Mental Health and Developmental Disabilities. This had the potential to affect all three (3) residents receiving assisted living services. 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 August 8, 2022, at 10:35 a.m., the surveyor observed the common areas of the facility which lacked a posting of the grievance procedure and OOLTC contact information. On August 10, 2022, at 3:07 p.m., assistant director (AD)-B acknowledged the grievance procedure was not posted in the facility. The licensee's grievance policy, dated August 1,	0 550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(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
0 550	Continued From page 30 2021, indicated, "A copy of the grievance procedure is conspicuously posted in the residence with the following information: -Name, phone number and email contact information for the individuals who are responsible for handling resident complaints -Contact information for the state and any regional Office of Ombudsman for Long-Term-Care -Contact information for the Office of Ombudsman for Mental Health and Developmental Disabilities: -Contact information for the Minnesota Adult Abuse Reporting Center". No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 640 SS=C	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by:	0 640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(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
0 640	Continued From page 31 Based on observation, interview, and record review, the licensee failed to post information and phone numbers for reporting to the Minnesota Adult Abuse Reporting Center (MAARC) in the assisted living facility. This had the potential to affect all three (3) residents, staff, and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On August 8, 2022, at 11:45 a.m., the surveyor observed the common area of the facility which lacked a posting of vulnerable adult abuse reporting information including the MAARC phone number. On August 10, 2022, at 3:07 p.m. assistant director (AD)-B confirmed the MAARC information was not posted in the facility. The licensee's Vulnerable Adult policy, dated August 1, 2021, indicated, "Contact information for the MAARC shall be posted in the facility." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640		
0 650 SS=F	144G.42 Subd. 8 Employee records	0 650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 650	Continued From page 32 (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure employee records included all required content for one of three employees (registered nurse (RN)-A) with employee records reviewed.	0 650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 650	Continued From page 33 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On August 8, 2022, at 10:25 a.m., during the entrance conference, assistant director (AD)-B indicated employee records were located in the facility, and stored in the office with the door locked when not in use. RN-A RN-A was hired May 30, 2022, and provided supervisory and direct care services to the residents of the facility. On August 8, 2022, at 11:40 a.m., the surveyor requested the employee file for RN-A. The record was not provided. RN-A lacked an employee record including the following required content: -evidence of current professional licensure; -record of orientation -current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; and -verification that required health screenings under subdivision 9 have taken place and the dates of those screenings. ULP-C ULP-C was hired November 22, 2022, and provided direct care services to the residents of	0 650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 650	Continued From page 34 the facility. On August 8, 2022, at 2:48 p.m., ULP-C's employee record was reviewed and noted to lack required the following required content: -record of orientation, training, and competency evaluations; and -verification that required health screenings under subdivision 9 have taken place and the dates of those screenings. On August 9, 2022, at 9:22 a.m., assistant director AD-B stated additional documentation including employee training and TB screening was located at the main office and not accessible because assisted living director (ALD)-D had the keys and was unavailable. ULP-H ULP-H was hired July 10, 2022, and provided direct care services to the residents of the facility. On August 9, 2022, at 9:50 a.m., ULP-H was observed to assist R1 with medication administration. -at 10:05 a.m., ULP-H was observed to assist R1 with activities of daily living (ADLs) and dressing. ULP-H's employee record lacked the following required content: -record of orientation, training, and competency evaluations; and -verification that required health screenings under subdivision 9 have taken place and the dates of those screenings. On August 9, 2022, during an 11:32 a.m. interview, RN-A stated they had been using an online training format, and she did not sign any documentation regarding staff training since she	0 650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 650	Continued From page 35 was hired. RN-A further stated she had not been provided the required training upon hire. RN-A further stated she had been tested for TB, but was not asked to provide documentation or to be tested for TB upon hire. RN-A further stated she filled out a TB history and symptom screening form. The form was not provided. The licensee's Personnel Records policy, dated February 27, 2021, indicated a personnel record would be started for every new employee upon hire, and would include: -Evidence of current professional licensure, registration or certification; -Results of background studies; -Records of annual training and infection control training; -Documentation of orientation; -Documentation of supervision, as applicable; -Performance reviews; -Competency evaluations; and -Signed job description. The policy further indicated, "Results of required health screening and medical examinations will be maintained in a separate, private file." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
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	0 660		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 660	Continued From page 36 and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included baseline testing and screening, and TB training for three of three employees (registered nurse (RN)-A, unlicensed personnel (ULP)-C, ULP-H) with employee records reviewed. 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: The Facility TB Risk Assessment dated May 21, 2021, identified the facility was at a low risk for transmission. RN-A was hired May 30, 2022, and provided	0 660		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 660	Continued From page 37 supervisory and direct care services to the residents of the facility. ULP-C was hired November 22, 2022, and provided direct care services to the residents of the facility. ULP-H was hired July 10, 2022, and provided direct care services to the residents of the facility. RN-A, ULP-C, and ULP-H's employee records all lacked documentation of TB education, baseline test and screening completed upon hire. On August 9, 2022, at 9:22 a.m., assistant director (AD)-B stated additional documentation including TB training and TB screening for ULP-C were all at the main office and not accessible because assisted living director (ALD)-D had the keys and was unavailable due to illness. On August 9, 2022, at 10:30 a.m., ULP-H stated she was not screened for TB, and did not receive any TB training upon hire. On August 9, 2022, during an 11:32 a.m. interview, RN-A stated she had not received TB training upon hire. RN-A further stated she has been tested for TB, but they did not ask for documentation upon hire. RN-A further stated she remembered filling out a history and symptom screening form, but was not sure where those documents would be kept. The Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013 noted training was required at the time of hire and included: pathogenesis, signs symptoms, and the licensee's infection control plan. In addition, baseline screening for all health care workers	0 660		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 660	Continued From page 38 (HCW) included a history and symptom screen and testing for the presence of TB infection. The regulations noted a blood test should include the date of the test. According to the regulations, if a HCW had documentation for latent TB, that documentation could be substituted for documentation of a previous positive TST or blood test. The licensee's Tuberculosis Screening/Prevention policy dated August 1, 2021, indicated all newly hired staff would receive TB education and screening to include baseline testing using a blood test or two-step Mantoux, as well as an assessment for TB history and current symptoms. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 680	Continued From page 39 (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop a written emergency preparedness (EP) plan with all the required content. This had the potential to affect all three (3) 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 August 8, 2022, the [Licensee] Emergency Preparedness Manual, last updated on August 15, 2021, was reviewed and noted to lack required information and customization to the licensee. The provided EP plan lacked individualized emergency procedures to include the following:	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 680	Continued From page 40 - risk assessment; - consider duration of interruptions; - arrangements/contracts to re-establish utility services; - an assessment of the at-risk population's needs; - categorize the various probable risks/hazards by likelihood of occurrence - develop strategies for addressing the licensee and community-based risks (evacuation plans, staffing/shortage, back-up plans) - a process for emergency preparedness cooperation with state and local EP officials/organizations; - a tracking system used to document locations of residents and staff; - the medical record documentation system to preserve resident information; - means of releasing and providing resident information in the event of an evacuation; - identify which qualified staff would assume specific roles; - means to providing information about the licensee occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee; - identify which staff would assume specific roles and in another staff members absence; - handling and use of volunteers; - plan to address food, water, medical supplies, and pharmaceutical supplies; - development of arrangements with other facilities/providers to receive residents in the event of limitations of operations to maintain continuity of services to residents including a contract and address: - alternate sources of emergency and standby power systems to help maintain safe temperature, sanitation, emergency lighting, fire detection, sewage;	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 680	Continued From page 41 - include a process for cooperating and collaboration with local tribal, regional, state, and federal EP to maintain integrated response; - EP training and testing program; - conducting exercises to test the EP at least twice per year; - participation in annual full-scale exercises; - analyze the licensee responses to and maintain documentation of all drills; - how the licensee would operate under an 1135 waiver; - a written communication plan that included: - names and contact information for staff, resident physicians, other facilities; and - a method of sharing information and medical documentation for residents; - contact information for Federal, State, tribal, regional, and local EP staff; - State Licensing and Certification Agency; - Minnesota Office of Ombudsman; - other sources of assistance; On August 8, 2022, at 3:45 p.m., the assistant director (AD)-B stated the EP plan provided to the survey team included all documentation for the EP plan. On August 8, 2022, at 4:00 p.m. AD-B confirmed the EP policy indicated an evacuation address which was the personal home of the assisted living director (ALD)-D. On August 10, 2022, at 11:09 a.m., AD-B acknowledged the EP plan was missing some required elements. On August 10, 2022, at 3:13 p.m., AD-B confirmed an emergency procedure was not posted in the facility.	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 680	Continued From page 42 The licensee provided an incomplete Fire Drill Log. The log specified fire drills were to be completed two times per year. The two logged dates were missing additional information designated by the form including signatures, scenario, summary, analysis, recommendations, and completed by: - December 16, 2021, at 10:00 a.m. - September 14, 2022, at 4:32 p.m. (which was a future date). The licensee's Emergency Preparedness policy, dated August 1, 2021, indicated, "[licensee] will have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services." No further information provided TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require	0 730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(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
0 730	Continued From page 43 documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record included documentation of all provided services for one of one residents (R1) with records reviewed.	0 730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(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
0 730	Continued From page 44 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 was admitted July 16, 2021. R1's care plan, signed July 6, 2021, indicated R1 received services to include assistance with bathing (three times weekly), dressing (daily), meal preparation (three times daily), clean room and bathroom (daily and PRN), laundry (two times weekly), shopping/errands (two times weekly). On August 8, 2022, at 3:30 p.m., assistant director (AD)-B stated the service administration documentation was not at the facility and was instead kept at the main office which was a different location. On August 8, 2022, at 3:42 p.m., RN-A stated she had a blank copy of the service administration form they use to document treatments. RN-A and AD-B both stated there was not documentation on location. The refrigerator in the kitchen displayed a check-off form, dated August 7, 2022, through August 19, 2022, indicating staff were to, "Clean [R1] & [R3] room", as well as other tasks that were not resident-specific. The form indicated the rooms were cleaned August 8, 2022.	0 730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(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
0 730	Continued From page 45 On August 9, 2022, at 9:20 a.m., unlicensed personnel (ULP)-H stated the form used to document room cleaning for the previous week was unavailable because it was located at the main office. On August 9, 2022, at 10:09 a.m., ULP-H stated staff documented the services provided in notes on the back of the medication administration record (MAR) sheets. ULP-H acknowledged the services provided were not documented daily. R1's MAR and the room cleaning checklist indicated the following scheduled services were not documented: AUGUST 2022: -bathing (3x weekly): 3 of 3 scheduled services; -dressing (daily): 8 of 8 scheduled services; -meal preparation (3x daily) 24 of 24 scheduled services; -clean room and bathroom (daily): 7 of 8 scheduled services; -laundry (2x weekly): 8 of 8 scheduled services; and -shopping/errands (2x weekly): 8 of 8 scheduled services. JULY 2022: -bathing (3x weekly): 12 of 12 scheduled services; -dressing (daily) 31 of 31 scheduled services; -meal preparation (3x daily): 88 of 93 scheduled services; -clean room and bathroom (daily): 31 of 31 scheduled services; -laundry (2x weekly): 8 of 8 scheduled services; and -shopping/errands (2x weekly): 8 of 8 scheduled services. JUNE 2022:	0 730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(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
0 730	Continued From page 46 -bathing (3x weekly): 12 of 12 scheduled services; -dressing (daily): 30 of 30 scheduled services; -meal preparation (3x daily): 82 of 90 scheduled services; -clean room and bathroom (daily): 30 of 30 scheduled services; -laundry (2x weekly): 8 of 8 scheduled services; and -shopping/errands (2x weekly): 8 of 8 scheduled services. On August 9, 2022, during an 11:32 a.m. interview, RN-A stated there was supposed to be a folder labeled "daily activity log" for staff to document items such as vital signs, pain assessments, activities, cleaning, and progress notes. The log was not provided. The licensee's Service Plan policy, dated August 1, 2021, indicated the licensee would provide all services agreed to in the resident's service plan. The licensee's Home Health Aide position description, undated, indicated unlicensed personnel job duties included observation, reporting and documentation of resident status, and the care or service furnished. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
