DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

November 13, 2025

Licensee
Wright Way Home Care LLC
3701 54th Avenue North
Brooklyn Center, MN 55429

RE: Project Number(s) SL38163016

Dear Licensee:

On October 13, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on June 13, 2025. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

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

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Electronically Delivered

August 11, 2025

Licensee
Wright Way Home Care LLC
3701 54th Avenue North
Brooklyn Center, MN 55429

RE: Project Number(s) SL38163016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 13, 2025, 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 2: a fine of $500 per violation, 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 - 0780 - 144g.45 Subd. 2 (a) (1) - Fire Protection And Physical Environment - $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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38163	A. BUILDING: _____ B. WING _____	06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WRIGHT WAY HOME CARE LLC	3701 54TH AVENUE NORTH BROOKLYN CENTER, MN 55429

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER 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: SL#38163016 On June 9, 2025, through June 13, 2025, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 2 active residents; 2 receiving services under the Assisted Living license. On June 10, 2025, an immediate correction order was issued for tag identification 0470. On June 11, 2025, an immediate correction order was issued for tag identification 1390. During the course of the survey, the licensee took action to mitigate the imminent risk related to order 0470. Noncompliance remained and the scope and level remain unchanged. During the course of the survey, the licensee took action to mitigate the imminent risk related to	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 License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	

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0 000	Continued From page 1 order 1390. Noncompliance remained and the scope and level remain unchanged.	0 000		
0 110 SS=C	144G.10 Subdivision 1a Assisted living director license required Each assisted living facility must employ an assisted living director who is licensed or permitted by the Board of Executives for Long Term Services and Supports and affiliated as the director of record with the board. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensed assisted living director (LALD) was listed as the Director of Record for the licensee through the Board of Executives for Long-Term Service and Supports (BELTSS) website. This had the potential to affect all the licensee's residents, staff, and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: LALD-C was licensed on July 7, 2021. On June 9, 2025, at 09:35 a.m. during the entrance conference, owner/unlicensed	0 110		

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0 110	Continued From page 2 personnel (O/ULP)-A stated they were not aware that LALD-C was required to identify themselves as the Director of Record on the BELTSS website and would have LALD-C log into the BELTSS website to identify themselves as the Director of Record. The BELTSS website accessed on June 4, 2025, at 9:05 a.m., indicated LALD-C was licensed but was not listed as the Director of Record for the licensee. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake;	0 470		

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0 470	Continued From page 3 (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure that one or more awake persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. This impacted all residents who received care from the licensee. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: The licensee held an assisted living facility license staffed with four personnel - owner/unlicensed personnel (O/ULP)-A, registered nurse (RN)-B, licensed assisted living director (LALD)-C, and ULP-D. The licensee was licensed for a bed capacity of three residents and had a current census of two residents. On June 9, 2025, at approximately 9:45 a.m.,	0 470	During the course of the survey, the licensee took action to mitigate the imminent risk related to order 0470. Noncompliance remained and the scope and level remain unchanged.	

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0 470	Continued From page 4 during the entrance conference, O/ULP-A stated O/ULP-A works the day shift and the night shift at the facility. O/ULP-A also stated there was no backup plan if a staff member was sick or needed a day off. O/ULP-A further stated RN-B was on-site for one to two days a month and LALD-C was on-site one day a month. The licensee's staffing schedule dated June 2025, indicated the licensee was staffed as follows: -O/ULP-A on-site seven days a week from 8:00 a.m. to 4:00p.m. and 10:00 p.m. to 8:00 a.m. -ULP-D on-site seven days a week from 4:00 p.m. to 10:00 p.m. On June 9, 2025, at approximately 10:30 a.m., during a tour of the facility, the surveyor observed on the main level two occupied resident bedrooms and a folded-up blanket and pillow stored on a chair in the living room. The surveyor also observed a bedroom in the lower level of the facility that contained: - a bedframe; - mattress covered with disheveled bedding; -closet full of clothing; -dresser with open drawers full of clothing; -clothes strewn across the floor; -multiple tote bags full of items; and -multiple boxes throughout the room. On June 9, 2025, at approximately 11:00 a.m., O/ULP-A stated the licensee utilized the lower-level bedroom to store O/ULP's personal effects. On June 9, 2025, at approximately 2:45 p.m., O/ULP-A stated O/ULP-A would sleep during the scheduled overnight shift on the couch in the main level living room while being the only staff	0 470		

