



Protecting, Maintaining and Improving the Health of All Minnesotans

June 7, 2023

Licensee
Hopeville Homes
4034 Lake Road Avenue
Minneapolis, MN 55442

RE: Project Number(s) SL38051015

Dear Licensee:

On April 26, 2023, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the January 31, 2023, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'Rhylee Gilb', with a stylized flourish at the end.

Rhylee Gilb, Supervisor
State Rapid Response Team
Email: rhylee.gilb@state.mn.us
Telephone: -218-232-8285 Fax: 651-215-6894

PMB



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

February 28, 2023

Licensee
Hopeville Homes
4034 Lake Road Avenue
Minneapolis, MN 55442

RE: Project Number(s) SL38051015

Dear Licensee:

This is your **official notice** that you have been **granted your assisted living facility license**. Your license effective and expiration dates remain the same as on your provisional license. Your updated status will be listed on the license certificate at renewal and **this letter serves as proof** in the meantime. If you have not received a letter from us with information regarding renewing your license within 60 days prior to your expiration date, please contact us at (651) 201-5273 or by email at Health.assistedliving@state.mn.us.

The Minnesota Department of Health completed an initial evaluation on January 31, 2023, for the purpose assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

STATE LICENSING ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement.

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;

Level 3: a fine of \$3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.

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

In accordance with Minn. Stat. § 144G.20, Subd. 4(a)(5), the Department of Health imposes fine amounts of either \$1,000 or \$5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of \$1,000 for each substantiated maltreatment violation that consists of abuse, neglect,

or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The Department of Health also may impose a fine of \$5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

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

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

St - 0 - 0680 - 144g.42 Subd. 10 - Disaster Planning And Emergency Preparedness - \$3,000.00

The total amount you are assessed is \$3,000.00. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

- 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 residents/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 issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the Department of Health within 15 calendar days of the correction order receipt date.

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

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

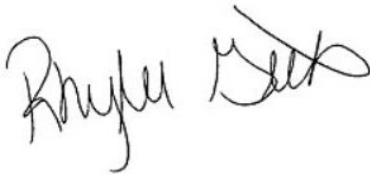
REQUESTING A HEARING

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. Requests for hearing may be emailed to: **Health.HRD.Appeals@state.mn.us**.

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.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,



Rhylee Gilb, Supervisor
Health Regulation Division
State Rapid Response Team
85 East Seventh Place, Suite 220
P.O. Box 64970
St. Paul, MN 55164-0970
Email: rhylee.gilb@state.mn.us
Phone: 651-201-5977 Fax: 651-215-6894

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38051	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/31/2023
NAME OF PROVIDER OR SUPPLIER HOPEVILLE HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 4034 LAKE ROAD AVENUE MINNEAPOLIS, MN 55442		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL38051015 On January 30, 2023 through January 31, 2023, 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 3 residents receiving services under the provider's Provisional Assisted Living Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for 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 subd. 1, 2, and 3.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that:	0 470		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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

Minnesota Department of Health

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0 470	Continued From page 2 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 January 30, 2023 at 10:10 a.m., during a provider tour with the director of nursing (DON)-C, the MDH surveyor observed a bulletin board in the common dining area used for postings. The bulletin board displayed information on COVID-19 safety, how to call 911, electronic monitoring in progress, a staff schedule and staff contact numbers. DON-C said the staff schedule was the staff plan. On January 31, 2023 at 3:30 p.m., licensed assisted living director (LALD)-A said he was not aware of needing a staffing plan and policy in addition to the staff schedule and would work on creating them. TIME PERIOD TO CORRECT: Twenty-one (21) Days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was	0 480		

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0 480	Continued From page 3 prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 included document titled, Food and Beverage Establishment Inspection Report dated January 30, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 680 SS=I	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	0 680		

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0 680	Continued From page 4 missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the provider failed to ensure their Appendix Z Emergency Preparedness Plan (EPP) contained all the required components. This had the potential to effect all three residents, staff and visitors. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On January 31, 2023 at 9:00 a.m.. the MDH surveyor requested and reviewed the provider's EPP. The EPP lacked the following components: - a risk assessment which included an all hazards approach, lacked plans for cyber-attacks, loss of a portion or all of the facility, and emergent	0 680		

