Electronically Delivered

September 22, 2025

Licensee
N&V Helpful Heart Care Inc
6620 Bryant Avenue North
Brooklyn Center, MN 55430

RE: Project Number(s) SL34008016

Dear Licensee:

On July 29, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on November 15, 2024. This follow-up survey verified that the facility is back 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 Zwart

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

HHH

Electronically Delivered

June 9, 2025

Licensee
N&v Helpful Heart Care Inc.
6620 Bryant Avenue North
Brooklyn Center, MN 55430

RE: Project Number(s) SL34008016

Dear Licensee:

On April 30, 2025, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on November 15, 2024 and the follow-up survey completed on February 4, 2025. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the November 15, 2024 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on November 15, 2024, found not corrected at the time of the April 30, 2025, follow-up survey and/or subject to penalty assessment are as follows:

0780 - Fire Protection And Physical Environment - 144g.45 Subd. 2 (a) (1) - $3,000.00

The details of the violations noted at the time of this follow-up survey completed on April 30, 2025 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

IMPOSITION OF FINES:

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

§144G.20.

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

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

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

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

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

We urge you to review these orders carefully. If you have questions, please contact Benjamin J. Zwart at 651-201-3715.

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

Sincerely,

Benjamin Zwart

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34008	A. BUILDING: _____ B. WING _____	R 04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
N&V HELPFUL HEART CARE INC	6620 BRYANT AVENUE NORTH BROOKLYN CENTER, MN 55430

(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 FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS SL34008016-2 On April 30, 2025, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on February 5, 2025. At the time of the survey, there were three residents; three receiving services under the Assisted Living License. As a result of the follow-up survey, the following orders were reissued.	{0 000}		
{0 480} SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota	{0 480}		

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{0 480}	Continued From page 1 Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by:	{0 480}	This correction order was not reviewed during this license order follow up.	

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{0 510}	Continued From page 2	{0 510}		
{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:	{0 510}	This correction order was not reviewed during this license order follow up.	
{0 660} SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity 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	{0 660}		

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{0 660}	Continued From page 3 compliance with this subdivision. This MN Requirement is not met as evidenced by:	{0 660}	This correction order was not reviewed during this license order follow up.	
{0 780} SS=I	144G.45 Subd. 2 (a) (1) Fire protection and physical environment 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 emergency escape and rescue	{0 780}		

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{0 780}	Continued From page 4 windows, and discard used cigarette butts in compliance with the Minnesota State Fire Code. This had the potential to directly affect all of the residents, staff, and visitors. 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). Findings include: On a facility tour on April 30, 2025, from 2:10 p.m. to 3:00 p.m., with unlicensed personnel (ULP)-H, it was observed that compliant emergency escape and rescue openings were not provided in resident sleeping room 3. During the tour documentation of fire watch records were provided and indicated the fire watch was completed through January 2025 only. During an interview on April 30, 2025, at 2:30 p.m., ULP-H, stated they had not completed and documented the fire watch according to the facility fire watch policy today. It was explained the fire watch is required to be continued until all non-compliant emergency escape and rescue openings are replaced and approved. During the tour owner (O)-C, stated over the phone they had told the staff to continue the fire watch until she gave them direction to stop the	{0 780}		

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{0 780}	Continued From page 5 fire watch. O-C, also stated over the phone they were still trying to figure out how to complete the replacement of the window in resident sleeping room 3. No further fire watch documentation was provided. OCCUPIED RESIDENT SLEEPING ROOMS Resident sleeping room 3, emergency escape and rescue clear window opening measurements were 17 inches wide, 51.5 inches in height and 876 square inches in openable area. The window was measured with ULP-H, and the surveyor present. The window did not meet the minimum requirements for clear opening minimum width. During the tour resident sleeping rooms 1 and 2 emergency escape and rescue openings were measured with ULP-H, and were in compliance for minimum size of existing emergency escape and rescue openings. At least one compliant emergency escape and rescue opening is required within each resident sleeping room. Existing emergency escape and rescue openings are required to meet a minimum clear opening area of 648 square inches and have a minimum dimension of 20 inches in height and a minimum dimension of 20 inches in width. If the window clear opening measures the minimum of 20 inches in one direction, the other measurement will be more than 20 inches in order to achieve the total square inch area of 648 square inches. These deficient conditions were visually verified by, ULP-H, accompanying on the tour. And	{0 780}		

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{0 780}	Continued From page 6 verbally by O-C, over the phone with. On the same facility tour on April 30, 2025, from 2:10 p.m. to 3:00 p.m., the surveyor made the following observations of non-compliance with the requirements of the Minnesota State Fire Code: USED SMOKING MATERIALS There were used cigarette butts discarded on the ground around the exterior of the door and under the steps and deck leading outside from the kitchen. Used cigarette butts are required to be discarded in an appropriate non-combustible container or container manufactured and tested for the use in accordance with Minnesota State Fire Code in Minnesota Rules Chapter 7511. These deficient conditions were visually verified by, ULP-H, accompanying on the tour.	{0 780}		
{0 810} SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive	{0 810}		

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{0 810}	Continued From page 7 training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by:	{0 810}	This correction order was not reviewed during this license order follow up.	
{01290} SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction	{01290}		

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{01290}	Continued From page 8 does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by:	{01290}	This correction order was not reviewed during this license order follow up.	
{01460} SS=F	144G.63 Subdivision 1 Orientation of staff and supervisors (a) All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility, except as provided in paragraph (b). (b) A staff person is not required to repeat the orientation required under subdivision 2 if the staff person transfers from one licensed assisted living facility to another facility operated by the same licensee or by a licensee affiliated with the same corporate organization as the licensee of the first facility, or to another facility managed by the same entity managing the first facility. The facility to which the staff person transfers must document that the staff person completed the orientation at the prior facility. The facility to which the staff person transfers must nonetheless provide the transferred staff person with supplemental orientation specific to the facility and document that the supplemental orientation was provided. The supplemental orientation must include the types of assisted living services the	{01460}		

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{01460}	Continued From page 9 staff person will be providing, the facility's category of licensure, and the facility's emergency procedures. A staff person cannot transfer to an assisted living facility with dementia care without satisfying the additional training requirements under section 144G.83. This MN Requirement is not met as evidenced by:	{01460}		
{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	{01620}	This correction order was not reviewed during this license order follow up.	