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0 470	Continued From page 5 on site. The licensee's undated Criteria for Admission policy indicated the licensee would have awake staff available 24 hours per day, seven days per week who is responsible for responding to the requests of assisted living residents for assistance with health or safety needs. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	0 470		
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 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	0 480		

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0 480	Continued From page 6 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: 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	0 480		

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0 480	Continued From page 7 resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated June 10, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to implement and maintain a	0 580		

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0 580	Continued From page 8 quality management program (QMP) appropriate to the size of the facility and relevant to the type of services provided. This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On June 9, 2025, at approximately 10:15 a.m., during the entrance conference, owner/unlicensed personnel (O/ULP)-A stated the licensee provided ongoing QMP areas were identified, but no meeting minutes, tracking, or specific improvement projects would be documented. The licensee's Quality Management Program policy undated, indicated a QMP would be implemented, and documentation would be provided upon request. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 580		
0 650 SS=D	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each	0 650		

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0 650	Continued From page 9 individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records included all required content for one of one employee (owner/unlicensed personnel (O/ULP)-A). 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).	0 650		

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0 650	Continued From page 10 The findings include: O/ULP-A was hired on October 26, 2022. O/ULP-A's employee record lacked evidence of orientation including initial 8 hours of dementia care training within 120 working hours. On June 9, 2025, at 12:30 p.m., O/ULP-A stated O/ULP-A completed the 8 hours of dementia care training and the missing employee record content was an oversight by licensee. The licensee's Employee Records policy, undated, indicated each employee record would include orientation records for staff. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control 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.	0 660		

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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
0 660	Continued From page 11 (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 and control program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) when the licensee failed to complete a facility TB risk assessment. 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 June 9, 2025, at approximately 10:00 a.m. during the entrance conference, owner/unlicensed personnel (O/ULP)-A acknowledged the licensee had not completed a facility TB risk assessment. O/ULP-A stated the licensee was not aware of the facility TB risk assessment and one was not completed. The licensee's Tuberculosis Screening policy, undated, indicated a facility TB risk assessment would be completed. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July	0 660		

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	38163	A. BUILDING: _____ B. WING _____	06/13/2025

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0 660	Continued From page 12 2013, and the CDC guidelines, indicated a TB infection control program should include a facility TB risk assessment. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced	0 680		

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0 680	Continued From page 13 by: Based on interview and record review, the licensee failed to have a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all visitors, employees, and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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: On June 9, 2025, at approximately 3:00 p.m., owner/unlicensed personnel (O/ULP)-A provided a packet and stated the contents were the licensee's EPP. The licensee's undated EPP lacked an individualized plan to include all the required content below: -missing annual reviews; -missing resident quarterly review; -missing HVA assessment; -process for EP collaboration; -development of all policies/procedures (P/P) based on HVA assessment; and -EP training and testing program. On June 9, 2025, at approximately 3:30 p.m., O/ULP-A acknowledged the licensee's EPP lacked the above listed required content. O/ULP-A stated she was not aware of the hazard and vulnerability assessment (HVA) and all the	0 680		

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0 680	Continued From page 14 requirements of Appendix Z. The licensee's Emergency Management policy, undated, indicated the licensee would have an identified plan in place to ensure the safety and well-being of residents and employees during periods of an emergency or a disaster that disrupts facility services. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (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	0 780		

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0 780	Continued From page 15 buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed provide interconnected smoke alarms in required locations. These deficient conditions had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On June 11, 2025, at approximately 9:30 a.m.., the surveyor toured the facility with owner/unlicensed personal (O/ULP)-A. During the tour, the surveyor observed a smoke alarm in the living room but not in the hallway in the immediate vicinity of the main level bedrooms. Smoke alarms are required in each bedroom, outside each separate sleeping area in the immediate vicinity of bedrooms, and on each story within a dwelling unit. During the facility tour interview on June 11, 2025, O/ULP-A stated, they would move the smoke alarm into the hallway in the immediate vicinity of	0 780		

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0 780	Continued From page 16 the bedrooms. 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 by: Based on observation and interview, the licensee failed to maintain the physical environment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 800		

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0 800	Continued From page 17 The findings include: On June 11, 2025, at approximately 9:30 a.m., the surveyor toured the facility with owner/unlicensed personal (O/ULP)-A. The following was observed. GENERAL MAINTENANCE: The mechanical room had standing water around the furnace. The wood walls around the standing water were absorbing water. The surveyor explained to O/ULP-A that saturated wood had the potential for mold growth, and potential health hazards to the residents and staff of the facility. On June 11, 2025, O/ULP-A stated the water was condensate of the furnace and the condensate pump was not working correctly. O/ULP-A stated they would get the leak fixed. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) 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	0 810		