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0 680	Continued From page 5 infectious diseases. - a risk assessment which included probable hazards and a missing resident plan; no quarterly review of missing resident plan - identify which staff assume specific roles in another's absence; how to outsource services that cannot be provided - collaboration process with local, tribal, regional, State and Federal EPP to maintain integrated response - development and implementation of EP policies based on risk assessment and communication plan - no EPP related to sewage and waste disposal - no documentation of specific name/location of receiving facility or other locations - no external sources of assistance listed - no EPP for sheltering in place for residents, staff, volunteers who stay in facility - no system to address medical documentation and preserving resident information and privacy - no EPP for volunteers and their roles - arrangement with other facilities/providers to receive residents if operations are limited or cease and continue services - no EPP on Waiver by Secretary for section 1135 of Act - no communication plan - no names and contact information of staff, residents, entities providing services under agreement, physicians, other facilities and volunteers - no emergency officials contact information - no communication plan with primary and alternate means of contacting facility staff, Federal, State and tribal, regional and local emergency management agencies - no method to share information - no sharing of information on occupancy/needs - no EPP training and testing	0 680		

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0 680	Continued From page 6 - no EPP training program - no EPP testing requirements at least twice per year - no documentation if provider has opted to be part of a healthcare system unified and integrated EPP. On January 31, 2023 at 9:43 a.m., licensed assisted living director (LALD)-A said residents could be moved to their other houses or the corporate office or a hotel. They could also take residents across the street to an assisted living facility they were not affiliated with. LALD-A said the alternate locations were not documented in the EPP. A policy titled Emergency Management, undated, indicated the provider would have an identified plan in place to ensure the safety and well-being of residents and employees during periods of an emergency or disaster that disrupts agency services. TIME PERIOD TO CORRECT: 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	0 780		

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0 780	Continued From page 7 of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure smoke alarms are interconnected so that the actuation of one alarm causes all alarms in the dwelling to actuate as required. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 residents). The findings include: On January 31, 2023, between 1:00 p.m. and 2:00 p.m., survey staff toured the facility with the director of nursing (DON)-C. During the facility	0 780		

Minnesota Department of Health

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0 780	Continued From page 8 tour, survey staff observed the smoke alarms were not interconnected throughout the facility when tested. During testing it was observed that there were two separate sets of interconnected smoke alarms in the facility that were not interconnected with each other. The upper level smoke alarms were all interconnected with the exception of the smoke alarm in bedroom #2, which was not interconnected with any other smoke alarms in the facility. The lower level smoke alarms were only interconnected with the other smoke alarms on the lower level. All smoke alarms are required to be interconnected throughout the entire facility so that the actuation of one smoke alarm causes all to alarm. DON-C verbally confirmed survey staff observations during the facility tour. No further information was provided. 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	0 800		

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0 800	Continued From page 9 failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 residents). The findings include: On January 31, 2023, from approximately 1:00 p.m. to 2:00 p.m., survey staff toured the facility with the director of nursing (DON)-C. During the facility tour, survey staff observed the following: There was a small hole in the ceiling of the shower area in the basement bathroom. Water vapor penetration above the ceiling could cause mold or structural damage to floor joists above if not taken care of. The egress window in basement bedroom #3 only had a clear opening of 19 inches wide when opened 90 degrees. The window hardware moved the window pane too far and reduced the required clear opening for safe evacuation. There was no resident or bed in the room at the time of the survey and DON-C stated they were not currently planning on using the room as a bedroom. No resident should be moved into the space until the egress window hardware is modified to allow the required minimum clear opening of 20 inches.	0 800		