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{01620}	Continued From page 10 resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by:	{01620}	This correction order was not reviewed during this license order follow up.	
{01700} SS=D	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced	{01700}		

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{01700}	Continued From page 11 by:	{01700}	This correction order was not reviewed during this license order follow up.	
{01790} SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be	{01790}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34008	A. BUILDING: _____ B. WING _____	R 04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
N&V HELPFUL HEART CARE INC	6620 BRYANT AVENUE NORTH BROOKLYN CENTER, MN 55430

(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
{01790}	Continued From page 12 labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by:	{01790}	This correction order was not reviewed during this license order follow up.	
{01810} SS=D	144G.71 Subd. 12 Medications; over-the-counter drugs; dietary An assisted living facility providing medication management services for over-the-counter drugs or dietary supplements must retain those items in the original labeled container with directions for use prior to setting up for immediate or later	{01810}		

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{01810}	Continued From page 13 administration. The facility must verify that the medications are up to date and stored as appropriate. This MN Requirement is not met as evidenced by:	{01810}	This correction order was not reviewed during this license order follow up.	

Electronically Delivered

March 6, 2025

Licensee
N&V Helpful Heart Care Inc
6620 Bryant Avenue North
Brooklyn Center, MN 55430

RE: Project Number(s) SL34008016

Dear Licensee:

On February 4, 2025, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on November 15, 2024. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the November 15, 2024 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on November 15, 2024, found not corrected at the time of the February 4, 2025, follow-up survey and/or subject to penalty assessment are as follows:

0780-Fire Protection And Physical Environment-144g.45 Subd. 2 (a) (1)
0800-Fire Protection And Physical Environment-144g.45 Subd. 2 (a) (4) - $500.00

The details of the violations noted at the time of this follow-up survey completed on February 4, 2025 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

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 outlined on the state form; however, plans of correction are not required to be submitted for approval.

IMPOSITION OF FINES:

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

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including

the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by MDH within 15 calendar days of the correction order receipt date.

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

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

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

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

We urge you to review these orders carefully. If you have questions, please contact Benjamin J. Zwart at 651-201-3715.

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

Sincerely,

Benjamin J. Zwart, Supervisor
State Evaluation Team
Email: Benjamin.Zwart@state.mn.us
Telephone: 651-201-3715 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34008	A. BUILDING: _____ B. WING _____	R 02/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS SL#3400816-1 On February 5, 2025, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on November 15, 2024. At the time of the survey, there were three residents: three receiving services under the Assisted Living License. As a result of the follow-up survey, the following orders were reissued.	{0 000}		
{0 480} SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated	{0 480}		

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{0 480}	Continued From page 1 correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by:	{0 480}	Not reviewed during this survey.	

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{0 510}	Continued From page 2	{0 510}		
{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:	{0 510}	Not reviewed during this survey.	
{0 660} SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity 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.	{0 660}		

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{0 660}	Continued From page 3 This MN Requirement is not met as evidenced by:	{0 660}	Not reviewed during this survey.	
{0 780} SS=I	144G.45 Subd. 2 (a) (1) Fire protection and physical environment 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 emergency escape and rescue windows in compliance with the Minnesota State Fire Code. This had the potential to directly affect	{0 780}		

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{0 780}	Continued From page 4 all or a large portion of the residents and staff. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On a facility tour on February 5, 2025, from 1:00 p.m. to 1:45 p.m., with owner (O)-C, it was observed that compliant emergency escape and rescue openings were not provided in resident sleeping rooms 1, 2, and 3. During the tour documentation of fire watch records were provided and complete as required, O-C, also stated they are waiting for building permits and the contractor to complete the window replacements. OCCUPIED RESIDENT SLEEPING ROOMS Resident sleeping room 1, emergency escape and rescue clear window opening measurements were 27 inches wide, 15.5 inches in height and 398 square inches in openable area. The window was measured with O-C, and the surveyor present. The window did not meet the minimum requirements for clear opening, minimum height, and total square inch openable area. Resident sleeping room 3, emergency escape and rescue clear window opening measurements were 17 inches wide, 51.5 inches in height and	{0 780}		

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{0 780}	Continued From page 5 876 square inches in openable area. The window was measured with O-C, and the surveyor present. The window did not meet the minimum requirements for clear opening minimum width. UNOCCUPIED RESIDENT SLEEPING ROOMS Resident sleeping room 2, emergency escape and rescue clear window opening measurements were 27 inches wide, 15.5 inches in height and 398 square inches in openable area. The window was measured with O-C, and the surveyor present. The window did not meet the minimum requirements for clear opening, minimum height, and total square inch openable area. At least one compliant emergency escape and rescue opening is required within each resident sleeping room. Existing emergency escape and rescue openings are required to meet a minimum clear opening area of 648 square inches and have a minimum dimension of 20 inches in height and a minimum dimension of 20 inches in width. If the window clear opening measures the minimum of 20 inches in one direction, the other measurement will be more than 20 inches in order to achieve the total square inch area of 648 square inches. These deficient conditions were visually verified by, O-C, accompanying on the tour. On the same facility tour on February 5, 2025, from 1:00 p.m. to 1:45 p.m., the surveyor made the following observations of non-compliance with the requirements of the Minnesota State Fire Code: USED SMOKING MATERIALS	{0 780}		

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{0 780}	Continued From page 6 There were used cigarette butts discarded on the ground around the exterior of the door leading outside from the kitchen. Used cigarette butts are required to be discarded in an appropriate non-combustible container or container manufactured and tested for the use in accordance with Minnesota State Fire Code. INTERCONNECTED SMOKE ALARMS The smoke alarms were tested, and the surveyor observed the hardwired (wired to the building electrical system) smoke alarms throughout the facility were not interconnected so activation of one alarm activates all alarms including additional battery-operated alarms in the resident sleeping rooms. The hardwired smoke alarms are required to be interconnected so activation of one alarm activates all alarms throughout the facility including the additional battery-operated smoke alarms in the sleeping rooms.	{0 780}		
{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	{0 800}		