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	0 780		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 780	Continued From page 47 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that are interconnected throughout the facility. This deficient condition had the ability to affect all residents, staff and visitors of 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 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 780		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 780	Continued From page 48 Findings include: During the facility tour on August 8, 2022, at approximately 11:30 a.m., with the assistant director (AD)-B, it was observed that the smoke alarms on each story and in the immediate vicinity of sleeping rooms were not interconnected so that the actuation of one would cause all alarms to operate. AD-B verbally confirmed survey staff observations during the facility tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain facility fire extinguishers. This had the potential to affect all current residents, staff and visitors.	0 790		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 790	Continued From page 49 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: During the facility tour on August 8, 2022, between 11:15 a.m. and 1:00 p.m., survey staff toured the facility with the assistant director (AD)-B, and observed the fire extinguishers located upstairs were stamped on the bottom "2021" and the extinguisher in the basement was stamped "2022". The surveyor was unable to verify when the extinguishers were purchased and or serviced. AD-B verbally confirmed survey staff observations during the facility tour. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 790		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program.	0 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 800	Continued From page 50 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive 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 August 08, 2022 between 11:15 a.m. and 1:00 p.m., survey staff toured the assistant director (AD)-B. During the facility tour, survey staff observed the following: 1. Room 1 was vacated and full of empty boxes and other combustible materials. 2. Room 3 had a heat register hanging from the ceiling. 3. Room 4's window screen was removed from the window. 4. Cigarette butts were observed in the rocks outside the window of room 4. 5. Cigarette butts were observed in the landscaping by front door. AD-B verbally confirmed survey staff observations during the facility tour. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	0 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 800	Continued From page 51 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; (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	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 810	Continued From page 52 by: Based on interview and record review, the licensee failed to develop a fire safety and evacuation plan with required elements, failed to provide required employee and resident training on fire safety and evacuation, and failed to conduct required evacuation drills. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or 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). On August 8, 2022, between 11:15 a.m. and 1:00 p.m., during the survey time, the following documents were requested from assistant director (AD)-B, but not provided: 1. a fire safety and evacuation map with location and resident rooms; 2. employee training logs for fire safety and evacuation; 3. the required employee training frequency; and 4. documentation of resident evacuation training. AD-B verbally confirmed survey staff observations during the facility tour. No additional information was provided TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(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
0 920	Continued From page 53	0 920		
0 920 SS=F	144G.50 Subd. 2 (c) Contract information (c) The contract must include: (1) a disclosure of the category of assisted living facility license held by the facility and, if the facility is not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license; (2) a description of all the terms and conditions of the contract, including a description of and any limitations to the housing or assisted living services to be provided for the contracted amount; (3) a delineation of the cost and nature of any other services to be provided for an additional fee; (4) a delineation and description of any additional fees the resident may be required to pay if the resident's condition changes during the term of the contract; (5) a delineation of the grounds under which the resident may be discharged, evicted, or transferred or have services terminated; (6) billing and payment procedures and requirements; and (7) disclosure of the facility's ability to provide specialized diets. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written assisted living contract with the required content for one of one resident (R1) with record reviewed. 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	0 920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(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
0 920	Continued From page 54 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 was admitted July 16, 2021. R1's service plan, signed July 6, 2021, indicated R1 received services including assistance with medication management, housekeeping, dressing, ADLs, meals, shopping, and transfers and mobility. R1's record contained two contracts, contract one titled, "[Licensee] Assisted Living Contract" signed July 4, 2022, and contract two, "[Licensee] Resident Contract for Assisted Living" signed July 16, 2021. Both contracts lacked: -a delineation of the cost and nature of any other services to be provided for an additional fee; and -a delineation and description of any additional fees the resident may be required to pay if the resident's condition changes during the term of the contract. On August 10, 2022, at 3:07 p.m., assistant director (AD)-B acknowledged the missing content. AD-B verified all residents received the same contracts. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 920		
0 930 SS=F	144G.50 Subd. 2 (d-e; 1-4) Contract information	0 930		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(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
0 930	Continued From page 55 (d) The contract must include a description of the facility's complaint resolution process available to residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints. (e) The contract must include a clear and conspicuous notice of: (1) the right under section 144G.54 to appeal the termination of an assisted living contract; (2) the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer; (3) contact information for the Office of Ombudsman for Long-Term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints; (4) the resident's right to obtain services from an unaffiliated service provider; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written assisted living contract with the required content for one of one resident (R1) with record reviewed. 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:	0 930		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(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
0 930	Continued From page 56 R1 was admitted to the facility on July 16, 2021. R1's service plan, signed July 6, 2021, indicated R1 received services including assistance with medication management, housekeeping, dressing, ADLs, meals, shopping, and transfers and mobility. R1's record contained two contracts, contract one titled, "[Licensee] Assisted Living Contract" signed July 4, 2022, and contract two, "[Licensee] Resident Contract for Assisted Living" signed July 16, 2021. Both contracts lacked the following: -a description of the facility's complaint resolution process available to residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints. R1's "[Licensee] Resident contract for Assisted Living" signed July 16, 2021, included a section titled Complaint Procedure, that indicated to refer to the, "Notice to the Clients on Complaint Process," which was not found in either contract. On August 10, 2022, at 3:07 p.m., assistant director (AD)-B acknowledged the missing content. AD-B verified all residents received the same contracts. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 930		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(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
0 950	Continued From page 57	0 950		
0 950 SS=F	144.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to offer the opportunity to identify a designated representative for one of one resident (R1) with records reviewed.	0 950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(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
0 950	Continued From page 58 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 was admitted July 16, 2021. R1's service plan, signed July 6, 2021, indicated R1 received services including assistance with medication management, housekeeping, dressing, ADLs, meals, shopping, and transfers and mobility. R1's record contained two contracts, contract one titled, "[Licensee] Assisted Living Contract" signed July 4, 2022, and contract two, "[Licensee] Resident Contract for Assisted Living" signed July 16, 2021. On August 8, 2022, both contracts were reviewed. Contract one addressed residents right to designate a representative, however, was left blank and was not provided as a document separate from the contract. Contract two did not address the resident right to designate a representative. On August 10, 2022, at 3:07 p.m. assistant director (AD)-B acknowledged contract one for R1 right to designate a representative section was blank. He also acknowledged the licensee did not have a right to designate a representative form separate from the contract. AD-B verified all three residents have the same contract.	0 950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(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
0 950	Continued From page 59 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950		
0 970 SS=F	144.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety, or personal property of a resident. This had the potential to affect one of one residents (R1) living at the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive 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:	0 970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 970	Continued From page 60 R1 was admitted July 16, 2021. R1's service plan, signed July 6, 2021, indicated R1 received services including assistance with medication management, housekeeping, dressing, ADLs, meals, shopping, and transfers and mobility. The licensee's Assisted Living Contract, signed by resident (R1) on July 4, 2021, included the following language indicating waivers of liability: Page 4: -"Security/Valuables/Keys: All resident rooms have security locks. If you choose not to lock your valuables, you assume liability for them."; Page 11: -"Insurance: Each resident should maintain his or her own health, personal property, liability and other applicable insurance policies. [Licensee] does not provide insurance for you or your property"; Page 11: -"Insurance Liability and Release: The resident shall maintain at all times his or her own health, personal property, liability, automobile (if applicable), and other insurance coverages and shall provide evidence of same by copies of binders or policies to [Licensee] upon request. The resident acknowledges that [Licensee] is not an insurer of the resident's person or property. The resident agrees that [Licensee] will not be liable to the resident for any personal injury or property damage (including, without limitation, damage to, or loss or theft of, automobiles or personal property of resident) suffered by the resident or the resident's agents, guests, or invitees, unless and to the extent that the injury or damage is caused by the negligence of [Licensee] or its employees or agents. The resident hereby releases [Licensee] from liability	0 970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 970	Continued From page 61 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."; Page 13: -"Indemnification: [Licensee] shall not be liable for any damage or injury to the resident, or any other person, or to any property, occurring on the premises, or any part thereof, or in common areas thereof, and the resident agrees to hold [Licensee] harmless from any claims or damages unless caused solely by negligence of [Licensee]. It is recommended that renter's insurance be purchased at the resident's expense. Nothing contained herein is intended to create a waiver of facility liability for the health and safety or personal property of a resident."; -"Liability: The resident agrees to be liable and responsible for all obligations herein referenced, monetary and otherwise, of the resident and where this Contract has been executed by a party designated below. Or where a separate Responsible Party Agreement has been executed by a third party, said third party and the resident shall be jointly and severally liable and responsible for all obligations, monetary and otherwise, of the resident herein referenced." On August 10, 2022, at 3:07 p.m., assistant director (AD)-B acknowledged the waiver of liability language. AD-B verified the language was present in the contracts for all residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01370	Continued From page 62	01370		
01370 SS=F	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various	01370		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01370	Continued From page 63 emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency to include all required content was completed for two of two unlicensed employees (unlicensed personnel (ULP)-C and ULP-H) with records reviewed. 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-C ULP-C was hired November 22, 2021, and provided direct care services to residents. ULP-C's employee record included documentation of training completed December 5, 2021, but lacked documentation of training for the following topics: -documentation requirements for all services provided; -reports of changes in the resident's condition to the supervisor designated by the facility; -basic infection control, including blood-borne pathogens; -maintenance of a clean and safe environment; -appropriate and safe techniques in personal	01370		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01370	Continued From page 64 hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; -standby assistance techniques and how to perform them; -preparation of modified diets as ordered by a licensed health professional; -communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; -awareness of confidentiality and privacy; -understanding appropriate boundaries between staff and residents and the resident's family; -awareness of commonly used health technology equipment and assistive devices; -observation, reporting, and documenting of client status; and -administering medications or treatments as required. ULP-C's record included an HHA Skills Competency certificate signed by registered nurse (RN)-Q May 13, 2021 (6 months prior to his start date). On August 8, 2022, at 2:50 p.m., ULP-C verified he was hired November 2021. ULP-C stated he had orientation and training to assisted living rules and all training required. On August 8, 2022, at 4:27 p.m., assistant director (AD)-B verified ULP-C was hired November 2021. AD-B stated RN-Q whose signature appeared on ULP-C's skills competency dated May 13, 2021, was not hired until October 2021 (5 months after the date of her	01370		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01370	Continued From page 65 signature). ULP-H ULP-H was hired July 10, 2022, and provided direct care services to residents. ULP-H's employee record lacked documentation of training and competency for the following topics: -documentation requirements for all services provided; -reports of changes in the resident's condition to the supervisor designated by the facility; -basic infection control, including blood-borne pathogens; -maintenance of a clean and safe environment; -preparation of modified diets as ordered by a licensed health professional; -communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; -understanding appropriate boundaries between staff and residents and the resident's family; -observation, reporting, and documenting of client status; -basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; -recognizing physical, emotional, cognitive, and developmental needs of the client; and -administering medications or treatments as required. On August 9, 2022, at 9:45 a.m., ULP-H stated she received training from house manager (HM)-J (an unlicensed personnel). -at 10:30 a.m., ULP-H stated HM-J trained her on items including the house, when to give meds,	01370		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01370	Continued From page 66 documentation, and a basic hand washing lesson. On August 9, 2022, at 11:32 a.m., registered nurse (RN)-A stated she had not signed any documentation regarding staff training since being hired (May 30, 2022). RN-A further stated staff had been using an online format for training, and the assisted living director (ALD)-D was hiring people to assist with training. The licensee's Staff Competency policy, dated August 1, 2021, indicated, "All residents will receive quality service delivered by staff who are educated and competent in the delivery of assisted living services. [Licensee] is committed to meeting or exceeding current practice standards." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01390 SS=I	144G.62 Subdivision 1 Availability of contact person to staff (a) Assisted living facilities must have a registered nurse available for consultation by staff performing delegated nursing tasks and must have an appropriate licensed health professional available if performing other delegated services such as therapies. This MN Requirement is not met as evidenced by: Based on documentation review and interview the licensee failed to ensure a registered nurse (RN)-A was readily available to staff performing	01390		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(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
01390	Continued From page 67	01390		

