DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

January 22, 2025

Licensee
First Choice Nursing Services Inc.
2108 Pearson Parkway
Brooklyn Park, MN 55444

RE: Project Number(s) SL26265015

Dear Licensee:

On November 26, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the August 28, 2024, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Benjamin J. Zwart, P.E., Supervisor
State Engineering Services Section
Health Regulation Division
Email: Benjamin.Zwart@state.mn.us
Telephone: 651-201-3715 Fax: 1-866-890-9290

JMD

Electronically Delivered

September 30, 2024

Licensee
First Choice Nursing Services Inc.
2108 Pearson Parkway
Brooklyn Park, MN 55444

RE: Project Number(s) SL26265015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 28, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00

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

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

The correction order documentation should include the following:

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

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

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

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

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

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

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

If you have any questions, please contact me.

Sincerely,

Jessie Chenze, Supervisor
State Evaluation Team
Email: jessie.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26265	A. BUILDING: _____ B. WING _____	08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIRST CHOICE NURSING SERVICES INC	2108 PEARSON PARKWAY 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 ******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: SL26265015-0 On August 26, 2024, 2024, through August 28, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were three residents; three receiving services under the provider's Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470		

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0 470	Continued From page 1 determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the required staffing plan was posted in a central location as required. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	0 470		

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0 470	Continued From page 2 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 26, 2024, at 11:08 a.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated the licensee was familiar with current minimum assisted living requirements. During the facility tour on August 26, 2024, at 12:09 p.m. until 12:24 p.m., the surveyor observed a Weekly Schedule dated August 12, 2024 through August 18, 2024 (eight days before survey entrance), posted on a bulletin board in the dining room located on the upper level of the facility. On August 23, 2024, at 12:24 p.m., LALD/LPN-A stated the housing manager was supposed to post a new schedule at the facility every Monday, however, an updated schedule had not been posted after August 18, 2024. The licensee's 4.06 Staffing and Scheduling policy dated November 1, 2021, indicated the clinical nurse supervisor (CNS) will develop a 24-hour daily staffing schedule and must be posted, after redacting direct-care staff members' resident assignments, at the beginning of each work shift in a central location. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0180, Subp. 4, effective October 2022, the daily work schedule in item A must be posted, after redacting direct-care staff members'	0 470		

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0 470	Continued From page 3 resident assignments, at the beginning of each work shift in a central location in each building of a facility or campus, accessible to staff, residents, volunteers, and the public. The facility shall not disclose any information that is protected by law from public disclosure. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
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, interview, and record review, the licensee failed to ensure infection control standards were followed to disinfect reusable resident equipment by one of one employee (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 510		

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0 510	Continued From page 4 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 26, 2024, at 11:08 a.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated the licensee was familiar with current minimum assisted living requirements. On August 27, 2024, at 7:08 a.m., the surveyor observed ULP-C remove an Sp02 monitor (a noninvasive device that measures the oxygen saturation level of the blood) and temporal thermometer from a zipped bag sitting on the dining room table. ULP-C completed R2's vital signs with the above equipment and then placed the thermometer and Sp02 monitor back into the zipped bag. The surveyor did not observe ULP-C disinfect the thermometer or Sp02 monitor before or after use. On August 27, 2024, at 9:11 a.m., the surveyor observed ULP-C remove the thermometer and Sp02 monitor out of the zipped bag on the dining room table. ULP-C completed R3's vital signs with the above equipment and then placed the thermometer and Sp02 monitor back into the zip bagged on the table. ULP-C returned the zip bag with shared equipment back into the locked medication cabinet in the hallway. The surveyor did not observe ULP-C disinfect the thermometer or Sp02 monitor before or after use. On August 27, 2024, at 10:03 a.m., ULP-C stated the licensee trained the staff to disinfect shared	0 510		