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{0 800}	Continued From page 7 by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On a facility tour on February 5, 2025, from 1:00 p.m. to 1:45 p.m., with owner (O)-C, the surveyor made the following observations of facility disrepair: The sink top on the vanity cabinet was not securely fastened to the cabinet and moved around easily putting stress on the plumbing pipes attached to the sink in the main floor bathroom. During a facility tour O-C, verified the above listed observations while accompanying on the tour.	{0 800}		
{0 810} SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The	{0 810}		

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{0 810}	Continued From page 8 plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by:	{0 810}	Not reviewed during this survey.	
{01290} SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly	{01290}		

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{01290}	Continued From page 9 scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by:	{01290}	Not reviewed during this survey.	
{01460} SS=F	144G.63 Subdivision 1 Orientation of staff and supervisors (a) All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility, except as provided in paragraph (b). (b) A staff person is not required to repeat the orientation required under subdivision 2 if the staff person transfers from one licensed assisted living facility to another facility operated by the same licensee or by a licensee affiliated with the same corporate organization as the licensee of	{01460}		

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{01460}	Continued From page 10 the first facility, or to another facility managed by the same entity managing the first facility. The facility to which the staff person transfers must document that the staff person completed the orientation at the prior facility. The facility to which the staff person transfers must nonetheless provide the transferred staff person with supplemental orientation specific to the facility and document that the supplemental orientation was provided. The supplemental orientation must include the types of assisted living services the staff person will be providing, the facility's category of licensure, and the facility's emergency procedures. A staff person cannot transfer to an assisted living facility with dementia care without satisfying the additional training requirements under section 144G.83. This MN Requirement is not met as evidenced by:	{01460}	Not reviewed during this survey.	
{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	{01620}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34008	A. BUILDING: _____ B. WING _____	R 02/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{01620}	Continued From page 11 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:	{01620}	Not reviewed during this survey.	
{01700} SS=D	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and	{01700}		

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{01700}	Continued From page 12 provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by:	{01700}	Not reviewed during this survey.	
{01790} SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel,	{01790}		

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{01790}	Continued From page 13 including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by:	{01790}	Not reviewed during this survey.	

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{01810}	Continued From page 14	{01810}		
{01810} SS=D	144G.71 Subd. 12 Medications; over-the-counter drugs; dietary An assisted living facility providing medication management services for over-the-counter drugs or dietary supplements must retain those items in the original labeled container with directions for use prior to setting up for immediate or later administration. The facility must verify that the medications are up to date and stored as appropriate. This MN Requirement is not met as evidenced by:	{01810}	Not reviewed during this survey.	

Electronically Delivered

December 30, 2024

Licensee
N&V Helpful Heart Care Inc
6620 Bryant Avenue North
Brooklyn Center, MN 55430

RE: Project Number(s) SL34008016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on November 15, 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:

St - 0 - 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,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: Jess.Schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 000	Initial Comments 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: SL34008016-0 On Novemeber 12, 2024, through November 15, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were three residents receiving services under the Assisted Living Facility license. An immediate order was issued on November 13, 2024, for tag identification 0780. On November 14, 2024, the licensee took action to mitigate the imminent risk. Noncompliance remained and the scope and level remain unchanged.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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0 480	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are	0 480		

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated November 12, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer	0 480		

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0 480	Continued From page 3 to the FBEIR for any compliance dates.	0 480		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program to comply with accepted health care, medical and nursing standards for infection control by 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:	0 510		

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0 510	Continued From page 4 During facility tour on November 12, 2024, at 11:00 a.m., the surveyor observed a rambler style home with a living room and next to it, a small area for a dining room table. Just past the dining room table was the kitchen and door to the basement. To the left of the living room included a full-size bathroom and three bedrooms. During observation and interview on November 13, 2024, at 9:00 a.m., the surveyor was sitting at the small dining room table directly across from R1 who was drinking a jug of clear laxative liquid in preparation for a colonoscopy. R1 was having a difficult time drinking the liquid and had vomited on the floor directly in front of her. Unlicensed personnel (ULP)-B placed paper towels on top of the vomit. R1 had vomited for the second time on top of the paper towels. With gloves on, ULP-B grabbed the broom and dustpan located next to the open garbage within the kitchen and swept the paper towels up and placed it in the garbage. The area where the vomit was located was the only pass through from the living/dining room to the kitchen. After several minutes, the surveyor had asked ULP-B to clean the floor to prevent cross contamination. ULP-B sprayed the direct and surrounding area with "Method Antibac all-purpose cleaner," then mopped the area with a mop head (it is unknown if there was cleaner within the mop head. The broom and dustpan were placed back next to the garbage ready for use and the mop was brought downstairs out of sight. The surveyor did not observe disinfection of the dining room table after the resident left for her procedure. ULP-B stated she received infection control training by clinical nurse supervisor (CNS)-D. ULP-E whom who helped mop stated they used products like Comet, bleach, and used the mop to clean vomit up. The mop head would then be cleaned with a bleach solution. The	0 510		

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0 510	Continued From page 5 surveyor did not observe Comet or bleach used on the floor. Right above the garbage was a posting labeled, "VOMIT CLEAN UP," which instructed staff to use the following equipment: cat litter, shovel and scraper, mask, gloves, goggles, disposable apron, garbage bags, soap and water, paper towels, and a norovirus sanitizer. On November 12, 2024, and November 14, 2024, throughout the survey, the surveyor observed the following sitting on top of the toilet tank: a roll of paper towel, brush and three combs lying flat, and a plastic cup holding three toothbrushes and two tubes of toothpaste within the cup. On November 14, 2024, at 10:55 a.m., clinical nurse supervisor (CNS)-A explained the vomit clean up was not done correctly. Owner and director (O)-C stated staff were trained on how to clean up vomit and the protocol was posted on the wall. Both agreed the broom should not have been used and proper personal protective equipment ((PPE)-gloves, goggles, apron, and mask) should have been used. The surveyor showed CNS-A the items on the toilet tank and CNS-A stated those items should be in the cabinet above the toilet. ULP-G stated they were always placed in the cabinet but R1 always put them on the toilet tank. CNS-A instructed ULP-G that if the items were found on the tank, to automatically place them back in the cabinet. The licensee's 8.01 Infection Control Policy revised December 21, 2023, indicated the licensee would observe the recommended precautions for home care as identified by the Centers for Disease Control and Prevention (CDC). The policy also indicated the licensee would have separate written standards and	0 510		