delegated nursing tasks and services. This had the potential to affect all three (3) residents and staff of the facility. The licensee hired RN-A to perform all nursing tasks. RN-A simultaneously held a nursing position working a 0.5 schedule (or approximately 20 hours per week) at a hospital which would not allow her to be available to leave to address facility emergencies or concerns. This resulted in an immediate correction order on August 9, 2022, at approximately 7:20 p.m.

This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).

The findings include:

RN-A was hired May 30, 2022, and provided supervisory and direct care services to the residents of the facility.

On August 8, 2022, at 10:43 a.m. at the entrance conference RN-A verified she was the only employed nurse working at the facility. RN-A indicated she worked at the assisted living facility every Monday for 3 hours, and remained on call at all other times. RN-A stated she had another position as an RN in a hospital where she worked a 0.5 schedule. RN-A further stated she can step away during her hospital shifts to take phone calls and always had her phone with her.

During an interview on August 9, 2022, at 9:20 a.m., R1 stated the nurse doesn ' t always make

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(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
01390	Continued From page 68 it during the week, but usually would then come on Saturday. R1 further stated about a week ago he missed 2 days of his medications because they were not available in the facility. R1 further stated, "the nurse finally came and fixed them". R1's medication administration record (MAR) for July and August 2022, indicated multiple days of medication administration not documented. On August 9, 2022, at 2:18 p.m. RN-A verified her previously discussed hospital work schedule. RN-A stated she only agreed to be on-call, for the facility. RN-A stated she told the facility when she was hired, she would be unable to leave her job at the hospital to address emergencies or other needs at the facility. RN-A stated if there were an emergency at the facility, she would ask her hospital supervisor if she could leave her shift but probably would not be able to. The Licensee's Delegation of Homecare Tasks policy, dated February 27, 2021, indicated, "A clinician (RN for consultation to staff performing delegated nursing tasks and/or another appropriately licensed health professional) will be readily available to staff performing delegated services via phone or by other appropriate means during times when the staff is performing services." No further documentation was provided. TIME PERIOD FOR CORRECTION: Immediate	01390		
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or	01440		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(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
01440	Continued From page 69 therapy tasks must be supervised by an 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 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 one of two unlicensed staff (unlicensed personnel (ULP)-C) with employee records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred	01440		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(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
01440	Continued From page 70 only occasionally). The findings include: ULP-C ULP-C was hired November 22, 2021, and provided direct care services to residents. ULP-C's employee record included a certificate of training for "Medication Administration for Home Health Aides" signed October 1, 2021. On August 8, 2022, at 2:50 p.m., ULP-C stated he was hired November 2021. ULP-C stated he had orientation and training including medication administration training. ULP-C's employee record lacked documentation of a 30-day supervision by an RN. On August 9, 2022, at 11:32 a.m., registered nurse (RN)-A stated there was a group training for medication administration training the RN did that included an observation of staff giving medications. RN-A further stated she observed medication administration completed on different shifts, but did not document it because she thought management completed it. The license's Personnel Records policy, dated August 1, 2021, indicated personnel records would include documentation of staff supervision. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(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
01470	Continued From page 71	01470		
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any	01470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(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
01470	Continued From page 72 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 the challenges it poses to communication; (2) 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 interview and record review, the licensee failed to ensure employees received orientation to all required assisted living regulation content for two of three employees (registered nurse (RN)-A, unlicensed personnel (ULP)-C) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: RN-A was hired May 30, 2022, and provided	01470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(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
01470	Continued From page 73 supervisory and direct care services to the residents of the facility. RN-A's employee record lacked documentation of orientation, as outlined in MN statute 144G.63, Subd. 2, to include: -an overview of this chapter; -an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; -handling of emergencies and use of emergency services; -compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); -the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; -handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; -consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and -a review of the types of assisted living services the employee will be providing and the facility's category of licensure. ULP-C was hired November 22, 2022, and provided direct care services to the residents of	01470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(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
01470	Continued From page 74 the facility. ULP-C's employee record lacked documentation of orientation, as outlined in MN statute 144G.63, Subd. 2, to include: -an overview of this chapter; -an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; -handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; -consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and -a review of the types of assisted living services the employee will be providing and the facility's category of licensure. On August 8, 2022, at 2:50 p.m., ULP-C verified he was hired November 2021. ULP-C stated he had orientation and training to assisted living rules and all training required. On August 9, 2022, at 10:00 a.m., assistant director (AD)-B stated staff is oriented and signed off when they had orientation. AD-B indicated the documentation was in a book. The indicated book was reviewed and lacked documentation of orientation.	01470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(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
01470	Continued From page 75 On August 9, 2022, during an 11:32 a.m. interview, RN-A stated they had been using an online training format, and she did not sign any documentation regarding staff training since she was hired. RN-A further stated she had not been provided the training required upon hire, and did not have any orientation regarding assisted living laws. The licensee's Staff Orientation and Education policy dated August 1, 2021, indicated, "All staff providing assisted living through [licensee] will be prepared to provide safe, effective services to all residents through a thorough orientation and education program pertinent to the needs of the residents." The policy further indicated, orientation topics would include the following: -Overview of Minnesota Assisted Living Statute 144G and Minnesota Rules Chapter 4659; -Review of the employee's job description and responsibilities; -Introduction to and review of the organization's policies and procedures related to the provision of assisted living services by the individual staff person; -Handling of emergencies and the use of emergency services; -Compliance with Minnesota's Vulnerable Adult (Sections 626.556 and 5572), including requirements based on organizational policy, identification of incidents of maltreatment (abuse, financial exploitation and neglect) and that ay act that constitutes maltreatment is prohibited; -The Assisted Living Bill of Rights and the employee's responsibilities to ensure the exercise and protection of those rights; -The principles of person-centered planning and service delivery and how they apply to direct support services provided by staff; -Gnevance Policy/Process, including reports to	01470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(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
01470	Continued From page 76 the Office of Health Facility Complaints; and -Consumer advocacy services, including i. Office of Ombudsman for Long-Term-Care ii. Office of Ombudsman for Mental Health and Developmental Disabilities. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
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	01530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(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
01530	Continued From page 77 each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to ensure the required amount of dementia care training was completed in the required time frame in accordance with 144G.64 for three of three employees (registered nurse (RN)-A, unlicensed personnel (ULP)-C, and ULP-H) with employee records reviewed. This had the potential to affect all three (3) residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: RN-A was hired May 30, 2022, and provided supervisory and direct care services to the residents of the facility. ULP-C was hired November 22, 2022, and provided direct care services to the residents of the facility. ULP-H was hired July 10, 2022, and provided direct care services to the residents of the facility. RN-A, ULP-C, and ULP-H's employee records all lacked documentation they completed the required amount of dementia care training in the required topics.	01530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(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
01530	Continued From page 78 On August 8, 2022, at 2:50 p.m., ULP-C stated he was hired November 2021. ULP-C stated he had orientation and training to assisted living rules and all training required. On August 9, 2022, at approximately 10:30 a.m., ULP-H stated house manager (HM)-J (an unlicensed personnal) trained her on items including the house, when to give meds, documentation, and a basic hand washing lesson. ULP-H further stated she had not been provided any dementia care education. On August 9, 2022, during an 11:32 a.m. interview, RN-A stated she had not provided dementia care training to any staff. RN-A further stated she had not received dementia care training provided by the licensee. RN-A indicated she had dementia care training for other employment, but the licensee did not request those records. The licensee's Dementia Education policy, dated August 1, 2021, indicated, supervisors of direct care staff would complete eight (8) hours of initial training within 120 hours of the employment start date, and direct care employees will complete eight (8) hours of initial training within 160 hours of the employment start date. The policy further indicated dementia care training would include: an explanation of Alzheimer's disease and other dementias, assistance with activities of daily living, problem solving with challenging behaviors, communication skills, and person centered planning and service delivery. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(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
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident monitoring and reassessment, not to exceed 90 calendar days from the last date of the assessment for one of one resident (R1) receiving services with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(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
01620	Continued From page 80 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted July 16, 2021. R1's service plan, signed July 6, 2021, indicated R1 received services including assistance with medication management, housekeeping, dressing, ADLs, meals, shopping, and transfers and mobility. R1's record included a nursing assessment dated January 17, 2022, and a subsequent assessment dated May 30, 2022 (133 days later), which exceeded 90 days since the previous RN assessment. On August 9, 2022, at 2:13 p.m., RN-A confirmed R1's assessment dates and noted the assessments were done prior to her hire date. RN-A stated if further assessments were done, they would be in R1's record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01650 SS=D	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include:	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(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
01650	Continued From page 81 (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to include required service plan content for one of one residents (R1) service plan. 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	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(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
01650	Continued From page 82 was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted July 16, 2021. R1's service plan, signed July 6, 2021, indicated R1 received services including assistance with medication management, diabetic management, housekeeping, dressing, ADLs, meals, shopping, and transfers and mobility. R1's service plan lacked the following information: -fee for services to be provided; and -contingency plan complete with an emergency contact. On August 10, 2022, at 3:10 p.m., assistant director (AD)-B acknowledged R1's service plan did not include fees for services or a contingency plan with emergency contact information. The licensee Service Plan policy, dated August 1, 2021, indicated, "The fees for services and the frequency of each service of each service." The policy further indicated a contingency plan requirement which included, "Action to be taken if the scheduled service cannot be provided, information and method for a resident or resident's representative to be contacted by [licensee], names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, the identification of and information as to who has the authority to sign for the resident in an emergency,	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(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
01650	Continued From page 83 circumstances in which emergency medical services are not to be summoned and declaration made by the resident related to health care directives." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		
01690 SS=I	144G.71 Subdivision 1 Medication management services (a) This section applies only to assisted living facilities that provide medication management services. (b) An assisted living facility that provides medication management services must develop, implement, and maintain current written medication management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse, licensed health professional, or pharmacist consistent with current practice standards and guidelines. (c) The written policies and procedures must address requesting and receiving prescriptions for medications; preparing and giving medications; verifying that prescription drugs are administered as prescribed; documenting medication management activities; controlling and storing medications; monitoring and evaluating medication use; resolving medication errors; communicating with the prescriber, pharmacist, and resident and legal and designated representatives; disposing of unused medications; and educating residents and legal and designated representatives about medications. When controlled substances are	01690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(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