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0 810	Continued From page 18 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 safety and evacuation plan with the required content and provide the required training. 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:	0 810		

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0 810	Continued From page 19 On June 11, 2025, at approximately 9:30 a.m., the surveyor observed the fire evacuation diagrams did not include the identification of the path of egress and labeled the garage as a designated exit. Egress from a room or space shall not pass through adjoining or intervening rooms or areas of a higher hazard. Exit plan diagrams must be correctly labeled to reduce confusion and potential obstructions to egress in a fire or similar emergency. On June 11, 2025, owner/unlicensed personal (O/ULP)-A 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's FSEP failed to include the following: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate) but the plan was designed for a building with life safety systems such as fire alarms. The policy had not been updated to provide complete actions for employees to take in the event of a fire or similar emergency at the licensed facility which did not have fire alarm systems. The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should	0 810		

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0 810	Continued From page 20 follow in case of a fire or similar emergency. The FSEP 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 plan did not include any procedures for assisting residents during evacuation nor did it include instructions for staff to follow in case of relocation. On June 11, 2025, O/ULP-A stated they would work on bringing the policies into compliance. TRAINING: The licensee failed to provide evacuation training to residents at least once per year. O/ULP-A lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan. The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. The licensee's training records indicated staff was last trained on 9-15-22. No other training documentation was provided. On June 11, 2025, O/ULP-A stated they understood the requirements for training residents and staff and would implement a training program that was compliant with statute requirements. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		

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0 970	Continued From page 21	0 970		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety, or personal property of a resident. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On June 9, 2025, at approximately 2:15 p.m., owner/unlicensed personnel (O/ULP)-A provided resident's (R2) Assisted Living Contract and indicated the contract was used by licensee for all residents who would live in the facility. The licensee's Assisted Living Contract, dated February 10, 2025, on page 16, included a	0 970		

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0 970	Continued From page 22 section titled Hold Harmless and read, "You agree to hold harmless [licensee], its owners, management, all of their officers, trustees, staff, and personnel from any and all claims arising from an injury or illness incurred through natural or normal causes during his life at [licensee]." The licensee's Assisted Living Contract, dated February 10, 2025, on page 16, included a section titled Liability and read, "The resident agrees to be liable and responsible for all obligations herein references, monetary and otherwise, of the resident and where this agreement has been executed by a party designated below." On June 9, 2025, at approximately 2:30 p.m., O/ULP-A acknowledged the licensee's assisted living contract included a waiver of liability for health and safety or personal property of the resident. O/ULP-A stated the liability waivers would need to be removed from the licensee's contracts. The licensee's Assisted Living Contracts policy undated, indicated the contract must not include a waiver of facility liability for the health and safety or personal property of the resident. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		
01390 SS=F	144G.62 Subdivision 1 Availability of contact person to staff (a) Assisted living facilities must have a registered nurse available for consultation by staff	01390		

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01390	Continued From page 23 performing delegated nursing tasks and must have an appropriate licensed health professional available if performing other delegated services such as therapies. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a registered nurse (RN)-B was available 24 hours a day, seven days a week to provide consultation to staff performing delegated nursing tasks and services when the licensee hired RN-B to perform all nursing tasks when RN-B simultaneously held a nursing position working a 0.9 schedule (or 72 hours every two weeks) at a hospital which would not allow them to be available 24 hours per day, 7 days per week, to address the licensee's emergencies or concerns. This had the potential to affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: The licensee held an assisted living facility license staffed with four personnel - owner/unlicensed personnel (O/ULP)-A, registered nurse (RN)-B, licensed assisted living director (LALD)-C, and unlicensed personnel (ULP)-D. The licensee was licensed for a bed capacity of three residents and had a current	01390	During the course of the survey, the licensee took action to mitigate the imminent risk related to order 1390. Noncompliance remained and the scope and level remain unchanged.	