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0 510	Continued From page 6 training procedures in the areas of infection control prevention. The CDC's (U.S. Centers for Disease Control and Prevention) "Guidelines for Environmental Infection Control in Health-Care Facilities," dated 2003, indicated to use a one-step process and an EPA-registered hospital disinfectant/detergent designed for general housekeeping purposes in patient-care areas when uncertainty exists as to the nature of the soil on these surfaces (e.g., blood or body fluid contamination versus routine dust or dirt). The CDC also indicated an EPA (Environmental Protection Agency)-registered sodium hypochlorite product is preferred, but if such products are not available, generic versions of sodium hypochlorite solutions (e.g., household chlorine bleach) may be used. Use a 1:100 dilution to decontaminate nonporous surfaces after cleaning a spill of either blood or body fluids in patient-care settings. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that	0 660		

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0 660	Continued From page 7 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 completion of a two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test, for one of one employee (unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: The licensee's Facility TB Risk Assessment dated August 25, 2023, indicated licensee's TB risk level was low. ULP-B was hired on September 17, 2024, to provide direct services to residents. ULP-B's employee record included the following:	0 660		

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0 660	Continued From page 8 -Baseline TB Screening Tool for Healthcare Workers, dated September 17, 2024, which ULP-B answered "no," to having a positive reaction to a TB skin test; and -a chest x-ray (CXR) dated July 25, 2024, which indicated ULP-B was free of any active communicable disease like TB. ULP-B's employee record lacked documentation of a positive two-step TST or Interferon-Gamma Release Assay (IGRA) test completed prior to the CXR and provider evaluation. On November 14, 2024, at 11:58 a.m., owner and director (O)-C was unable to provide a positive test to accompany the CXR and a provider evaluation for ULP-B. The licensee's 8.16 Tuberculosis Screening policy revised August 30, 2024, indicated the licensee would observe the recommended precautions related to TB prevention as identified by the CDC. The licensee would maintain a current community TB risk assessment and would be updated annually using data and form provided by MDH. The policy also stated new staff would have an IGRA blood test or a two-step Mantoux conducted. The policy did not provide procedures for a follow up CXR after a positive test. The MDH website, Assisted Living Resources & Frequently-Asked Questions (FAQs) dated October 15, 2024, indicated a CXR alone was not acceptable documentation. Staff either need to provide documentation of the following: -a positive two-step TST or IGRA test along with a CXR with provider evaluation after that date; or -documentation of refusal of both the two-step TST and IGRA followed by a new CXR and	0 660		

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0 660	Continued From page 9 provider evaluation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 780 SS=I	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by:	0 780		

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0 780	Continued From page 10 Based on observation and interview, the licensee failed to provide emergency escape and rescue windows in compliance with the Minnesota State Fire Code. This had the potential to directly affect all or a large portion of the residents and staff. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On a facility tour on November 13, 2024, from 11:00 a.m. to 12:00 p.m., with owner and director (O)-C, and unlicensed personnel (ULP)-B it was observed that compliant emergency escape and rescue openings were not provided in resident sleeping rooms 1, 2, and 3. OCCUPIED RESIDENT SLEEPING ROOMS Resident sleeping room 1, emergency escape and rescue clear window opening measurements were 27 inches wide, 15.5 inches in height and 398 square inches in openable area. The window was measured with O-C, ULP-B, and the surveyor present. The window did not meet the minimum requirements for clear opening, minimum height, and total square inch openable area. Resident sleeping room 3, emergency escape and rescue clear window opening measurements were 17 inches wide, 51.5 inches in height and	0 780		

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0 780	Continued From page 11 876 square inches in openable area. The window was measured with O-C, ULP-B, and the surveyor present. The window did not meet the minimum requirements for clear opening minimum width. UNOCCUPIED RESIDENT SLEEPING ROOMS Resident sleeping room 2, emergency escape and rescue clear window opening measurements were 27 inches wide, 15.5 inches in height and 398 square inches in openable area. The window was measured with O-C, ULP-B, and the surveyor present. The window did not meet the minimum requirements for clear opening, minimum height, and total square inch openable area. It was explained to O-C, and ULP-B, that at least one compliant emergency escape and rescue opening is required within each resident sleeping room. Existing emergency escape and rescue openings are required to meet a minimum clear opening area of 648 square inches and have a minimum dimension of 20 inches in height and a minimum dimension of 20 inches in width. If the window clear opening measures the minimum of 20 inches in one direction, the other measurement will be more than 20 inches in order to achieve the total square inch area of 648 square inches. These deficient conditions were visually verified by O-C and ULP-B, accompanying on the tour. Survey staff explained that an immediate correction order was issued for the above findings. TIME PERIOD FOR CORRECTION: Immediate	0 780		

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0 780	Continued From page 12 On November 14, 2024, the licensee took action to mitigate the imminent risk. Noncompliance remained and the scope and level remain unchanged. On the same facility tour on November 13, 2024, from 11:30 a.m. to 12:30 p.m., the surveyor made the following observations of non-compliance with the requirements of the Minnesota State Fire Code: USED SMOKING MATERIALS There were used cigarette butts discarded on the ground around the exterior of the door leading outside from the kitchen. Used cigarette butts are required to be discarded in an appropriate non-combustible container or container manufactured and tested for the use in accordance with Minnesota State Fire Code Section 310. There was plastic bucket used to discard used cigarette butts on the exterior back steps leading out of the kitchen. Cigarette butt dispensers are required to be non-combustible material or manufactured and tested for the use of discarding used cigarette butts in accordance with Minnesota State Fire Code Section 310. INTERCONNECTED SMOKE ALARMS The smoke alarms were tested, and the surveyor observed the smoke alarms throughout the facility were not interconnected so activation of one alarm activates all alarms. The surveyor explained that smoke alarms are required to be interconnected so activation of one alarm activates all alarms throughout the facility.	0 780		