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0 510	Continued From page 5 medical equipment with disinfecting wipes provided by the licensee, however, ULP-C stated ULP-C did not disinfect the shared medical equipment in between residents this morning. On August 27, 2024, at 11:36 a.m., clinical nurse supervisor (CNS)-B stated resident shared medical equipment was supposed to be cleaned in between each resident use. The licensee's 8.03 Cleaning of Shared Medical Equipment policy dated November 1, 2021, indicated [licensee name] will implement and maintain processes to ensure all reusable resident care equipment is routinely cleaned, and when appropriate, disinfected, before and after reuse. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 570 SS=C	144G.42 Subdivision 1 Display of license The original current license must be displayed at the main entrance of each assisted living facility. The facility must provide a copy of the license to any person who requests it. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to display the original current assisted living license at the main entrance of the assisted living facility as required. This had the potential to affect all the licensee's current residents, staff, and visitors.	0 570		

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0 570	Continued From page 6 This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the facility tour on August 26, 2024, at 12:09 p.m. until 12:24 p.m., the surveyor observed a paper copy of the licensee's current assisted living licensee displayed on the dining room wall on the upper level of the facility. On August 26, 2024, at 12:24 p.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated the Minnesota Department of Health (MDH) no longer mailed out the original license certificate and LALD/LPN-A had never been informed the original license needed to be posted at the main entrance. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0040, Subp. 2, effective October 2022, the facility must post the original license certificate issued by the commissioner at the main public entrance of the facility. A campus with multiple buildings must post the original certificate issued by the commissioner at the main public entrance of each building licensed as a facility on the campus. A separate license certificate shall be issued for each building on the campus. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 570		

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0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for one of one resident (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: During the entrance conference on August 26, 2024, at 11:08 a.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated the licensee was familiar with current minimum assisted living requirements.	0 630		

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0 630	Continued From page 8 R3's diagnoses included schizoaffective disorder, hypertension (HTN-high blood pressure) traumatic brain injury (TBI), and asthma. R3's service plan dated, August 21, 2023, indicated R3 received medication administration, vital sign monitoring, and behavior management. On August 27, 2024, at 9:19 a.m., the surveyor observed unlicensed personnel (ULP)-C provide schedule morning medication administration to R3. R3's resident record contained a Vulnerability Assessment dated August 4, 2024. R3's Vulnerability Assessment addressed R3's risk of being abused, including by other vulnerable adults, and R3's risk of abuse to others. R3's record lacked R3's risk for self-abuse. On August 27, 2024, at 11:50 a.m., clinical nurse supervisor (CNS)-B stated CNS-B used the same IAPP for all residents and the IAPP did not address resident self-abuse. CNS-B further stated CNS-B would have addressed resident self-abuse by handwriting it on the IAPP if CNS-B had a concern regarding resident self-abuse. The licensee's IAPP policy dated November 1, 2021, indicated for purposes of the abuse prevention plan, abuse includes self-abuse. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		

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0 660	Continued From page 9	0 660		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on 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) and Minnesota Department of Health (MDH), including a completion of a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test for one of two employees (clinical nurse supervisor (CNS)-B). This practice resulted in a level two 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 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	0 660		

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0 660	Continued From page 10 only occasionally). The findings include: The facility's TB risk assessment was completed on July 1, 2024, and the facility was determined to be a low risk level. CNS-B was hired on February 1, 2019, and had begun to provide direct care services to residents and supervision of staff at the assisted living facility on August 1, 2021. CNS-B's employee record contained a Baseline TB Screening Tool for Health Care Workers (HCWs) dated February 6, 2019, which indicated CNS-B had a QuantiFERON (a blood test used to detect TB) test on January 15, 2019, and the result was handwritten negative, however, no official results for the QuantiFERON test was in CNS-B's employee record. In addition, CNS-B's employee record contained a Baseline TB Screening Tool for Health Care Personnel (HCPs) dated December 30, 2023, which indicated CNS-B had a TB skin test in the past 12 months, however, handwritten below the question was "not in chart". CNS-B's employee record lacked evidence of a completion of a two-step TST or other evidence of TB screening such as a blood test. On August 27, 2024, at 12:59 p.m., CNS-B stated CNS-B could not recall upon hire if CNS-B had a two step TST or other evidence of a blood test. CNS-B further stated CNS-B may have official results from the blood test located at a sister location, however, no additional documentation was provided to the surveyor.	0 660		

