Electronically Delivered

August 11, 2025

Licensee
Keshi Health Care Services Inc
9501 Washburn Avenue North
Brooklyn Park, MN 55444

RE: Project Number(s) SL39261016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 12, 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.

MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

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 . . ."

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

DOCUMENTATION OF ACTION TO COMPLY
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

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,

Renee L. Anderson

Renee L. Anderson, Supervisor
State Evaluation Team
Email: Renee.L.Anderson@state.mn.us
Telephone: 651-201-5871 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
	39261	A. BUILDING: _____ B. WING _____	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KESHI HEALTH CARE SERVICES INC	9501 WASHBURN AVENUE NORTH BROOKLYN PARK, MN 55444

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been 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: SL39261016-0 On June 9, 2025 through June 12, 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 four (4) residents; all receiving services under the provider's Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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.	
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control	0 660		

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0 660	Continued From page 1 (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by theMinnesota Department of Health (MDH) and the Centers for Disease Control and Prevention (CDC) which included baseline TB history and symptom screening upon hire, and Tuberculin Skin Testing (TST) or TB blood testing, no greater than 90 days prior to hire date for three of three employees (registered nurse (RN)-D, unlicensed personnel (ULP)-E, ULP-F). 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	0 660		

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0 660	Continued From page 2 a large portion or all of the residents). The findings include: The facility TB risk assessment dated August 21, 2023, indicated the facility was a low risk setting for TB transmission. RN-D RN-D was hired April 15, 2021, and provided supervision of staff and direct cares for residents of the facility. RN-D's employee record included a negative TB chest x-ray dated March 21, 2023. The record did not include a positive TB test prior to or associated with the chest x-ray. RN-D's record lacked baseline TB history and symptom screening upon hire, and lacked documentation of a baseline TST or TB blood test, no greater than 90 days prior to hire date. ULP-E ULP-E was hired March 18, 2024, and provided direct cares and services for residents of the facility. ULP-E's employee record included documentation of a negative TB blood test dated March 16, 2024. ULP-E's record lacked baseline TB history and symptom screening completed upon hire. ULP-F ULP-F was hired March 11, 2024, and provided direct cares and services for residents of the facility. ULP-F's employee record included documentation of a positive TB blood test dated	0 660		

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0 660	Continued From page 3 February 10, 2024, and a negative chest x-ray dated February 19, 2024. ULP-F's record lacked baseline TB history and symptom screening completed upon hire. On June 11, 2025, at 7:16 p.m., administrator (A)-A stated, via email, RN-D declined TB blood testing due to personal reasons; therefore, her employee record lacked the required documentation noted above. On June 12, 2025, at 12:13 p.m., during a telephone call, A-A stated during the hiring process, the licensee would send new hires out of the facility for TB testing: however, some of the employees had not trusted the system; therefore, lacked all the required testing noted above. The licensee's undated TB Infection Control policy indicated it would be the policy of the licensee to adhere to the Occupational Safety and Health Administration (OSHA) standards related to respiratory protection and the current CDC guidelines for TB monitoring & testing. Furthermore, a 2-step Mantoux (skin test) would be required for all agency field staff with resident contact, upon hire (or a negative 2-step test completed within 12 months of hire) and a TB questionnaire every year, unless they have a positive result from the skin test, in which case a chest x-ray would be conducted. In accordance with CDC guideline, no follow up chest x-ray would be required, only an annual TB Verification/Attestation/ TB questionnaire. The MDH Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013 noted training was required at the time of hire and included: pathogenesis, signs symptoms, and the licensee's infection control plan. In addition,	0 660		

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0 660	Continued From page 4 baseline screening for all health care workers (HCW) included a history and symptom screen and testing for the presence of TB infection. The regulations noted a blood test should include the date of the test. According to the regulations, if a HCW had documentation for latent TB, that documentation could be substituted for documentation of a previous positive TST or blood test. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (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	0 680		

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0 680	Continued From page 5 allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness (EP) plan that included all required content. This had the potential to affect all residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: The licensee's undated EP plan lacked the following required content: - annual review and updated EP plan, policies, and procedures; - annual review and updated hazard vulnerability risk assessment by likelihood of occurrence; - quarterly updated missing resident plan; - policies and procedures for use of volunteers; - policies and procedures to address role of facility under a waiver declared by the Secretary in accordance with section 1135 of the Act; - development of a communication plan, including the names/contact information for: residents' physicians and volunteers; - EP training and testing program;	0 680		