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0 780	Continued From page 13 EXTERIOR DOOR AND GATE LOCKS The required main front exit door had an interior lock requiring a key to open from the inside installed. Required exterior exit doors in the marked path of exit are required to be readily openable from the inside without the use of keys tools or special knowledge in accordance with Minnesota State Fire Code Section 1010. The exterior exit door as marked on the evacuation map from the kitchen had an interior lock requiring a key to open from the inside installed. Exterior exit doors in the marked path of exit are required to be readily openable from the inside without the use of keys tools or special knowledge in accordance with Minnesota State Fire Code Section 1010. The exterior gate outside the kitchen door in the path of exit to the public way was locked with a chain and padlock. Exterior gates in the path of exit are required to be readily openable from the inside without the use of keys tools or special knowledge in accordance with Minnesota State Fire Code Section 1010. STORAGE There was combustible storage around and near the furnace in the basement mechanical room. Combustible storage is required to be kept clear of heating appliances in accordance with the manufacture installation instructions and the Minnesota State Fire Code Section 603. There were garbage bags blocking the exterior exit gate in the marked exit path near the driveway. Exit paths are required to be maintained clear of obstructions that prevent full	0 780		

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0 780	Continued From page 14 and immediate use in accordance with Minnesota State Fire Code Section 1031. GAS WATER HEATER VENT There was a missing plug in the vertical gas vent for the gas water heater. Gas appliance vents are required to be maintained sealed to prevent the escape of the products of combustion into the occupied space in accordance with Minnesota State Fire Code Section 603. CLOTHES DRYER VENT The clothes dryer vent in the basement laundry room was disconnected near the ceiling and discharging lint and exhaust into the basement causing an accumulation of lint on the ceiling surfaces. Dryer vents are required to be maintained and regularly cleaned in accordance with Minnesota State Fire Code Section 304. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
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	0 800		

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0 800	Continued From page 15 by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On a facility tour on November 13, 2024, from 11:00 a.m. to 12:00 p.m., with owner and director (O)-C, and unlicensed personnel (ULP)-B, the surveyor made the following observations of facility disrepair: The sink top on the vanity cabinet was not securely fastened to the cabinet and moved around easily putting stress on the plumbing pipes attached to the sink in the main floor bathroom. During a facility tour, O-C and ULP-B verified the above listed observations. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		

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0 810	Continued From page 16	0 810		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire	0 810		

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0 810	Continued From page 17 safety and evacuation plan with required content and provide 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 November 13, 2024, at 12:30 p.m., owner and director (O)-C, provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee provided the FSEP but failed to include the following: The available FSEP included standard resident evacuation procedures, but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The FSEP failed to include evacuation status and unique needs for evacuation for each individual resident in writing and available for immediate reference in the event of a fire or similar emergency. During an interview on November 13, 2024, at 12:45 p.m., O-C, stated the resident evacuation	0 810		

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0 810	Continued From page 18 status/ unique needs for evacuation was not readily available for each resident. TRAINING Record review of the available documentation indicated the licensee failed to provide training to employees based on the FSEP upon hire and at least twice per year as evident by not providing documentation the required site specific FSEP employee training was completed. Record review of the available documentation indicated the licensee failed to provide evacuation training to residents at least once per year as evident by not providing documentation the required FSEP training was provided to residents. During an interview on November 13, 2024, at 12:50 p.m., O-C, stated training completed by employees was only general fire safety training and not site specific and documentation was not available FSEP training was provided to residents. DRILLS Record review of the available documentation indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month as evident by providing documentation evacuation drills were completed in August 2024, and October 2024 only. During an interview on November 13, 2024, at 12:55 p.m., O-C, stated documentation was not available indicating evacuation drills were performed as required.	0 810		

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0 810	Continued From page 19 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01290 SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a background study was submitted and received in affiliation with the assisted living license for three of nineteen employees (unlicensed personnel (ULP)-B, ULP-F, ULP-G). 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	01290		

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01290	Continued From page 20 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-B, ULP-F, and ULP-G began employment on September 17, 2024, June 24, 2024, and April 19, 2017, respectively, to provide direct care for the licensee's residents. The licensee's staff schedule dated November 1, 2024, through November 30, 2024, indicated the following: -ULP-B was scheduled to work ten (10) shifts, eight hours each shift; -ULP-F was scheduled to work 13 shifts, eight hours each shift; and -ULP-G was scheduled to work 31 shifts, eight hours each shift. ULP-B's employee record contained a background study dated September 26, 2024, submitted through a separate facility under licensee's sister facility with Health Facility Identification (HFID) 32413; however, ULP-B's employee record lacked evidence the licensee affiliated a background study under this facility's HFID 34008. On November 12, 2024, between 10:00 a.m., and 3:00 p.m., the surveyor observed ULP-F working their shift by tending to residents. On November 12, 2024, at approximately 3:00 p.m., ULP-G arrived to work evening shift. On November 13, 2024, at 11:00 a.m., owner and director (O)-C pulled up the NETStudy 2.0 roster on their computer as requested. The roster indicated ULP-B, ULP-F, and ULP-G were not	01290		

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	34008	A. BUILDING: _____ B. WING _____	11/15/2024

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01290	Continued From page 21 affiliated to HFID 34008. On November 13, 2024, at 2:50 p.m., O-C stated when she completed a background study, she picked one facility to affiliate the employee, but said she did have the ability to affiliate the employee to all of the facilities and will do that going forward as she wasn't aware of that requirement. On November 13, 2024, from 9:00 a.m. through 3:00 p.m., the surveyor observed ULP-B administer medications, perform housekeeping, and provide breakfast to licensee's residents. The licensee's 4.02 Background Studies policy revised August 5, 2024, indicated the employment process included a criminal background check would be submitted to Minnesota Department of Human Services (DHS). The policy lacked direction that the background study must be affiliated with the licensee, as required. The Minnesota Department of Health (MDH) document titled Resources & Frequently - Asked Questions (FAQs) last updated October 15, 2024, read, "If you have an existing background study for someone at one facility, you can affiliate the person's background study to another facility if the Sensitive Information Person (SIP) is the same." No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		