01690	Continued From page 84 being managed, the policies and procedures must also identify how the provider will ensure security and accountability for the overall management, control, and disposition of those substances in compliance with state and federal regulations and with subdivision 23. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to implement current medication management policies and procedures, which were developed under the supervision and direction of a registered nurse (RN), consistent with current practice standards and guidelines related to medication management, delegation and pain management. The deficient practice had the potential to affect all three (3) residents of the facility. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 was admitted on July 16, 2021, and had diagnoses including chronic pain, hemophilia, and diabetes. R1's service plan, signed July 6, 2021, indicated R1 received services including assistance with medication management, diabetic management, housekeeping, dressing, activities of daily living (ADLs), meals, shopping, and transfers and	01690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(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
01690	Continued From page 85 mobility. On August 9, 2022, at 9:50 a.m., unlicensed personnel (ULP)-H was observed to administer medications to R1. R1's record included a hospital discharge after visit summary (AVS), dated July 19, 2022. The AVS included a current medication list, and changes made to medications for R1. The AVS was electronically signed by doctor (MD)-P on July 19, 2022. R1's medication administration record (MAR) for August 2022 indicated R1 received the following medications: amlodipine 10 milligrams (mg), buproprion hydrochloride (anti-anxiety) 450 mg, escitalopram (anti-depressant) 10 mg, gabapentin (for pain) 400 mg, lidocare (for pain)) 4 mg, losartan/hydrochlorothiazide (for blood pressure) 50-12.5 mg, psyllium fiber 0.52 grams (gm), Rybelsus (semaglutide-for diabetes) 75 mg, spiriva (tiotropium bromide-for asthma and chronic obstructive pulmonary disease (COPD)) 2.5 micrograms (mcg), zanaflex (tizanidine-for muscle spasm) 4 mg, atorvastatin (for high cholesterol) 40 mg, metoprolol (for blood pressure) 50 mg, and trazadone (sleep aid) 150 mg. AVAILABILITY OF RN RN-A was hired May 30, 2022, and provided supervisory and direct care services to the residents of the facility. The licensee hired RN-A to perform all nursing tasks. RN-A simultaneously held a nursing position working a 0.5 schedule (or approximately 20 hours per week) at a hospital which would not allow her to be available to leave to address	01690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(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
01690	Continued From page 86 facility emergencies or concerns. See also immediate correction order 1390 related to MN statute 144G.61 Subd. 1 DELEGATION OF MEDICATION ADMINISTRATION ULP-C ULP-C was hired November 22, 2021, and provided direct care services to residents. R1's medication administration record (MAR) for July 2022 indicated ULP-C administered medications to R1 on July 29-31, 2022. ULP-C's employee record lacked documentation of medication administration training and competency completed prior to administering medications to R1. ULP-C's record lacked documentation of a 30-day supervision of performing delegated tasks. ULP-H ULP-H was hired July 10, 2022, and provided direct care services to residents. On August 9, 2022, at 9:50 a.m., unlicensed personnel (ULP)-H was observed to administer medications to R1. R1's MAR for July 2022 indicated ULP-H also administered medications to R1 on July 12-14, 2022. ULP-H's employee record lacked documentation of medication administration training and competency completed prior to administering medications to R1.	01690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(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
01690	Continued From page 87 On August 9, 2022, at 10:30 a.m. ULP-H stated she received training from house manager (HM)-J (an unlicensed personnel) on medication administration. Also see immediate correction order 1750 related to MN statute 144g.71 Subd. 7, and correction order 1440 related to MN statute 144G.62 Subd. 4. DOCUMENTATION: PAIN MEDICATION/ASSESSMENT R1's medication administration record (MAR) indicated R1 was administered the following PRN medication (documented as administered 27 times in July, 2022, and 6 times in August, 2022): -oxycodone/APAP (acetaminophen) 5-325 milligram (mg) tablet: Take 1 tablet by mouth every 6 hours PRN. R1's MAR indicated the following medications were available for pain, but were not documented as administered to R1 in July and August 2022: -Acetaminophen 500 mg tablet: Take 2 tablets by mouth twice a day PRN; -Tizanidine 2 mg tablet: Take 2 tablets (4mg) by mouth every 6 hours as needed for muscle spasms. R1's record lacked documentation of any pain assessment or effectiveness of the PRN pain medication administered. Also see the correction order 1760 related to MN statute 144G.71 Subd. 8 DOCUMENTATION: MEDICATION ADMINISTRATION R1's medication administration records (MAR) for	01690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(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
01690	Continued From page 88 July 2022, and August 2022, lacked documentation the following scheduled medications were administered: -Amlodipine 10 mg: Take 1 tablet by mouth daily for blood pressure (13 of 31 days for July, 2022, and 5 of 8 days in August, 2022, were undocumented); -Atorvastatin 40 mg tablet: Take 1 tablet by mouth daily for cholesterol/heart (6 of 31 days for July, 2022, and 5 of 8 days in August, 2022, were undocumented); -Bupropion HCL 150 mg extended release (XL) tablet: Take 1 tablet by mouth every morning with 300 mg for a total daily dose of 450 mg (13 of 31 days for July, 2022, and 5 of 8 days in August, 2022, were undocumented); -Bupropion HCL 300 mg XL tablet: Take 1 tablet by mouth every morning with 150 mg tablet for total daily dose of 450 mg (13 of 31 days for July, 2022, and 5 of 8 days in August, 2022, were undocumented); -Escitalopram 10 mg tablet: Take 1 tablet by mouth daily. Stop fluoxetine. (13 of 31 days for July, 2022, and 5 of 8 days in August, 2022, were undocumented); -Gabapentin 400 mg capsule. Take 1 capsule by mouth every morning and every afternoon with dose in pack for total daily dose of 2 capsules three times a day (54 of 93 administration opportunities for July, 2022, and 19 of 27 opportunities for August, 2022, were undocumented); -Gabapentin 400 mg capsule: Take 2 capsules by mouth three times a day (21 of 27 administration opportunities for August, 2022, were undocumented); -Lidocare 4% pad: Place 1 patch onto the skin daily 12 hours on, 12 hours off (13 of 31 days for July, 2022, and 5 of 8 days in August, 2022, were undocumented);	01690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(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
01690	Continued From page 89 -Losartan/hydrochlorothiazide 50-12.5 mg tablet: Take 1 tablet by mouth every morning for blood pressure (13 of 31 days for July, 2022, and 5 of 8 days in August, 2022, were undocumented); -Metoprolol Succinate extended release (ER) 50 mg: Take 1 tablet by mouth daily (6 of 31 days for July, 2022, and 5 of 8 days in August, 2022, were undocumented); -Psyllium Fiber 0.52 grams (g) capsule: Take 1 capsule by mouth daily (13 of 31 days for July, 2022, and 5 of 8 days in August, 2022, were undocumented); -Spiriva Respimat 2.5 micrograms (mcg): Inhale 2 puffs into the lungs daily (13 of 31 days for July, 2022, and 5 of 8 days in August, 2022, were undocumented). Also see the correction order 1760 related to MN statute 144G.71 Subd. 8 PRESCRIPTIONS RN-A failed to ensure there was a written or electronically recorded prescription order for all medications administered or available to be administered as needed to R1. Also see the correction order 1820 related to MN statute 144g.71 Subd. 13 TRANSCRIPTION OF ORDERS R1's record included an after visit summary (AVS) from R1's pain clinic, dated June 20, 2022, indicating R1 should continue to take Oxycodone 10 mg, up to three times daily as needed for pain. R1's AVS dated July 19, 2022, included the following new medication orders: -ipratropium - albuterol 0.5 mg/2.5 mg/3 milliliters (mL) neb solution: Tale 1 vial by nebulization 4 times daily as needed for wheezing or shortness	01690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(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
01690	Continued From page 90 of breath/dyspnea; -Trulicity 1.5 mg/0.5 mL: Inject 1.5 mg subcutaneous every 7 days. The AVS further indicated R1 should continue: -oxycodone 10 mg tablet: Take 1 tablet (10 mg) by mouth every 4 hours as needed; and -ferrous sulfate 325 mg tablet: Tale 1 tablet by mouth daily (with breakfast). R1's MAR for June, July and August 2022 did not include the above listed medications. On August 9, 2022, at 11:32 a.m., RN-A stated R1 was not currently taking Oxycodone because the prescription ran out and they were not able to get it refilled. RN-A further stated she was not responsible for ordering medications, and assistant director AD-B was responsible for refilling medications. MEDICATION ALLERGY R1's MAR for July and August 2022, indicated acetaminophen and oxycodone/APAP were available as PRN medications. R1's MAR further indicated oxycodone/APAP had been administered in July and August, 2022. R1's MAR for June, July, and August 2022, Care Plan signed July 6, 2021, and nursing assessments dated December 19, 2021, May 30, 2022, July 11, 2022, and August 8, 2022, all indicated acetaminophen/Tylenol was a medical allergy for R1. Also see the correction order 1760 related to MN statute 144G.71 Subd. 8 MEDICATION MANAGEMENT PLAN R1's record lacked a medication management	01690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(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
01690	Continued From page 91 plan to include the following: -a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; -documentation of specific resident instructions relating to the administration of medications; -procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and -any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. R1's nursing assessment dated December 19, 2021, indicated R1 had been sent to the hospital for pain at a level 10 out of 10. The assessment included the following interventions should be implemented by the RN according to discharge instructions: - Warm and cold packs to be applied as needed. - Physical medicine and rehab consultation - Dilaudid for more severe pain - Prednisone taper to decrease inflammation R1's care plan and medication management plan, both dated June 6, 2021, were not updated to include non-pharmacological interventions to be used for pain management. Also see correction order 1730 related to MN statute 144G.71 Subd. 5. MEDICATION ASSESSMENT R1's record lacked a medication assessment with the required content completed in the last 12	01690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(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
01690	Continued From page 92 months, or with changes. R1's record included nursing assessments completed July 11, 2022, and August 8, 2022 (during the survey). The assessments lacked a review of R1's medications. R1's record indicated R1 was hospitalized December 19, 2021, and July 19, 2022. Post-hospitalization assessments lacked a review of medications, and failed to identify changes made to R1's medication orders. Also see correction order 1710 related to MN statute 144G.71 Subd. 3. MEDICATION SET-UP R1's MAR lacked documentation of medication set-up performed by the RN. Also see the correction order number 1770 related to MN statute 144G.71 Subd. 9. On August 9, 2022, during an 11:32 a.m. interview, RN-A stated she provided training on medication administration to unlicensed personal, but did not document the training. RN-A acknowledged staff were not appropriately documenting medication administration. RN-A further acknowledged staff would need additional training on medication administration and documentation. On August 9, 2022, during an 11:32 a.m. interview, RN-A indicated she had not received orientation to assisted living laws and regulations or any other required training. RN-A stated she provided training on medication administration to unlicensed staff, but did not document the training, because she thought management	01690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(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
01690	Continued From page 93 would document. RN-A further stated the pain assessment would be documented for R1 in an activity log (the log was requested but not provided). RN-A acknowledged staff are not appropriately documenting medication administration. RN-A stated her expectation would be that pain would be assessed and documented when R1 requested pain medication. RN-A further acknowledged staff needed retraining on medication and documentation. The licensee's Service Plan for Medication Management policy, dated August 1, 2021, indicated, "The registered nurse is responsible for preparing and documenting the Medication Management Plan." The policy further indicated, "The Medication Management Plan will be kept current and updated with any changes." The licensee's Medication Administration policy dated August 1, 2021, indicated, "Residents of [licensee] are entitled to the safe administration of medications by qualified personnel according to a written Medication Management Plan." The policy further indicated, "The licensed nurse is responsible for assessing medications to assure that all medications are current and ordered by the prescriber and to identify any expired or outdated medications, which will be disposed according to policy." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01690		
01710 SS=G	144G.71 Subd. 3 Individualized medication monitoring and reas	01710		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(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
01710	Continued From page 94 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: Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) conducted a face-to-face medication management reassessment to include all required content for one of one resident (R1). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted July 16, 2021, and had diagnoses including chronic pain, hemophilia, and diabetes. On August 9, 2022, at 9:50 a.m., ULP-H was observed to administer medications to R1. R1's service plan signed July 6, 2021, indicated R1 received services including assistance with medication management. R1's record included a list of completed	01710		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(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
01710	Continued From page 95 assessments printed August 9, 2022, indicating R1 had a "post ER assessment" completed December 19, 2021. R1's nursing assessment completed December 19, 2021, lacked a review of medications. The assessment indicated, "Client went to an ER for Pain greater than 10/10 that was not leviated (sic) after taking Dilaudid. Client recently had another ER visit for the same pain. MRI examination revealed this was due to Lumbar degenration. Physical therapy, weight management and Pain medication were perscribed as a care". R1's record lacked a medication assessment subsequent to the above referenced ER visit related to pain. R1's record included an after visit summary (AVS) dated July 19, 2022, subsequent to a hospitalization related to Shortness of Breath. The AVS included the following new medication orders: -ipratropium - albuterol 0.5 mg/2.5 mg/3 milliliters (mL) neb solution: Tale 1 vial by nebulization 4 times daily as needed for wheezing or shortness of breath/dyspnea; -Trulicity 1.5 mg/0.5 milliliters (mL): Inject 1.5 mg subcutaneous every 7 days; The AVS further indicated R1 should continue: "oxycodone 10 [milligram (mg)] tablet: Take 1 tablet (10 mg) by mouth every 4 hours as needed". The AVS further indicated R1 should stop taking Rybelsus 7 mg tablet. R1's nursing assessment, dated July 19, 2022, indicated the assessment was a "post hospital" assessment. The assessment lacked a review of medications. The assessment indicated no	01710		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(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