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0 680	Continued From page 6 - EP training program for staff (including documentation of training provided); and - EP testing/annual testing requirements. On June 9, 2025, at 1:35 p.m., administrator (A)-A stated that he was not aware of all the requirements of the EP program and that he would take a closer look at the plan and make the necessary changes/updates. A-A further stated licensee had not participated in table-top of full-scale exercises but would reach out to the EP Metro Coalition for more information regarding drills. The licensee's Emergency Preparedness policy dated August 1, 2021, indicated licensee would have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services. Furthermore, the EP plan would consider the organization's commitment to provide services while ensuring the safety of its employees and residents. Moreover, licensee would implement the emergency management program as soon as the agency became aware of the existence of an emergency. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the	0 800		

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0 800	Continued From page 7 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). The findings include: On June 11, 2025, at approximately 11:00 a.m., the surveyor toured the facility with administrator (A)-A. The following was observed. GENERAL MAINTENANCE: The bath fan in the upper-level bathroom was not functioning. The lack of bathroom ventilation has the potential to affect indoor air quality for the resident. On June 11, 2025, A-A acknowledged the	0 800		

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0 800	Continued From page 8 deficiency during the facility tour. 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 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.	0 810		

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0 810	Continued From page 9 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: On June 11, 2025, administrator (A)-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	0 810		

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0 810	Continued From page 10 such as a fire alarm system. 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 life safety 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 follow in case of a fire or similar emergency. On June 11, 2025, A-A stated they understood the areas of their policy that were incomplete and would bringing them into compliance. TRAINING: The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. A-A stated that staff training was done in Educare and not on the facilities written FSEP. No other training documentation was provided. On June 11, 2025, A-A stated they understood the requirements for training staff and would implement a training program that was compliant with statute requirements. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01060 SS=D	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member.	01060		

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01060	Continued From page 11 An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by:	01060		

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01060	Continued From page 12 Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R2's service plan dated June 11, 2025, indicated R2 received assistance with medication management, medication set-up, medication administration, obtaining vital signs, safety checks, meal assistance, behavior management, dressing, grooming, and bathing assistance, laundry and housekeeping services, appointment reminders, and activity assistance. R2's record included a progress note dated January 30, 2025, at 10:36 a.m., indicating due to abdominal pain and swelling, R2 wanted to go to the hospital, and asked staff to call for emergency services. Emergency services was summoned by staff and R2 was taken to the hospital for further evaluation. R2's record included a progress note dated January 30, 2025, at 8:34 p.m., indicating R2 called administrator (A)-A and informed him that the hospital would be keeping him overnight, to observe him better, since the lab work showed he was bleeding inside. The progress note further indicated the licensee would continue to follow up	01060		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39261	A. BUILDING: _____ B. WING _____	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01060	Continued From page 13 with R2 and update all as needed. R2's hospital Provider Note dated February 2, 2025, at 12:16 p.m., indicated R2 was discharged from the hospital at about 11:45 a.m., and was advised to schedule a follow-up appointment with his primary care doctor. R2's record lacked evidence that, upon being relocated to the hospital, a written notice was provided to the resident, legal representative, and designated representative that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident had been relocated and any new service provider; - contact information for the Office of Ombudsman for Long-Term Care (OOLTC) and the Office of Ombudsman for Mental Health and Developmental Disabilities (OMHDD); and - a statement that, if the facility refused to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. On June 12, 2025, at 12:19 a.m., A-A stated R2 was a recent move-in and licensee had been in communication with R2's case manager regarding his hospitalization. Furthermore, A-A indicated licensee was not aware of the requirement. The licensee's undated Notice of Emergency Relocation policy indicated licensee may remove a resident from the facility in an emergency, if necessary, due to a resident's urgent medical needs or an imminent risk the resident posed to	01060		

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01060	Continued From page 14 the health or safety of another facility resident or facility staff member. Furthermore, in the event of an emergency, licensee would provide a written notice that contained, at a minimum: - the contact information for the location to which the resident has been relocated and any new service provider; - contact information for the Office of Ombudsman for Long-Term Care; and - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal: and - notification to the Office of Ombudsman for Long-Term Care if the resident had been relocated and had not returned to the facility within four days. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure all medications were securely locked in substantially constructed compartments and permit only	01880		

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01880	Continued From page 15 authorized personnel to have access. This had the potential to affect all residents in the facility. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 11:45 a.m., the surveyor observed unlicensed personnel (ULP)-E assist R1 with medication administration, which included 14 units of Humalog ® (a short-acting insulin, for diabetes) via insulin KwikPen. On June 9, 2025, at 12:00 p.m., during a review of stored medications, the surveyor observed the medication storage refrigerator was unlocked. The refrigerator contained three unopened boxes of LANTUS® SoloStar® insulin (a long-acting insulin, for diabetes), each containing five pens, and four unopened boxes of Humalog® insulin (a short-acting insulin), each containing five KwikPens. Both medications were prescribed to R1. On June 9, 2025, at 12:05 p.m., administrator (A)-A stated there was not a lock on the medication refrigerator, and they were unaware the medication refrigerator was required to be locked. The licensee's Storage/Control of Medication policy dated August 1, 2021, indicated when	01880		