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01460	Continued From page 22	01460		
01460 SS=F	144G.63 Subdivision 1 Orientation of staff and supervisors (a) All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility, except as provided in paragraph (b). (b) A staff person is not required to repeat the orientation required under subdivision 2 if the staff person transfers from one licensed assisted living facility to another facility operated by the same licensee or by a licensee affiliated with the same corporate organization as the licensee of the first facility, or to another facility managed by the same entity managing the first facility. The facility to which the staff person transfers must document that the staff person completed the orientation at the prior facility. The facility to which the staff person transfers must nonetheless provide the transferred staff person with supplemental orientation specific to the facility and document that the supplemental orientation was provided. The supplemental orientation must include the types of assisted living services the staff person will be providing, the facility's category of licensure, and the facility's emergency procedures. A staff person cannot transfer to an assisted living facility with dementia care without satisfying the additional training requirements under section 144G.83. This MN Requirement is not met as evidenced by:	01460		

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01460	Continued From page 23 Based on interview and record review, the licensee failed to provide staff orientation to assisted living licensing requirements and regulations for one of three employees (licensed assisted living director (LALD)-D). 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 November 12, 2024, at 10:15 a.m., owner and director (O)-C stated the licensee was aware of required contents for an employee record. O-C stated she had been working on obtaining her license to become an LALD, but in the meantime, she hired LALD-D. The surveyor observed LALD-D's license posted on the wall near the dining room table. On the Minnesota Board of Executives for Long-Term Services and Supports (BELTSS) credential search, indicated LALD-D became director of record for licensee on October 11, 2024. LALD-D lacked an employee record. On November 13, 2024, at 1:18 p.m., LALD-D stated she was not aware she needed to complete any orientation training outside of what she completed under BELTSS's requirement.	01460		

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01460	Continued From page 24 LALD-D stated she had not personally met or spoke with any staff but was "exposed" to the facility. She stated she needed to get together with O-C to "clear up" what her role would be. On November 13, 2024, at approximately 2:00 p.m., the surveyor requested LALD-D's orientation training. O-C stated she did not have an employee record for LALD-D nor had she completed orientation training. The licensee's 5.01 Orientation of Staff and Supervisors & Content policy effective March 3, 2022, indicated all [Licensee] employees must complete the orientation to assisted living facility requirements before providing assisted living services to residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01460		
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	01620		

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01620	Continued From page 25 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 all areas of the uniform assessment tool as required per Minnesota Administrative Rule 4659.0150 were addressed for one of two residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included anxiety, bipolar disorder, and panic disorder. R1's Service Plan dated February 16, 2022, indicated R1 received assistance with toileting, laundry, housekeeping, food preparation, dressing, grooming, bathing, and medication administration.	01620		

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01620	Continued From page 26 R1's Uniform Assessment Tool (UAT) form dated January 13, 2022, contained pages one through seven (1-7) out of 23 pages total. The assessment lacked the following required content: - activities of daily living; - instrumental activities of daily living; - infectious conditions; - review of medications including prescriptions, over-the-counter medications and supplements; - emotional and mental health conditions; - cognition; - skin conditions; - list of treatments, including type, frequency, and level of assistance needed; - nursing needs, including potential to receive nursing delegated services; - risk factors including complex medication regimen and elopement risk including history or previous elopements; and - the need for follow-up referrals for additional medical or cognitive care by health professionals. On November 14, 2024, at 9:54 a.m., clinical nurse supervisor (CNS)-A explained it was her process to complete the UTA form upon admission, then at the 14-day and every 90-day assessment, she would review the completed tool then after assessing the resident, she documented the date of assessment, method, any notes, any changes to the service plan and signed it. CNS-A was unaware pages 8-23 were missing from R1's record and was unable to locate it. The licensee's 6.01 Assessments, Reviews & Monitoring policy revised January 2, 2024, noted the initial nursing assessment or reassessment must include all the elements of the uniform	01620		

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01620	Continued From page 27 assessment tool as required. The licensee's 6.03 Uniform Assessment Tool policy revised November 8, 2024, indicated the licensee would use a uniform assessment tool that addresses all of the required elements. Minnesota Administrative Rules Chapter 4659.0140, Subp. 2, effective October 2022, a nursing assessment or reassessment under Minnesota Statutes, section 144G.70, subdivision 2, paragraphs (b) and (c), must be conducted on a prospective resident or resident receiving any of the assisted living services identified in Minnesota Statutes, section 144G.08, subdivision 9, clauses (6) to (12). B. The nursing assessment or reassessment under item A must: (1) address part 4659.0150, subpart 2, items A to N; (2) be conducted in person unless an exception under Minnesota Statues, section 144G.70, subdivision 2, paragraph (b), applies; (3) be conducted using a uniform assessment tool that complies with part 4659.0150; and (4) be in writing, dated, and signed by the registered nurse who conducted the assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01700 SS=D	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have	01700		

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01700	Continued From page 28 a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. 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 assessment to include all required content for one of one resident (R1), who received medication management 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, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a	01700		

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01700	Continued From page 29 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 November 12, 2024, at 10:16 a.m., clinical nurse supervisor (CNS)-A stated the licensee provided medication management services to residents at the facility. R1's diagnoses included anxiety, bipolar disorder, and panic disorder. R1's Service Plan dated February 16, 2022, indicated R1 received assistance with toileting, laundry, housekeeping, food preparation, dressing, grooming, bathing, and medication administration. On November 13, 2024, at 9:00 a.m., the surveyor observed unlicensed personnel (ULP)-B provide polyethylene glycol (laxative), suboxone (treat opioid use disorder), vitamin D (supplement), furosemide (helps rid the body of extra fluids), and pantoprazole (treats gastroesophageal reflux) to R1, which R1 refused to administer until after the colonoscopy so they were locked back up in the medication closet. R1's prescriber orders dated August 23, 2024, included the above medications provided. R1's Medication Administration Record for November 2024 included staff initials through November 12, 2024, to indicate R1 had received her prescribed medications. R1's record lacked a medication assessment to include:	01700		