01710	Continued From page 96 change to medications or to R1's care plan, and further indicated to "continue POC" (plan of care). R1's record included a progress note dated July 19, 2022, that indicated there was a new insulin order, but did not address other changes to medications for R1. Regarding medications, the progress note indicated, "No changes reported. Writer set up the weekly meds for the client and instructed staff to administer medications as instructed in the MAR [medication administration record]". R1's record lacked a medication assessment completed subsequent to the above referenced hospitalization related to shortness of breath. R1's MAR for July and August, 2022, indicated R1 continued to be administered Rybelsus, and was not administered the duoneb or Trulicity as indicated in the AVS. Further, Oxycodone 10 mg did not appear on R1's MAR as an available medication as indicated in the AVS. On August 9, 2022, during an 11:32 a.m. interview, RN-A stated she completed a medication assessment every week that was documented through the licensee's electronic documentation program. RN-A further stated R1 sometimes took Oxycodone for pain, and sometimes the medication ran out. RN-A indicated the prescription was unable to be renewed at that time. R1's electronic nursing progress notes were reviewed. The provided documentation lacked evidence the RN conducted a review of all medications the resident was known to be taking to include a review of the side effects and contraindications.	01710		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(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
01710	Continued From page 97 The licensee's Assessment for Medication Management Program policy dated February 22, 2021, indicated, "Medication reassessment will occur at the following times i. Client symptomology ii. Problems or concerns that may be medication-related iii. With new prescription, OTC or herbal products iv. Annually." The policy further indicated the assessment would include identification of all medications, medication reconciliation (comparing the client record to the most accurate list from a provider or other source, assessment for effectiveness, side effects, noncompliance, changes in condition, etc), and potential for diversion. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01710		
01730 SS=G	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01730	Continued From page 98 on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop and maintain a current individualized medication management plan to include all required content for one of one resident (R1) with record reviewed. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death,	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01730	Continued From page 99 or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted July 16, 2021, and had diagnoses including chronic pain, hemophilia, and diabetes. On August 9, 2022, at 9:50 a.m., ULP-H was observed to administer medications to R1. R1's service plan signed July 6, 2021, indicated R1 received services including assistance with medication management. R1's medication managment plan, dated July 6, 2021, lacked the following: -description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; -documentation of specific resident instructions relating to the administration of medications; -procedures for staff notifying a registered nurse (RN) or appropriate licensed health professional when a problem arose with medication management services; and -any resident-specific requirements relating to documentation of medication administration, verifications that all medications are administered as prescribed and monitoring of medication use to prevent possible complications or adverse reactions. R1's nursing assessment dated December 19,	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01730	Continued From page 100 2021, indicated R1 had been sent to the hospital for pain at a level 10 out of 10. The assessment included the following interventions should be implemented by the RN according to discharge instructions: - Warm and cold packs to be applied as needed. - Physical medicine and rehab consultation - Dilaudid for more severe pain - Prednisone taper to decrease inflammation R1's medication management plan, and care plan, both dated June 6, 2021, were not updated to include non-pharmacological interventions to be used for pain management. On August 10, 2022, at 10:29 a.m., registered nurse (RN)-A verified R1's medication management plan was lacking required content. RN-A agreed the existing plan, which was found partially completed on three separate documents, would need to be updated. The licensee's Service Plan for Medication Management policy, dated February 22, 2021, indicated, "[Licensee] will prepare and document a Medication Management Plan as part of the Service Plan for each client receiving medication management services". The policy further indicated, "The written Medication Management Plan includes the following provisions. a. A statement describing the medication management services to be provided b. A description of the storage of medications based on the client assessment* and addressing i. Client preference ii. Risk of diversion iii. Instructions per manufacturer c. Documentation procedures d. Procedures for verifying the prescription medications are administered as prescribed	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01730	Continued From page 101 e. Procedures for medication reconciliation* f. Identification of person(s) responsible for monitoring medication supplies and ensuring refills are ordered/timely g. Description of medication management tasks to be delegated to unlicensed personnel h. Plans for notifying licensed health professional when/if a problem with medication management services arises." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01750 SS=I	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure, prior to delegating nursing tasks, the unlicensed personnel (ULP) were trained in the proper methods to perform the task or procedure for each resident and were able to demonstrate the	01750		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01750	Continued From page 102 ability to competently follow the procedure to perform the tasks for two of two employees (ULP-C, ULP-H) with employee records reviewed. This resulted in an immediate correction order on August 9, 2022, at approximately 7:20 p.m. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 was admitted July 16, 2021, and had diagnoses including chronic pain, hemophilia, and diabetes. R1's record lacked a medication management plan to include the following: -a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; -documentation of specific resident instructions relating to the administration of medications; -procedures for staff notifying a registered nurse (RN) or appropriate licensed health professional when a problem arose with medication management services; and -any resident-specific requirements relating to documenting medication administration, verifications all medications were administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions.	01750		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01750	Continued From page 103 ULP-H ULP-H was hired July 10, 2022, and provided direct care services to residents. On August 9, 2022, at 9:50 a.m., unlicensed personnel (ULP)-H was observed to administer medications to R1. R1's MAR for July 2022 indicated ULP-H administered medications to R1 on July 12-14, 2022. ULP-H's employee record lacked documentation of medication administration training and competency completed prior to administering medications to R1. On August 9, 2022, at 10:30 a.m. ULP-H stated she received training from house manager (HM)-J (an unlicensed personnel) on medication administration. On August 9, 2022, during an 11:32 a.m. interview, RN-A stated she provided training on medication administration to unlicensed personnell, but did not document the training. RN-A acknowledged staff were not appropriately documenting medication administration. RN-A further acknowledged staff would need additional training on medication administration and documentation. On August 9, 2022, at 12:43 p.m., ULP-H stated she reached out to RN-A 7/28/22 to request pain medication for R1. ULP-H stated RN-A gave permission to give acetaminophen. ULP-H stated R1 did not have the medication, but she got it from a bottle in the kitchen cabinet, and administered one tablet of acetaminophen to R1.	01750		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01750	Continued From page 104 R1's medication administration record (MAR) for July 2022 lacked documentation of acetaminophen administered July 28, 2022. R1's MAR further identified R1's allergies included acetaminophen. ULP-C ULP-C was hired November 22, 2021, and provided direct care services to residents. R1's medication administration record (MAR) for July 2022 indicated ULP-C administered medications to R1 on July 29-31, 2022. ULP-C's employee record lacked documentation of medication administration training and competency completed prior to administering medications to R1. ULP-C's record lacked documentation of a 30-day supervision of performing delegated tasks. ULP-C's record included an Medication Administration for Home Health Aides certificate signed by registered nurse (RN)-Q October 1, 2021 (7 weeks prior to his start date). ULP-C's record included an additional Medication Administration certificate signed by RN-Q with no name entered to indicate the staff trained. On August 8, 2022, at 2:50 p.m., ULP-C verified he was hired November 2021. On August 8, 2022, at 4:27 p.m., assistant director (AD)-B verified ULP-C was hired November 2021. AD-B stated RN-Q whose signature appeared on ULP-C's skills competency dated October 1, 2021, was hired in	01750		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01750	Continued From page 105 October 2021. On August 10, at 2:26 p.m., assistant director (AD)-B stated as of that time, three ULPs that would be working on that day had received medication administration training and competency. AD-B further stated RN-A would be performing further training for each remaining ULP at the start of their next shift. Medication administration training documents were provided for ULP-H, ULP-I, and ULP-M, all dated August 10, 2022. No further documentation of training was provided. The licensee's Delegation of Assisted Living Tasks policy dated August 1, 2021, indicated, "The clinician (registered nurse or licensed health professional) is responsible for appropriately delegating tasks to staff who are competent and possess the knowledge and skills consistent with the complexity of the tasks in accordance with the appropriate Minnesota Practice Act." No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	01750		
01760 SS=G	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(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
01760	Continued From page 106 reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to document medication administration, and effectiveness of as-needed (PRN) medication per provider orders, and failed to transcribe ordered medications correctly for one of one residents (R1) with records reviewed. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted on July 16, 2021, and had diagnoses including chronic pain, hemophilia, and diabetes. R1's service plan, signed July 6, 2021, indicated R1 received services including assistance with medication management, diabetic management, housekeeping, dressing, activities of daily living (ADLs), meals, shopping, and transfers and mobility.	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(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
01760	Continued From page 107 On August 9, 2022, at 9:50 a.m., unlicensed personnel (ULP)-H was observed to administer medications to R1. R1's record included a hospital discharge after visit summary (AVS), dated July 19, 2022. The AVS included a current medication list, and changes made to medications for R1. The AVS was electronically signed by doctor (MD)-P on July 19, 2022. DOCUMENTATION: PAIN MEDICATION/ASSESSMENT R1's nursing assessment completed December 19, 2021, indicated, "Client went to an [emergency room (ER)] for Pain greater than 10/10 that was not leviated (sic) after taking Dilaudid. Client recently had another ER visit for the same pain. [Magnetic Resonance Imaging (MRI)] examination revealed this was due to Lumbar degenration (sic). Physical therapy, weight management and Pain medication were perscribed (sic) as a care". R1's medication administration record (MAR) indicated R1 was administered the following PRN medication (documented as administered 27 times in July, 2022, and 6 times in August, 2022): -oxycodone/APAP (acetaminophen) 5-325 milligram (mg) tablet: Take 1 tablet by mouth every 6 hours PRN. R1's MAR indicated the following medications were available for pain, but were not documented as administered to R1 in July and August 2022: -Acetaminophen 500 mg tablet: Take 2 tablets by mouth twice a day PRN; -Tizanidine 2 mg tablet: Take 2 tablets (4mg) by mouth every 6 hours as needed for muscle spasms.	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(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
01760	Continued From page 108 R1's record lacked documentation of any pain assessment or effectiveness of the PRN pain medication administered. On August 8, 2022, at approximately 11:00 a.m., R1 was observed to ambulate with standby assistance from his room to the stairs, saying "ouch" and exhibiting pain symptoms. R1 paused, and asked if the car was close before he proceeded down the stairs. R1 then proceeded down the stairs, continuing verbal expressions of pain. On August 9, 2022, at 10:01 a.m., R1 was observed to be in the bathroom. ULP-H assisted R1 to stand, and R1 was observed to yell out in pain. ULP-H was not observed to request a pain scale rating or administer PRN pain medication. On August 9, 2022, during an 11:32 a.m. interview, RN-A stated pain was assessed with oxycodone administration. RN-A further stated there was supposed to be a folder labeled "daily activity log" for staff to document items such as vital signs, pain assessments, activities, cleaning, and progress notes. The log was not provided. On August 9, 2022, at 12:38 p.m., assistant director (AD)-B stated any documentation of pain assessment for R1 for PRN medication administration would be on the back of the MAR. The MAR for July and August 2022 did not include any pain assessment documentation. DOCUMENTATION: MEDICATION ADMINISTRATION R1's medication administration records (MAR) for July 2022, and August 2022, lacked documentation the following scheduled	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(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
01760	Continued From page 109 medications were administered: -Amlodipine 10 mg: Take 1 tablet by mouth daily for blood pressure (13 of 31 days for July, 2022, and 5 of 8 days in August, 2022, were undocumented); -Atorvastatin 40 mg tablet: Take 1 tablet by mouth daily for cholesterol/heart (6 of 31 days for July, 2022, and 5 of 8 days in August, 2022, were undocumented); -Bupropion HCL 150 mg extended release (XL) tablet: Take 1 tablet by mouth every morning with 300 mg for a total daily dose of 450 mg (13 of 31 days for July, 2022, and 5 of 8 days in August, 2022, were undocumented); -Bupropion HCL 300 mg XL tablet: Take 1 tablet by mouth every morning with 150 mg tablet for total daily dose of 450 mg (13 of 31 days for July, 2022, and 5 of 8 days in August, 2022, were undocumented); -Escitalopram 10 mg tablet: Take 1 tablet by mouth daily. Stop fluoxetine. (13 of 31 days for July, 2022, and 5 of 8 days in August, 2022, were undocumented); -Gabapentin 400 mg capsule. Take 1 capsule by mouth every morning and every afternoon with dose in pack for total daily dose of 2 capsules three times a day (54 of 93 administration opportunities for July, 2022, and 19 of 27 opportunities for August, 2022, were undocumented); -Gabapentin 400 mg capsule: Take 2 capsules by mouth three times a day (21 of 27 administration opportunities for August, 2022, were undocumented); -Lidocare 4% pad: Place 1 patch onto the skin daily 12 hours on, 12 hours off (13 of 31 days for July, 2022, and 5 of 8 days in August, 2022, were undocumented); -Losartan/hydrochlorothiazide 50-12.5 mg tablet: Take 1 tablet by mouth every morning for blood	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(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
01760	Continued From page 110	01760		