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01880	Continued From page 16 licensee was providing storage of medications outside of the resident's private living space, all prescription drugs would be securely locked in substantially constructed compartments according to the manufacturer's directions. Furthermore, only authorized personnel would have access to the stored medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure all medications were labeled correctly 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) 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).	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01890	Continued From page 17 The findings include: On June 9, 2025, at 11:45 a.m., the surveyor observed unlicensed personnel (ULP)-E draw up 14 units of Humalog ® (a rapid-acting insulin, for diabetes) via KwikPen for R1, which lacked a label to include R1's name, date the medication had been opened and the medication expiration date. R1's medication administration record dated June 2025, included administration of Humalog ® insulin three times daily and administration of LANTUS® SoloStar® insulin twice daily On June 9, 2025, at 12:00 p.m., during a review of stored medications, the surveyor observed an in-use LANTUS® SoloStar® (a long-acting insulin, for diabetes) pen for R1, which lacked a label to include R1's name, date the medication had been opened and the medication expiration date. The manufacturer's instructions dated 2023, for Humalog ® KwikPen indicated once the insulin pen had been taken out of cool storage, for use, it should be discarded after 28 days, even if it still had any remaining insulin in it. The manufacturer's instructions dated December 1, 2021, for LANTUS® SoloStar® pen indicated once the insulin pen had been taken out of cool storage, for use, it should be discarded after 28 days, even if it still had any remaining insulin in it. On June 9, 2025, at 12:05 p.m., administrator (A)-A stated licensee was unaware R1 medications had not been labeled properly. The licensee's Storage/Control of Medication	01890		

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01890	Continued From page 18 policy dated August 1, 2021, indicated prescription drugs, prior to being set up for immediate or later administration, would be kept in the original container(s) in which they had been dispensed by the pharmacy, bearing the original prescription label with legible information. Furthermore, the medication label would contain the following: a. Prescription number and name of medication; b. Strength and quantity; c. Expiration date for time-dated drugs; d. Directions for use; e. Resident's name; f. Prescriber's name; g. Date issued; and h. name and address of licensed pharmacy issuing the medication. Moreover, the licensed nurse would be responsible for dating time-sensitive medications when opened. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

St Cloud District Office
Minnesota Department of Health
4140 Thielman Lane, Suite 101
St Cloud, MN 56301
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

Keshi Health Care Services Inc
9501 Washburn Avenue North
Brooklyn Park, MN 55444
Hennepin County
Parcel:

Phone:

License Info

License: HFID 39261

Risk:
License:
Expires on:
CFPM: Stephen Emelike Nwokocha
CFPM #: 41423; Exp: 11/23/2028

Inspection Info

Report Number: F1051251034
Inspection Type: Full - Single
Date: 6/9/2025 Time: 11:40:00 AM
Duration: 30 minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

No orders were issued for this inspection report.

Food & Beverage General Comment

MET WITH NURSE EVALUATOR, RHONDA MAKELA.

DISCUSSED THE FOLLOWING WITH STEPHEN:

EMPLOYEE ILLNESS LOG
VOMIT CLEAN-UP PROCEDURE
HANDWASHING & GLOVE USE

THE KITCHEN HAS VINYL FLOORS, A SMOOTH TEXTURE CEILING, LAMINATE COUNTERTOPS WITH HOLLOW BASES, MDF WOODEN CABINETS, AND A NSF 184 DISHWASHER.

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 St Cloud District Office inspection report number F1051251034 from 6/9/2025

Stephen E. Nwokocha

Kai Yang,
Public Health Sanitarian 1
320-640-3532
kai.yang@state.mn.us

St Cloud District Office
Minnesota Department of Health
4140 Thielman Lane, Suite 101
St Cloud, MN 56301

Temperature Observations/Recordings

Establishment Info

Keshi Health Care Services Inc
Brooklyn Park
County/Group: Hennepin County

Inspection Info

Report Number: F1051251034
Inspection Type: Full
Date: 6/9/2025
Time: 11:40:00 AM

Equipment Temperature: Product/Item/Unit: AMBIENT**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 41 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: MILK**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 40 Degrees F.
Comment: BASEMENT
Violation Issued?: No