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FIRST CHOICE NURSING SERVICES INC	2108 PEARSON PARKWAY 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 11 The licensee's 8.16 TB Screening policy dated November 1, 2021, indicated new staff will have an IGRA blood test (blood test used to detect TB) or a two-step Mantoux [sic] conducted with results documented on the Baseline TB Screening Tool for HCWs. In addition, no staff will be permitted to begin work where the work involves sharing the air space with residents until the negative results of the first Mantoux [sic] are read and documented or a negative IGRA blood test result is received and documented. The MDH TB Screening and Education Requirements for Assisted Living Facilities and Home Care Providers dated February 3, 2022, indicated baseline TB screening is required at the time of hire for all health care personnel in Minnesota. Baseline TB screening includes assessing for current symptoms of active TB disease; assessing TB history; and testing for the presence of infection with Mycobacterium TB by administering either a two-step TB skin test or a single TB blood test. 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	0 680		

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0 680	Continued From page 12 emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. This had the potential to affect all residents, staff, and visitors 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), 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 licensee's EPP dated June 1, 2024, lacked	0 680		

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0 680	Continued From page 13 the following content and/or policies and procedures to address: - a description of the population served by the licensee; - procedure for tracking staff and residents; - subsistence needs for staff and residents during emergency situation; -food, water, medical supplies, pharmaceutical supplies, and alternate sources of energy - development of policies/procedures to address: - evacuation plan (not customized for the facility); - fire (not customized for the facility); - shelter in place; - a tracking system used to document locations or residents and staff; - the medical record documentation system to preserve resident information; - emergency staff strategies including surge planning and use of volunteers; - a communication plan that included: - arrangement with other facilities; - names and contact information for staff, resident physicians, other facilities, volunteers; - contact information for local EP staff; - primary and alternative means for communicating with facility staff, federal, state, regional and local emergency management agencies; - a method of sharing information and medical documentation for residents - a means to provide information regarding the facility's needs, and the ability to provide assistance to include information about their occupancy; -a method of sharing information from the emergency plan with residents and their families; and - must conduct exercises to test the EPP at least twice per year, including unannounced staff drills	0 680		

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0 680	Continued From page 14 using the EPP. On August 27, 2024, at 11:29 a.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated the licensee did not have time to update the EPP and was aware the EPP was lacking contents after a sister facility had an assisted living survey. The licensee's 9.01 Emergency Preparedness Plan- Appendix Z Compliance policy dated November 1, 2021, indicated the EPP will include all required elements of appendix [sic] Z. In addition, the licensee will conduct, at minimum, two EP drills every 12 months- these drills to not include required fire/evacuation drills. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0100, sections A and B, effective October 2022, assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.73, or successor requirements. This part references documents, specifications, methods, and standards in "State Operations Manual Appendix Z - Emergency Preparedness for All Providers and Certified Supplier Types: Interpretive Guidance," which is incorporated by reference. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 700 SS=F	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or	0 700		

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0 700	Continued From page 15 electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure three of three resident's (R2, R3, R4) personal health and medical information was kept private. This had the potential to affect all three 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: During the entrance conference on August 26, 2024, at 11:08 a.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated the licensee was familiar with current minimum assisted living requirements. From August 26, 2024, at 11:00 a.m. through August 27, 2024, at 1:23 p.m., the surveyor observed R2, R3, and R4's resident record binders sitting on top of a file cabinet located in the community dining room on the upper level of the facility. Each binder identified the resident's	0 700		