pressure (13 of 31 days for July, 2022, and 5 of 8 days in August, 2022, were undocumented);
-Metoprolol Succinate extended release (ER) 50 mg: Take 1 tablet by mouth daily (6 of 31 days for July, 2022, and 5 of 8 days in August, 2022, were undocumented);
-Psyllium Fiber 0.52 grams (g) capsule: Take 1 capsule by mouth daily (13 of 31 days for July, 2022, and 5 of 8 days in August, 2022, were undocumented);
-Spiriva Respimat 2.5 micrograms (mcg): Inhale 2 puffs into the lungs daily (13 of 31 days for July, 2022, and 5 of 8 days in August, 2022, were undocumented).

On August 8, 2022, at 1:41 p.m., RN-A was shown R1's MAR for June, July, and August, 2022, and acknowledged MAR documentation was missing medication administration documentation. RN-A stated they have been having issues with staff documenting what they had administered. RN-A stated it was something they had been trying to address with staff and needs to have another meeting to get the problem fixed. RN-A again acknowledged this had been an ongoing problem.

Oxycodone/acetaminophen
R1's MAR for July and August 2022, indicated, oxycodone/acetaminophen (APAP) 5-325 mg tablet: Take 1 tablet by mouth every six hours PRN for severe pain. The MAR indicated this PRN medication was administered 27 times in July, 2022, and 6 times in August, 2022.

On August 22, 2022, at 8:04 a.m., Pharmacy Manager (PM)-O stated they had not dispensed oxycodone/acetaminophen to the facility since August 13, 2021, and the medication should no longer have been on the MAR for R1.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(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
01760	Continued From page 111 TRANSCRIPTION R1's AVS dated July 19, 2022, included the following new medication orders: -ipratropium - albuterol 0.5 mg/2.5 mg/3 milliliters (mL) neb solution: Tale 1 vial by nebulization 4 times daily as needed for wheezing or shortness of breath/dyspnea; -Trulicity 1.5 mg/0.5 mL: Inject 1.5 mg subcutaneous every 7 days. The AVS further indicated R1 should continue: -oxycodone 10 mg tablet: Take 1 tablet (10 mg) by mouth every 4 hours as needed; and -ferrous sulfate 325 mg tablet: Tale 1 tablet by mouth daily (with breakfast). R1's MAR for July and August 2022 did not include the above listed medications. Gabapentin The AVS dated July 19, 2022, indicated, "Gabapentin 400 mg capsule. Take 1 capsule by mouth every morning and every afternoon with dose in pack for total daily dose of 2 capsules three times a day". R1's August, 2022 MAR contained two separate orders for gabapentin: -Gabapentin 400 mg capsule. Take 1 capsule by mouth every morning and every afternoon with dose in pack for total daily dose of 2 capsules three times a day (documented as administered 8 times in August, 2022); -Gabapentin 400 mg capsule: Take 2 capsules by mouth three times a day (documented as administered 6 times in August 2022); A nursing progress note dated August 8, 2022, at 1:33 p.m., by RN-A, indicated the pharmacy was	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(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
01760	Continued From page 112	01760		

contacted to confirmed R1's order was for gabapentin 400 mg capsules: take 2 capsules three times daily. The progress note further indicated to "follow the MAR as instructed".

On August 9, 2022, at 9:50 a.m. ULP-H was observed administering the correct dose of gabapentin to R1; however, the MAR was not updated to reflect the confirmed order.

Rybelsus
R1's AVS dated July 19, 2022, indicated R1 should stop taking Rybelsus 7 mg tablet.

R1's MAR for July and August 2022, indicated, "Rybelsus 7 mg tablet: Take 1 tablet by mouth daily with no more than 4 ounces of water and 30 minutes before (sic)". The MAR indicated Rybelsus 7mg continued to be administered July 22, 23, 24, 29, 30, 31, and August 5, 6, and 7, 2022, after being discontinued.

Medication allergy:
R1's MAR for June, July, and August 2022, Care Plan signed July 6, 2021, and nursing assessments dated December 19, 2021, May 30, 2022, July 11, 2022, and August 8, 2022, all indicated acetaminophen/Tylenol was a medical allergy. R1's MAR indicated acetaminophen and oxycodone/APAP were PRN medications. R1's MAR indicated oxycodone/APAP had been administered in July and August, 2022, (see above).

On August 9, 2022, at 11:32 a.m. registered nurse RN-A acknowledged the MAR for July and August, 2022, were missing documentation of a medication being administered or were documented as being given when they had not been. RN-A stated staff were blindly signing off