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01390	Continued From page 24 census of two residents. On June 9, 2025, at approximately 9:45 a.m., during the entrance conference, O/ULP-A stated RN-B was on-site for one to two days a month and available via telephone around the clock. O/ULP-A also stated RN-B held a RN position elsewhere at a hospital. On June 10, 2025, at approximately 5:10 p.m., RN-B confirmed RN-B was simultaneously working another RN position 72 hours every two weeks at a hospital on a post cardiac catheterization lab floor and post emergency room observation floor providing direct patient cares which would not allow RN-B to be available 24 hours per day, 7 days per week, to address emergencies or concerns. RN-B stated while working at the hospital, availability to the licensee was by telephone or text because RN-B may not be able to leave the hospital while working. The licensee's Criteria for Admission policy undated, indicated the licensee would provide staff access to an on-call registered nurse available 24 hours per day, seven days per week. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01390		
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual	01500		

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01500	Continued From page 25 training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication;	01500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38163	A. BUILDING: _____ B. WING _____	06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WRIGHT WAY HOME CARE LLC	3701 54TH AVENUE NORTH BROOKLYN CENTER, MN 55429

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01500	Continued From page 26 (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an employee received at least eight hours of annual training for each 12 months of employment for one of one employee (owner/unlicensed personnel (O/ULP)-A). 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 included: O/ULP-A had a hire date of October 26, 2022. O/ULP-A's training record lacked evidence of the eight hours annual training requirement to include all the required content below: -Reporting maltreatment of vulnerable adults or minors; -Assisted Living bill of rights; -Infection control techniques;	01500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38163	A. BUILDING: _____ B. WING _____	06/13/2025

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WRIGHT WAY HOME CARE LLC	3701 54TH AVENUE NORTH BROOKLYN CENTER, MN 55429

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01500	Continued From page 27 -Review of provider's policies and procedures; -Principles of person-centered planning/service delivery; and -Dementia training two hours. On June 9, 2025, at 12:45 p.m., O/ULP-A stated O/ULP-A did not complete the required annual training and was unaware of all the required annual training content. O/ULP-A also stated would ensure all the required annual training for employees would be completed. The licensee's Annual Training Requirements policy undated, indicated the required trainings would be completed annually. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		
02320 SS=F	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered in accordance with accepted standards for all two residents (R2, R3) of the facility whose medications were set up by	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38163	A. BUILDING: _____ B. WING _____	06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WRIGHT WAY HOME CARE LLC	3701 54TH AVENUE NORTH BROOKLYN CENTER, MN 55429

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02320	Continued From page 28 unlicensed personnel (ULP) ahead of time for later administration. 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 June 9, 2025, at 9:55 a.m. during the entrance conference, owner/unlicensed personnel (O/ULP)-A stated O/ULP-A set up medications with a medication planner box for R2 and R3. On June 9, 2025, at 11:00 a.m., surveyor observed medication planner boxes for R2 and R3 in the locked medication cabinet in the kitchen. R2 admitted on December 4, 2024. R2's Master Care Plan dated May 21, 2025, indicated R2 received full medication management and set up. R2's Assessment dated May 21, 2025, indicated R2 needed full medication management and set up. R3 admitted on February 10, 2025. R3's Master Care Plan dated March 24, 2025, indicated R3 received full medication	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38163	A. BUILDING: _____ B. WING _____	06/13/2025

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02320	Continued From page 29 management and set up. R3's Assessment dated March 24, 2025, indicated R3 needed full medication management and set up. On June 10, 2025, at 5:15 p.m. by phone interview, registered nurse (RN)-B confirmed O/ULP-A set up medications for R2 and R3 using a medication planner box. RN-B stated RN-B was new to assisted living and was not aware that wasn't acceptable practice. RN-B also stated RN-B would complete all future medication set ups for R2 and R3. The licensee's Setup policy, undated, indicated a licensed nurse will set up medications and licensee staff would follow accepted standards of practice. According to the American Nurses Association (ANA) effective April 29, 2019, the licensed nurse cannot delegate nursing judgement or any activity that will involve nursing judgement or critical decision making. MN Statute 144G.08, Subd. 41. Medication setup. "Medication setup" means arranging medications by a nurse, pharmacy, or authorized prescriber for later administration by the resident or by facility staff. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

Wright Way Home Care LLC
3701 54th Avenue North
Brooklyn Center, MN 55429
Hennepin County
Parcel:

Phone:

License Info

License: HFID 38163

Risk:
License:
Expires on:
CFPM: AMINA F. WRIGHT
CFPM #: FM118925; Exp: 09/19/2026

Inspection Info

Report Number: F1005251036
Inspection Type: Full - Single
Date: 6/10/2025 Time: 10:00:01 AM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 3
Total Priority 2 Orders: 1
Total Priority 3 Orders: 0
Delivery: Emailed