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01700	Continued From page 30 - identification and review of all medications the resident is known to be taking; - indications for medications: - side effects; - contraindications; - allergic or adverse reactions; and - actions to address these issues. On November 14, 2024, at 9:54 a.m., clinical nurse supervisor (CNS)-A explained it was her process to complete the Uniform Assessment Tool (UAT) upon admission (included the medication assessment), then at the 14-day and every 90-day assessment, she would review the completed UAT then after assessing the resident, she documented the date of assessment, method, any notes, any changes to the service plan and signed it. CNS-A was unaware pages 8-23 were missing from R1's UAT dated January 13, 2022, and was unable to locate it. The licensee's 7.01 Medication Management - Assessment, Monitoring & Reassessment policy revised December 10, 2023, indicated prior to providing medication management services the RN would conduct an assessment to determine what services would be provided to include an identification and review of all medications the resident was taking, the indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address the issues. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700		

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01790	Continued From page 31	01790		
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in	01790		

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01790	Continued From page 32 the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. 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) developed training and competencies for unlicensed personnel (ULP) providing medications to residents for unplanned time away from home when the licensed nurse was not available for two of two employees (ULP-D, ULP-E). The licensee also failed to ensure the registered nurse (RN) developed comprehensive written procedures for the ULP providing medications for residents having unplanned time away when the licensed nurse was not available. This practice resulted in a level two violation (a violation that did not harm a resident's health or	01790		

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01790	Continued From page 33 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 the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on November 12, 2024, at 10:16 a.m., clinical nurse supervisor (CNS)-A and owner and director (O)-C stated the licensee provided medication management services for the licensee's residents including medication administration and ULPs administered those medications after being trained by CNS-A. On November 14, 2024, at 8:52 a.m., ULP-G was not familiar with written procedures to follow for providing medication for unplanned time away from home. ULP-G explained how they would go about setting the medications up and documenting the task in the resident's record. ULP-G did not state they would send any information with the resident or the resident's designated representative. On November 14, 2024, at 9:35 a.m., the surveyor observed ULP-G administer blood pressure medications, aspirin, medications for slowing the progression of dementia, and a vitamin to R2. On November 14, 2024, at 10:45 a.m., CNS-A and O-C stated ULP-B had not been trained on providing medications for unplanned time away. They stated this was an issue at a different facility recently surveyed. They also stated all of the newer staff did not receive training, but the	01790		

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N&V HELPFUL HEART CARE INC	6620 BRYANT AVENUE NORTH BROOKLYN CENTER, MN 55430

(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
01790	Continued From page 34 long-term staff did. O-C stated she had worked on the written procedures, but it was not available to staff. The licensee's 7.10 Medication Management-Planned & Unplanned Time Away policy effective December 10, 2023, indicated, for unplanned time away when the licensed nurse was not available, the registered nurse had trained the unlicensed staff and determined the unlicensed staff was competent to follow the procedures for giving medications to residents. The policy also included, "the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		
01810 SS=D	144G.71 Subd. 12 Medications; over-the-counter drugs; dietary An assisted living facility providing medication management services for over-the-counter drugs or dietary supplements must retain those items in the original labeled container with directions for use prior to setting up for immediate or later administration. The facility must verify that the medications are up to date and stored as appropriate. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure	01810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34008	A. BUILDING: _____ B. WING _____	11/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
N&V HELPFUL HEART CARE INC	6620 BRYANT AVENUE NORTH BROOKLYN CENTER, MN 55430

(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
01810	Continued From page 35 over-the-counter (OTC) drugs were stored as appropriate for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During observation and interview on November 13, 2024, at 2:30 p.m., the surveyor observed the licensee's medication closet and observed the following expired medications for R1: -acetaminophen 500 milligrams (mg)-21 tablets expired July 20, 2024; and -ibuprofen 600 mg-seven (7) tablets expired July 20, 2024. Owner and director (O)-C stated clinical nurse supervisor (CNS)-A was responsible for handling expired medications but was not sure how often the RN checked for expired medications or what her process was. On November 14, 2024, at 9:54 a.m., CNS-A stated she performed bi-weekly medication checks to ensure medication was stocked, being given appropriately, and checked for expired medications. CNS-A explained R1 was no longer using ibuprofen and the acetaminophen was the incorrect dose so they would dispose the medications. The licensee's 7.23 Medication Disposal policy revised December 8, 2023, indicated the facility	01810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34008	A. BUILDING: _____ B. WING _____	11/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
N&V HELPFUL HEART CARE INC	6620 BRYANT AVENUE NORTH BROOKLYN CENTER, MN 55430

(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
01810	Continued From page 36 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. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01810		

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

Type: Follow-Up
Date: *12/02/24*
Time: 10:15:00
Report: 1021241368

Food and Beverage Establishment Inspection Report

Location:
N&V Helpful Heart Care Inc
6620 Bryant Avenue North
Brooklyn Center, MN55430
Hennepin County, 27

Establishment Info:
ID #: 0038436
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 7634420460
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 previously issued on 01/03/22 have NOT been corrected.

2-100 Supervision

2-102.12AMN

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

FIRST ISSUED 10/20/21: NO CERTIFIED FOOD PROTECTION MANAGER (CFPM) WAS EMPLOYED AT THIS ESTABLISHMENT. DIRECTOR IS IN THE PROCESS OF GETTING THE CFPM CERTIFICATE. REPEAT 12/02/24.

Issued on: 01/03/22 *Comply By: 01/03/22*

No NEW orders were issued during this inspection.

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

TODAY'S FOLLOW UP WAS TO ADDRESS AND CLEAR PREVIOUSLY WRITTEN ORDERS FROM A FULL INSPECTION CONDUCTED ON 11/12/24. 6 OUT OF 7 ORDERS WERE CLEARED FROM THE REPORT.