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(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
01760	Continued From page 113 on the MAR rather than reading the MAR and documenting accurately. RN-A stated staff were not compliant with documentation in the MAR and were not getting enough training. On August 9, 2022, at 2:33 p.m., RN-R (a clinic nurse from R1's care team) indicated R1 was to limit the use of acetaminophen due to a history of hepatitis C (a viral infection that causes liver inflammation). The licensee's Medication Administration policy, dated August 1, 2021, indicated, "The licensed nurse is responsible for assessing medications to assure that all medications are current and ordered by the prescriber and to identify any expired or outdated medications, which will be disposed according to policy." No further information provided TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01770 SS=G	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure documentation of medication setup included all the required content for one of one residents (R1)	01770		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(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
01770	Continued From page 114 with records reviewed. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted July 16, 2021. R1's service plan signed July 6, 2021, indicated R1 received services including assistance with medication management, housekeeping, bathing, activities of daily living (ADLs), meals, shopping, and transfers and mobility. On August 8, 2022, at 1:41 p.m., registered nurse (RN)-A stated she set up R1's medications in a pillbox for unlicensed personnel (ULP) to administer, but acknowledged she did not have documentation of setting up the medication. On August 8, 2022, at 1:56 p.m., RN-A stated she documented the weekly medication setup in progress notes on the electronic record system. On August 9, 2022, at 9:50 a.m., ULP-H was observed to administer R1's medications which were previously set up in a pillbox by RN-A. R1's nursing progress notes dated June 13, July 4, 11, 13, 25, and August 8, 2022, lacked documentation RN-A completed set up of medication. Further, progress notes dated June	01770		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(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
01770	Continued From page 115 6, 20, 27, July 19, and August 1, 2022, indicated medications were set up on those days, but lacked documentation of the medications and dosages set up for later administration. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770		
01820 SS=G	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure written or electronically recorded prescriptions were obtained for one of one residents (R1) with record reviewed. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted July 16, 2021.	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01820	Continued From page 116 R1's service plan signed July 6, 2021, indicated R1 received services including assistance with medication management, laundry, housekeeping, meals, shopping, bathing, and activities of daily living (ADLs). On August 9, 2022, at 9:50 a.m., unlicensed personnel (ULP)-H was observed to administer medications to R1. R1's medication administration record (MAR) for July and August 2022, indicated medications were administered including the following: -Lidocare 4% pad: Place 1 patch onto the skin daily 12 hours on, 12 hours off (administered July 1-10, 12, 13, 14, 21, 22, 23, 29, 30, 31, and August 5, 6, and 7, 2022); -oxycodone/APAP 5-325 mg tablet: Take 1 tablet by mouth daily (administered July 1-14, 16, 17, 19, 20, 21, 22, 24, 29, 30, 31, and August 5, 6, 7, 2022); -Psyllium Fiber 0.52 grams (g) capsule: Take 1 capsule by mouth daily (administered July 1-10, 12, 13, 14, 22, 23, 24, 29, 30, 31, and August 5, 6, and 7, 2022); R1's MAR further indicated the following medications were available for R1 as needed, although they were not documented as administered in July or August 2022: -acetaminophen 500 mg tablet: Take 2 tablets by mouth twice a day as needed; -Calmoseptine ointment: Apply to affected area(s) topically four times a day as needed for skin protection; -Bisacodyl 5 mg enteric coated (EC) tablet: Take 1 tablet by mouth daily for 3 days as needed; -nicotine transdermal patch 21 mg/24 hours: Remove old patch and apply one new patch onto	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01820	Continued From page 117 skin daily as needed; -Optichamber diamond: Use with multidose albuterol as needed. R1's record included an after visit summary (AVS) signed by doctor (MD)-P July 19, 2022, that included a medication list, but lacked signed orders for the above listed medications. On August 8, 2022, at 3:09 p.m., registered nurse (RN)-A and assistant director (AD)-B stated they faxed a request for orders signed by the provider in May, 2022, but an unsigned list was returned. AD-B provided a copy of the faxed response, dated May 5, 2022, that included a medication list but lacked a written or electronic provider signature. RN-A stated she looked through R1's record and was unable to find signed orders for medications. On August 8, 2022, at 3:28 p.m. RN-A stated she was unable to find signed orders for R1 after an additional search. On August 9, 2022, during an 11:32 a.m. interview, RN-A indicated all the medication administration records were not accurate. RN-A stated staff were "just blindly signing every box without reading". RN-A further stated staff were provided training on documentation, but they need additional training and she had raised the issue with management multiple times. On August 22, 2022, at 8:04 a.m., pharmacy manager (PM)-O stated the pharmacy did maintain current signed orders on file for themselves for all medications listed on the resident's MAR and sent to the facility. PM-O further stated they would only send medications out if they had a signed order on file.	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01820	Continued From page 118 The licensee's Medication & Treatment Orders policy dated January 1, 2022, indicated the RN is responsible for assuring that current, authorized prescriber orders for medications or treatments administered by the staff are kept on file in the residents' records. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
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 and interview, the licensee failed to ensure all medications were securely locked in substantially constructed compartments and permit only authorized personnel had access. This had the potential to affect all three (3) 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 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).	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01880	Continued From page 119 The findings include: On August 9, 2022, at 12:43 p.m., unlicensed personnel (ULP)-H stated she contacted registered nurse (RN)-A on July 28, 2022 to request pain medication for R1. ULP-H stated she subsequently retrieved acetaminophen for R1 from the kitchen cabinet. On August 9, 2022, at 12:48 p.m., the surveyor observed a bottle of Equaline brand acetaminophen 500 mg tablets, stored in an unlocked cabinet in the common kitchen area. -at 12:50 p.m., ULP-H verified the acetaminophen was regularly kept in that cabinet. ULP-H further indicated no other medications were stored there. On August 9, 2022 at 2:13 p.m., RN-A confirmed she gave permission for ULP-H to administer acetaminophen to R1 for pain "if it was prescribed for [R1]". RN-A stated she was not aware there was any medication stored in the kitchen. The licensee's Storage/Control of Medications policy, dated February 22, 2021, indicated, "Medications are stored in a secured medication cabinet. Only authorized nursing personnel have access to the locked cabinet." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(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
01910	Continued From page 120 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 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 interview and record review, the licensee failed to provide documentation in the resident's record regarding the disposition of medication to include quantity and names of staff and other individuals involved in the disposition of medications for one of one discharged resident (R2) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include:	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(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
01910	Continued From page 121 R2 was admitted February 25, 2021, and discharged December 8, 2021. R2 received services including assistance with medication administration. R2's discharge summary, signed December 8, 2021, indicated R2 had the following medications at discharge: Amlodipine (for high blood pressure) 5 milligrams (mg), buproprion (an anti-depressant) 300 mg, hydrochlorothiazide (for high blood pressure) 25 mg, losartan (for high blood pressure) 100 mg, omeprazole (for heartburn, acid reflux) 40 mg, and terbinafine (an antifungal) 250 mg. The discharge summary lacked information related to the transfer or disposition of medications to include the quantity of medications and who received the medications. On August 8, 2022, at 1:04 p.m., assistant director (AD)-B confirmed the medication list on R2's discharge summary form was everything documented related to disposition of medications upon discharge for R2. AD-B verified the list did not include the quantity of each medication and who received the medications. AD-B stated complete information including quantity would be included in the disposition of medications going forward. The licensee's Disposition and Disposal of Medications policy, dated August 1, 2021, indicated, "Upon disposition, [licensee] will document the following information In the clinical record a. Name, strength and prescription number of medication, as applicable b. Quantity c. Method of disposition or to whom the	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(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
01910	Continued From page 122 medications were given d. Date of disposition e. Name(s)/signature(s) of staff or other individuals involved in disposition f. If applicable, to whom the medications were given." No further information provided. Time period for correction: Twenty-one (21) days	01910		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(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