! **New Order: 3-500B Microbial Control: hot and cold holding**
3-501.16A *Priority Level: Priority 1 CFP#: 22*
MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.
COMMENT: TCS FOODS IN THE KITCHEN REFRIGERATOR WERE ABOVE 41 DEGREES F. OPERATOR TURNED UNIT TO A COLDER SETTING. MONITOR FOOD TEMPERATURES TO ENSURE THEY COME TO 41 DEGREES F OR BELOW.
Comply By: 6/10/2025 Originally Issued On: 6/10/2025

! **New Order: 3-500D Microbial Control: disposition of food**
3-501.18A *Priority Level: Priority 1 CFP#: 23*
MN Rule 4626.0405A Discard all TCS food prepared in the establishment or opened commercially packaged food when the time exceeds 7 days from the preparation or opening date or if the container or package is not marked.
COMMENT: TURKEY DELI MEAT HAD A DATE MARK OF 6/1 (10 DAYS OLD). TURKEY WAS DISCARDED, FACT SHEET LEFT ON SITE.
Comply By: 6/10/2025 Originally Issued On: 6/10/2025

New Order: 4-300 Equipment Numbers and Capacities
4-302.12B *Priority Level: Priority 2 CFP#: 36*
MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.
COMMENT: THERE IS NO FOOD THERMOMETER ON SITE. PROVIDE A SMALL DIAMETER PROBE THERMOMETER FOR MONITORING COLD HOLDING AND COOKING TEMPERATURES.
Comply By: 6/17/2025 Originally Issued On: 6/10/2025

! **New Order: 7-200 Toxic Supplies and Applications**
7-204.11 *Priority Level: Priority 1 CFP#: 28*
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.
COMMENT: CHLORINE IN THE SPRAY BOTTLE USED FOR WIPING COUNTERS WAS SO STRONG IT BLEACHED OUT THE TEST STRIP. INSTRUCTED OPERATOR TO DILUTE SOLUTION TO 50-100 PPM CHLORINE.
Comply By: 6/10/2025 Originally Issued On: 6/10/2025

Food & Beverage General Comment

INSPECTION COMPLETED WITH OWNER AND EMAILED TO HRD NURSING EVALUATOR CARL SAMROCK.

OPERATOR HAD JUST RUN A THERMOLABEL THROUGH THE DISHWASHER, WHICH SHOWED IT PROVIDED A UTENSIL SURFACE TEMPERATURE OF AT LEAST 170 DEGREES F.

DISCUSSED DATE MARKING, GLOVE USE, COOKING TEMPERATURES, CROSS-CONTAMINATION, AND EMPLOYEE ILLNESS.

KITCHEN IS RESIDENTIAL AND FOOD IS PREPARED FOR SAME DAY SERVICE.

CABINETS ARE WOOD WITH HOLLOW BASE. ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT SUCH A TIME THEY ARE FOUND TO BE A CONCERN OR RISK OF CONTAMINATION, THEY WILL BE ORDERED TO BE REPLACED AND BROUGHT UP TO CODE.

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Metro District Office inspection report number F1005251036 from 6/10/2025

AMINA WRIGHT
OWNER / OPERATOR

Jessica Davis, REHS
Public Health Sanitarian 3
651-201-3961
jessica.davis@state.mn.us

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

Temperature Observations/Recordings

Establishment Info

Wright Way Home Care LLC
Brooklyn Center
County/Group: Hennepin County

Inspection Info

Report Number: F1005251036
Inspection Type: Full
Date: 6/10/2025
Time: 10:00:01 AM

Food Temperature: Product/Item/Unit: POTATO SALAD**; Temperature Process:** Cold-Holding
Location: KITCHEN REFRIGERATOR at 43 Degrees F.
Comment:
Violation Issued?: Yes

Equipment Temperature: Product/Item/Unit: AMBIENT**; Temperature Process:** Cold-Holding
Location: KITCHEN REFRIGERATOR at 47 Degrees F.
Comment:
Violation Issued?: Yes

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

Sanitizer Observations/Recordings

Establishment Info

Wright Way Home Care LLC
Brooklyn Center
County/Group: Hennepin County

Inspection Info

Report Number: F1005251036
Inspection Type: Full
Date: 6/10/2025
Time: 10:00:01 AM

Sanitizing Chemical: **Product:** Chlorine**; Sanitizing Process:** Spray Bottle
Location: Greater Than 200 PPM
Comment:
Violation Issued?: Yes

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** DISHWASHER
Location: Equal To 170 Degrees F.
Comment: AT LEAST 170 DEGREES F, AS MEASURED BY THERMOLABEL
Violation Issued?: No