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0 700	Continued From page 16 name on the outside. Throughout the survey, the surveyor observed residents come in and out of the dining room. On August 27, 2024, at 10:02 a.m., unlicensed personnel (ULP)-C stated the binders contained completed paperwork for each resident and the binders were always stored on top of the file cabinet in the dining room. On August 27, 2024, at 11:41 a.m., LALD/LPN-A stated the binders contained resident personal health and medical information. LALD/LPN-A further stated all residents and visitors had access to the dining room area and the binders were typically placed in the locked medication closet. The licensee's Resident Record- Access and Storage policy dated November 1, 2021, indicated resident records will be kept confidential and locked in a secured in an [sic] area where only authorized staff of [licensee name] will have access. The licensee's 2.12 Confidentiality policy dated November 1, 2021, indicated personal, financial, medical, or other private information regarding residents or staff should not be disclosed to any other person except: - as may be required by law - to other staff as appropriate or necessary to provide services - to persons authorized in writing by the resident or resident's responsible person to receive information, including third party payers, or - to representatives of the commissioner authorized to survey or investigate any part of the community.	0 700		

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0 700	Continued From page 17 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 700		
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 the portable fire extinguishers. This deficient condition 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) 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:	0 790		

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0 790	Continued From page 18 On August 27, 2024, at approximately 12:30 p.m. to 1:35 p.m., survey staff conducted a facility tour with licensed assisted living director/licensed practical nurse (LALD/LPN)-A, survey staff observed that the fire extinguishers throughout the facility did not have documentation of monthly inspections. Monthly inspections of the fire extinguishers are required to ensure that all systems are maintained and remain in working order. LALD/LPN-A stated they understood the requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to	0 800		

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0 800	Continued From page 19 the health, safety, comfort, and well-being of the residents. This deficient condition 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). The findings include: On August 27, 2024, from approximately 12:37 p.m. to 1:35 p.m., survey staff toured the facility with licensed assisted living director/licensed practical nurse (LALD/LPN)-A. The following was observed. GENERAL MAINTENANCE: Dining room and kitchen floor had holes in the vinyl flooring. Bedroom # 1 had scratches on the closet door. Bedroom # 2 had stains on the ceiling. Main-floor bathroom had a rusty vent, and the vanity doors and draws were falling off and its finishes coming off. The ceiling above the shower was stained. Main-floor hallway vinyl flooring was coming up and vent was rusty. Basement bathroom vanity doors were coming off	0 800		

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0 800	Continued From page 20 and the wall under the toilet had been filled with dry wall putty and not painted. The family room and bedroom #3 had newly drywalled walls and ceilings. The floor coverings had been removed in each of these rooms. LALD/LPN-A stated, "these rooms will be getting new flooring as the resident that had been staying in this room had trashed the place". LALD/LPN-A stated they understood the above-listed deficiencies. TIME PERIOD FOR CORRECTION: twenty-one (21) 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	0 810		

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0 810	Continued From page 21 readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 27, 2024, at approximately 1:15 p.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for	0 810		

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0 810	Continued From page 22 the facility. FIRE SAFETY AND EVACUATION PLAN: The FSEP (fire safety and evacuation plan) included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate) and the plan was designed for a building with life safety systems such as fire alarm pull stations and an automatic sprinkler system. The policy had not been updated to provide complete actions for employees and residents to take in the event of a fire or similar emergency at the licensed facility which did not have life safety systems or a fire-resistant construction type. DRILLS: The licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. Record review lacked this documentation. TRAINING: The licensee failed to provide evacuation training to residents at least once per year. LALD/LPN-A lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		

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0 820	Continued From page 23	0 820		
0 820 SS=F	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide facilities that were not a distinct hazard to life. This had the potential to directly affect all residents 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 potential to affect a large portion or all of the residents). Findings include: On facility tour with the licensed assisted living director/licensed practical nurse (LALD/LPN)-A on August 27, 2024, between 12:30 p.m. and 1:35 p.m. it was observed that cigarette ashes and	0 820		