01940	Continued From page 123 monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of one resident (R1) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1 was admitted July 16, 2021, and began receiving assisted living services August 1, 2021. R1's service plan signed July 6, 2021, indicated R1 received services including assistance with medication management, diabetic management, laundry, housekeeping, meals, shopping, bathing, and activities of daily living (ADLs). R1's record included an after visit summary (AVS) dated July 19, 2022, that included an order for CPAP (a device worn to assist with breathing) indicating, "CPAP device with setting of + 12 [centimeters] [water] and Oxygen to be bled in at 2 [liters]". The AVS further indicated R1's blood	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(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
01940	Continued From page 124 glucose should be checked "three times daily before meals and at bedtime". The AVS was electronically signed by doctor (MD)-P on July 19, 2022. The RN assessment completed July 19, 2022, after a hospitalization, indicated R1 had a new CPAP machine with oxygen to be used as needed. The assessment further indicated no changes were made to R1's care plan, and that management was asked to "host O2 & CPAP education for staff". On August 10, 2022, at 9:40 a.m., R1's room was observed to have a CPAP machine and an oxygen concentrator with a line attached to a CPAP mask. R1 stated he managed the CPAP with oxygen himself but staff assisted him occasionally because sometimes he would get confused. R1 stated he got the machine a few weeks ago. R1 further stated the machine had not needed cleaning yet, but that staff had assisted with adding water to the machine. R1's service plan signed July 6, 2021, indicated R1 received services which included assistance with medication management, and diabetic management, including blood glucose checks. R1's service plan had not been updated to include assistance with CPAP and oxygen administration. R1's record lacked a treatment or therapy management plan to include the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(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
01940	Continued From page 125 will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. On August 10, 2022, at 10:25 a.m., RN-A stated she had not yet developed a treatment or therapy management plan for R1. RN-A further stated she would need to develop one for him, although staff did not assist R1 with the CPAP. After discussion with the surveyor, RN-A acknowledged staff would need to know how to assist R1 with the CPAP and oxygen as needed, and assist R1 with cleaning and keeping the machine filled with water. The licensee's Treatment and Therapy Management Plan policy, dated February 27, 2021, indicated, "The RN or licensed professional will prepare an individualized treatment or therapy management plan for each client receiving ordered or prescribed treatments or therapy services, which addresses a. Type of service to be provided b. Procedures for documenting treatments or therapies c. Procedures for monitoring treatments or therapies to prevent possible complications or adverse reactions d. Identification of treatment or therapy tasks delegated to unlicensed personnel e. Procedures for notifying the RN or licensed health professional when a problem arises related	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(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
01940	Continued From page 126 to the treatment or therapy service". No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01940		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to document treatment administration for one of one resident (R1) with records reviewed. 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).	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(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
01960	Continued From page 127 The findings include: R1 was admitted July 16, 2021. R1's service plan signed July 6, 2021, indicated R1 received services including assistance with medication management, diabetic management, laundry, housekeeping, meals, shopping, bathing, and activities of daily living (ADLs). R1's record included an after visit summary (AVS) electronically signed by doctor (MD)-P on July 19, 2022. The AVS included an order for CPAP (a device worn to assist with breathing) indicating, "CPAP device with setting of + 12 [centimeters] [water] and Oxygen to be bled in at 2 [liters]". The AVS further indicated R1's blood glucose (BG) should be checked "three times daily before meals and at bedtime". On August 8, 2022, at 3:30 p.m., assistant director (AD)-B stated the treatment administration record (TAR) was not at the facility and was instead kept at the main office. On August 9, 2022, at 10:09 a.m., unlicensed personnel (ULP)-H stated she logged treatments on the back of the medication administration record (MAR) sheets in the medication administration binder. BG CHECKS R1's MAR for July 2022, and August 2022 indicated BG levels were documented for 18 of 31 days in July, 2022, and 3 of 8 days in August, 2022. No refusal of BG checks were indicated. On August 9, 2022, at 9:20 a.m., R1 stated he was not diabetic and never allowed anyone to check his BG level.	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(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
01960	Continued From page 128 On August 9, 2022, at 10:28 a.m., ULP-H stated R1 had never allowed her to check his BG level. ULP-H indicated she was told not to worry about BG checks for R1 as he did not want it checked. ULP-H acknowledged BG checks were documented as completed by her in July, 2022, despite never having performed the BG checks. On August 9, 2022, at 11:32 a.m., registered nurse (RN)-A stated R1 does not allow staff to check his BG levels. RN-A acknowledged the MAR for July and August, 2022, incorrectly indicated BG checks were completed for R1. RN-A acknowledged they were not being completed, and stated staff were "blindly signing off on the MAR rather than reading and documenting accurately". RN-A further stated staff were not compliant with documentation in the MAR and needed more training. CPAP/OXYGEN On August 10, 2022, at 9:40 a.m., R1 stated staff assisted him occasionally with his CPAP and oxygen. R1 stated staff assisted him with filling the CPAP with water. R1's record lacked any documentation of assistance with use or care of the CPAP maching and oxygen. On August 10, 2022, at 10:25 a.m., RN-A stated she had not yet developed a treatment or therapy management plan for R1. RN-A further stated she would need to develop one for him, although staff did not assist R1 with the CPAP. After discussion with the surveyor, RN-A acknowledged staff would need to know how to assist R1 with the CPAP and oxygen as needed, and assist R1 with cleaning and keeping the machine filled with	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(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
01960	Continued From page 129 water. The licensee's Treatment and Therapy Management policy, dated August 1, 2021, indicated, "Each staff member who administers a treatment or therapy is responsible for documenting this in the clinical record." It further indicated, "When a treatment or therapy is not administered as ordered or prescribed, staff will document the reason why it was not administered and any follow-up procedures provided to meet the resident's needs as documented in the care plan or treatment plan or as ordered by the authorized prescriber." No further information was provided. TIME PERIOD OF CORRECTION: Seven (7) days	01960		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors Subd. 8.Notice to visitors. (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the required notice was posted at the main entry way of the establishment to display statutory language to disclose electronic	03090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36282	A. BUILDING: _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444

(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
03090	Continued From page 130 monitoring activity, potentially affecting all current residents in the assisted living facility, staff, and any visitors to the facility. This practice resulted in a level one violation (a violation that has not 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: On August 8, 2022, at 10:10 a.m., upon entrance to the facility, the surveyor observed the facility front door and common areas and noted the lack of the required posting of the electronic monitoring notice to visitors. On August 8, 2022, at 10:41 a.m., assistant director (AD)-B verified there was no electronic monitoring notice to visitors with statutory language posted. AD-B indicated he understood the requirement for the posting. The licensee's electronic monitoring policy, dated February 27, 2021, indicated, "[Licensee] will post a sign at each facility entrance accessible to visitors that states: 'Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities'." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	03090		

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

Type: Full
Date: *08/08/22*
Time: 19:00:00
Report: 8041221201

Food and Beverage Establishment Inspection Report

Location:
Warm Touch Home Care
7548 Fremont Ave N
Brooklyn Park, MN55443
Hennepin County, 27

Establishment Info:
ID #: N040595
Risk:
Announced Inspection: No

License Categories:
,

Expires on: 12/31/22

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.

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

NO CERTIFIED FOOD PROTECTION MANAGER ON SITE. ASSISTANT DIRECTOR HAS TAKEN A FOOD SAFETY COURSE. APPLY FOR STATE CFPM CERTIFICATE. APPLICATION EMAILED TO ESTABLISHMENT.

Comply By: 08/29/22

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 37 Degrees Fahrenheit - Location: Frigidaire refrigerator: milk
Violation Issued: No

Process/Item: Cold Holding
Temperature: 35 Degrees Fahrenheit - Location: Frigidaire refrigerator: turkey
Violation Issued: No

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

Inspection was completed with Nebiyu (Tony) Ashagre. Renee Anderson was the lead RN with HRD completing the site survey.

Kitchen is residential and food is prepared for same day service only. There were three residents on site at time of inspection. Frozen prep-packaged meals are typically delivered weekly from Tovala. Company supplies oven to re-heat meals. Oven was being cleaned at the main office at time of inspection.

Establishment has a residential NSF dishwasher with a sanitizing cycle option. Thermal strips provided

for establishment to verify utensil surface temperature is at least 160 Deg. F to properly sanitize equipment and utensils.

Floor is wood, cabinets are wood with a hollow base and solid surface, ceiling is popcorn texture.

Employee illness policy and logging requirements reviewed. Also discussed handwashing, glove-use, vomit clean-up procedures and date marking.

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 8041221201 of 08/08/22.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed:_____

Nebiyu Ashagre
Assistant Director

Signed: Sarah Conboy

Sarah Conboy
Public Health Sanitarian III
651-201-3984
sarah.conboy@state.mn.us