Type: Follow-Up
Date: *12/02/24*
Time: 10:15:00
Report: 1021241368
N&V Helpful Heart Care Inc

Food and Beverage Establishment Inspection Report

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 1021241368 of 12/02/24.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed:_____
VERA DIXON
DIRECTOR

Signed:_____
Melissa Ramos
Environmental Health Specialist
Metro District Office
651-201-4495
Melissa.Ramos@state.mn.us

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

Type: Full
Date: *11/12/24*
Time: 13:15:56
Report: 1021241349

Food and Beverage Establishment Inspection Report

Location:
N&V Helpful Heart Care Inc
6620 Bryant Avenue North
Brooklyn Center, MN55430
Hennepin County, 27

Establishment Info:
ID #: 0038436
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 7634420460
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 previously issued on 01/03/22 have NOT been corrected.

4-300 Equipment Numbers and Capacities

4-302.12A ***** Priority 2 *****

MN Rule 4626.0705A Provide a readily accessible food temperature measuring device to ensure attainment and maintenance of food temperatures.

FIRST ISSUED 10/20/21: ESTABLISHMENT DOES NOT HAVE A MEASURING DEVICE THAT INDICATES THE FINAL UTENSIL SURFACE TEMPERATURE IN HIGH TEMPERATURE DISH MACHINE. PROVIDE. REPEAT 11/12/24.

Issued on: 01/03/22 *Comply By: 01/03/22*

2-100 Supervision

2-102.12AMN

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

FIRST ISSUED 10/20/21: NO CERTIFIED FOOD PROTECTION MANAGER (CFPM) WAS EMPLOYED AT THIS ESTABLISHMENT. INFORMATION ON HOW TO OBTAIN CFPM CERTIFICATE SENT WITH REPORT. REPEAT 11/12/24.

Issued on: 01/03/22 *Comply By: 01/03/22*

The following orders were issued during this inspection.

4-700 Sanitizing Equipment and Utensils

4-702.11 ***** Priority 1 *****

MN Rule 4626.0900 Sanitize utensils and food contact surfaces of equipment before use, after cleaning.

THE DISH MACHINE IN THE KITCHEN HAS NOT BEEN WORKING FOR A WHILE AND PER CONVERSATION WITH STAFF, THEY ARE ONLY WASHING AND RINSING IN THE TWO COMPARTMENT SINK. ALL DISHES AND UTENSILS NEED TO BE WASHED, RINSED AND SANITIZED EACH TIME. SEE COMMENTS.

Comply By: 11/12/24

7-200 Toxic Supplies and Applications

7-204.11 ***** Priority 1 *****

MN Rule 4626.1620 Discontinue using chemical sanitizers, including chemical sanitizing solutions generated on site and other chemical antimicrobials on food-contact surfaces that do not meet the requirements specified in 40 CFR part 180, section 180.940, or part 180, subpart E, section 180.2020.

THE CHLORINE ON-SITE IS NOT INTENDED FOR FOOD CONTACT SURFACES. STAFF WILL GET APPROVED CHLORINE TO USE IN THE KITCHEN. FACT SHEET WITH APPROVED FOOD CONTACT SANITIZERS SENT WITH REPORT.

Comply By: 11/14/24

4-300 Equipment Numbers and Capacities

4-302.14 ***** Priority 2 *****

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

NO TEST KIT ON-SITE TO MEASURE THE CONCENTRATION OF CHLORINE. PROVIDE.

Comply By: 11/20/24

4-500 Equipment Maintenance and Operation

4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

THE DISH MACHINE IS CURRENTLY NOT WORKING. STAFF WILL GET DISH MACHINE REPAIRED OR REPLACED. IN THE MEANTIME, THEY WILL MANUALLY SANITIZE ALL OF THEIR DISHES AND UTENSILS WITH A CHEMICAL SANITIZER.

Comply By: 11/12/24

4-600 Cleaning Equipment and Utensils

4-601.11C

MN Rule 4626.0840C Clean non-food contact surfaces of equipment and maintain free of accumulations of dust, dirt, food residue, and other debris.

FRONT PANEL OF THE MICROWAVE AND STOVE HAS VISIBLE GREASE SPLATTER. DISH MACHINE HAS ACCUMULATION OF DRIED FOOD DEBRIS AND SPLASHING OF DRIED LIQUIDS. PLASTIC SHELVES & DRAWERS IN THE KITCHEN REFRIGERATOR CONTAINS ACCUMULATION OF DRIED FOOD DEBRIS.

Comply By: 11/15/24

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

ALL FINDINGS ON THIS REPORT WERE DISCUSSED WITH DIRECTOR, VERA DIXON AND HEALTH REGULATION DIVISION NURSE EVALUATOR, ANNA BOHNEN.

THIS FACILITY IS A RESIDENTIAL HOME AND THEY CURRENTLY HAVE 3 CLIENTS AND THE FACILITY CAN HAVE UP TO 4 CLIENTS.

PER CONVERSATION WITH STAFF, FOOD IS MADE FOR SAME DAY SERVICE. NO LEFTOVERS ARE KEPT.

CONTINUATION OF MN Rule 4626.0900
STAFF WILL MANUALLY SANITIZE IN A CONTAINER WITH WATER AND CHLORINE. INFORMATION ON MANUALLY WAREWASHING SENT WITH REPORT.

CONTINUATION OF MN Rule 4626.0840C
CLEAN AND MAINTAIN CLEAN ALL NON-FOOD CONTACT SURFACES OF EQUIPMENT.

THE KITCHEN HAS RESIDENTIAL EQUIPMENT, PAINTED DRYWALL, LAMINATE COUNTERTOPS AND WOOD CABINETS. PHYSICAL FACILITY ITEMS WILL BE MONITORED DURING FUTURE INSPECTIONS.

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 1021241349 of 11/12/24.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/__/____

Inspection report reviewed with person in charge and emailed.

Signed:_____

VERA DIXON
DIRECTOR

Signed:_____

Melissa Ramos
Environmental Health Specialist
Metro District Office
651-201-4495
Melissa.Ramos@state.mn.us