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0 820	Continued From page 24 cigarette burns were found on the deck boards and handrail inside the four-season porch. The residents were using an old coffee pot to dispose of the cigarette butts. The surveyor explained to the LALD/LPN-A, that all cigarette butts shall be properly discarded into an approved container and that cigarette smoking should take place outside in the designated area away from the structure. The deficient condition was visually verified by the LALD/LPN-A accompanying on the tour. TIME PERIOD FOR CORRECTION: Two (2) days.	0 820		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property of a resident. This had the potential to affect all residents. This practice resulted in a level one violation (a	0 970		

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FIRST CHOICE NURSING SERVICES INC	2108 PEARSON PARKWAY BROOKLYN PARK, MN 55444

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0 970	Continued From page 25 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: The licensee's Assist Living Contract dated 2021, included the following clauses that a resident would waive the facility's liability for health, safety, or personal property of the resident: -page 13 Miscellaneous Provisions 1: The resident agrees that [licensee name] 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 ...unless and to the extent that the injury or damage is caused by the negligence of [licensee name] or its employees or agents; and -page 15 Indemnification: ...and the resident agrees to hold [licensee name] harmless from any claims or damages unless caused solely by negligence of [licensee name] Assisted Living. On August 27, 2024, at 11:23 a.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated the licensee used the same contract for all residents. LALD/LPN-A further stated the licensee had become familiar with the waiver of liability language last week at a sister site location, however, LALD/LPN-A stated the licensee had not updated the contract to remove the waiver of liability sections. No further information was provided.	0 970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26265	A. BUILDING: _____ B. WING _____	08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIRST CHOICE NURSING SERVICES INC	2108 PEARSON PARKWAY BROOKLYN PARK, MN 55444

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0 970	Continued From page 26 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01650 SS=D	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (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 observation, interview, and record review, the licensee failed to ensure service plans	01650		

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01650	Continued From page 27 included the required content for one of one resident (R3). This practice resulted in a level two 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: During the entrance conference on August 26, 2024, at 11:08 a.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated the licensee was familiar with current minimum assisted living requirements. R3's diagnoses included schizoaffective disorder, hypertension (HTN-high blood pressure) traumatic brain injury (TBI), and asthma. R3's service plan dated August 21, 2023, indicated R3 received medication administration, vital sign monitoring, and behavior management. On August 27, 2024, at 9:19 a.m., the surveyor observed unlicensed personnel (ULP)-C provide schedule morning medication administration to R3. R3's service plan lacked the frequency of medication administration and a contingency plan that included the action to be taken if the scheduled service cannot be provided. On August 27, 2024, at 11:45 a.m., clinical nurse supervisor (CNS)-B stated R3's service plan was	01650		

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01650	Continued From page 28 not filled out entirely and the areas left blank were an oversight. The licensee's 6.08 Service Plan policy dated November 1, 2021, indicated the service plan will include the frequency of each service to be provided and a contingency plan that includes actions [licensee name] will take if scheduled services cannot be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		
01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service 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.	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01910	Continued From page 29 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident's record the disposition of the medications with all required content for one of one resident (R1) upon discharge. 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: During the entrance conference on August 26, 2024, at 11:08 a.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated the licensee was familiar with current minimum assisted living requirements. The licensee's Discharged or Deceased Resident Roster: State Evaluations dated June 3, 2024, indicated R1 was admitted to the assisted living on June 22, 2015, and discharged from the facility on July 20, 2024. R1's diagnoses included schizoaffective disorder, hypertension (HTN-high blood pressure), and traumatic brain injury (TBI). R1's Service Plan was requested, however, not provided. R1's Medication Administration Record (MAR)	01910		

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	26265	A. BUILDING: _____ B. WING _____	08/28/2024

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01910	Continued From page 30 dated July 2024, indicated R1 received the following medications: -multiple vitamin (supplement) daily -amlodipine (antihypertensive) 5 milligrams (mg) daily -clonazepam (antianxiety) 1 mg twice daily -propranolol HCL (antihypertensive) 80 mg twice daily -ziprasidone HCL (antipsychotic) 60 mg twice daily -benztropine (antianxiety) 0.5 mg daily -divalproex sodium extended release (for bipolar) 2,000 mg daily -haloperidol (for agitated movements) 5 mg daily -olanzapine (antipsychotic) 20 mg daily -temazepam (for insomnia) 30 mg daily -trazodone HCL (for insomnia) 200 mg daily -zolpidem tartrate (for insomnia) 10 mg daily R1's prescriber orders dated May 3, 2024, and June 13, 2024, respectively, included the above noted medications. R1's Discharge Summary dated July 20, 2024, indicated R1 was at the hospital and awaiting potential hospital return. R1's record lacked documentation for the disposition of the above medications to include 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. On August 27, 2024, at 11:31 a.m., clinical nurse supervisor (CNS)-B stated R1 moved to a sister facility after hospitalization and the medications were transported by CNS-B to the sister facility. CNS-B further stated CNS-B didn't think	01910		

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01910	Continued From page 31 medication disposition was completed and "now that you (surveyor) mention it the other nurse said it wasn't done." CNS-B further stated the licensee documented medication destruction for medications that were discontinued, however, the licensee was not aware medication disposition needed to be completed for resident's current medications going from one assisted living to another assisted living. The licensee's 7.23 Medication Disposal policy dated November 1, 2021, indicated current unused medications managed by [licensee name] will be returned to the pharmacy for credit, or given to the resident or the resident's representative, when the resident's medications are no longer managed by the facility or the medication has been discontinued by the prescriber. 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. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		

Minnesota Department of Health

625 North Robert Street
Saint Paul, MN
651-201-5000

Type: Full
Date: *08/26/24*
Time: 16:00:00
Report: 8087241197

Food and Beverage Establishment Inspection Report

Location:

First Choice Nursing And Homec
2108 Pearson Parkway
Brooklyn Park, MN55444
Hennepin County, 27

Establishment Info:

ID #: 0037721
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7635660643
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.

No NEW orders were issued during this inspection.

Food and Equipment Temperatures

Process/Item: Ambient Air
Temperature: 4 Degrees Fahrenheit - Location: STAND-UP FREEZER
Violation Issued: No

Process/Item: Ambient Air
Temperature: 40 Degrees Fahrenheit - Location: STAND-UP REFRIGERATOR
Violation Issued: No

Process/Item: Cold Holding: CHEESE
Temperature: 40 Degrees Fahrenheit - Location: STAND-UP REFRIGERATOR
Violation Issued: No

Process/Item: Cold Holding: MILK
Temperature: 39 Degrees Fahrenheit - Location: STAND-UP REFRIGERATOR
Violation Issued: No

Process/Item: Cold Holding: YOGURT
Temperature: 40 Degrees Fahrenheit - Location: STAND-UP REFRIGERATOR
Violation Issued: No

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

THIS WAS AN ANNOUNCED AND SCHEDULED FULL INSPECTION.

INSPECTION CONDUCTED IN THE PRESENCE OF NURSE EVALUATOR SARA UMLAUF.

FLOORS ARE LINOLEUM, CABINETS ARE HARDWOOD, COUNTERTOPS ARE LAMINATE AND CEILING IS TEXTURED BUT APPEARS TO BE DURABLE. ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT SUCH A TIME

THEY ARE FOUND TO BE A CONCERN OR RISK OF CONTAMINATION, THEY WILL BE ORDERED TO BE REPLACED AND BROUGHT UP TO CODE.

DESIGNATED HAND WASHING SINK IN THE KITCHEN IN 2-BIN, STAINLESS STEEL RESIDENTIAL KITCHEN SINK.

INSPECTION REPORT EMAILED TO SARA UMLAUF.

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 8087241197 of 08/26/24.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed:_____
SARA UMLAUF

Signed:_____
John Boettcher
Public Health Sanitarian 3
St. Paul, MN / Freeman
651-201-5076
john.boettcher@state.mn.us