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0 800	Continued From page 10 DON-C verbally confirmed survey staff observations during the facility tour. No further information was provided. 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) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees	0 810		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38051	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/31/2023
NAME OF PROVIDER OR SUPPLIER HOPEVILLE HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 4034 LAKE ROAD AVENUE MINNEAPOLIS, MN 55442		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 810	Continued From page 11 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 interview and record review, the licensee failed to develop and maintain fire safety and evacuation plans, failed to provide required training to residents and employees for fire safety and evacuation, and failed to conduct required employee evacuation drills. This had the potential to affect all current residents, staff, and visitors to the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all residents). The findings include: During interview on January 31, 2023, at 2:45 p.m., the licensed assisted living director (LALD)-A stated they had done one evacuation drill for each shift since opening, but no record of completed drills was on-site at the time of the survey. LALD-A and the director of nursing (DON)-C both stated that staff was currently being trained through an online, third-party system that does not allow facility-specific content to be uploaded to their system. Staff and	0 810		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38051	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/31/2023
NAME OF PROVIDER OR SUPPLIER HOPEVILLE HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 4034 LAKE ROAD AVENUE MINNEAPOLIS, MN 55442		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 810	Continued From page 12 residents are required to be trained on facility-specific procedures. Review of the fire safety and evacuation policy showed the following: 1. No evacuation plan or documentation on specific procedures for the residents including procedures for their movements, and relocation during a fire or similar emergency. No written instructions for addressing any unique situation during an evacuation, especially for residents who need assistance during an evacuation. The policy was a basic policy from a third-party provider and had not been edited or updated to fit the facility. 2. No record of required employee evacuation drills. 3. No schedule or records on the training of employees on fire safety and evacuation; on proper actions to take in the event of a fire or emergency for the safety of residents including movement, evacuation, or relocation. 4. No schedule or records on the training of residents who are capable of assisting in their evacuation; on proper actions to take in the event of a fire or emergency for their safety including movement, evacuation, or relocation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must	01500		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38051	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/31/2023
NAME OF PROVIDER OR SUPPLIER HOPEVILLE HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 4034 LAKE ROAD AVENUE MINNEAPOLIS, MN 55442		
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01500	Continued From page 13 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 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	01500		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38051	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/31/2023
NAME OF PROVIDER OR SUPPLIER HOPEVILLE HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 4034 LAKE ROAD AVENUE MINNEAPOLIS, MN 55442		
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01500	Continued From page 14 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; (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 8 hours of annual training on required topics for every 12 months of employment for one of two staff, director of nursing (DON)-C. DON-C also lacked an annual performance evaluation identifying areas of improvement needed and training needs. 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: DON-C had a hire date of February 7, 2021.	01500		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38051	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/31/2023
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01500	Continued From page 15 DON-C's personnel record lacked evidence of annual training on infection control, competency and an annual performance evaluation with identified areas of improvement and any training needs. On January 31, 2023, at 12:59 p.m., licensed assisted living director (LALD)-A said DON-C worked at his other homes and her personnel file was not just for one site. LALD-A said staff should have annual performance reviews and they were not up-to-date on annual reviews for multiple staff members. On January 31, 2023, at 2:30 p.m., DON-C said she did not have any annual training or review review because she was not employed at the home for 12 months, but acknowledged she has worked at the other provider homes during the past 2 years. DON-C gave the MDH surveyor a blank on-line education checklist for orienting new hire unlicensed staff and said this is what she and LALD-A had new staff review upon hire. An undated policy titled Personnel Records, indicated the personal record for an employee shall include records of annual training including infection control and competency and annual performance evaluation that identifies area of improvement needed and training needs. TIME PERIOD TO CORRECT: Twenty-one (21) Days	01500		

Type: Full
Date: 01/30/23
Time: 12:00:55
Report: 1029231015

Food and Beverage Establishment Inspection Report

Page 1

Location:

Hopeville Homes
4034 Lake Road Avenue
Robbinsdale, MN55422
Hennepin County, 27

Establishment Info:

ID #: 0041056
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/23

Operator:

Phone #:
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

The following orders were issued during this inspection.

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment. CFPM not employed by establishment. Instructed operators to employ CFPM.

Comply By: 03/17/23

Food and Equipment Temperatures

Process/Item: milk

Temperature: 39 Degrees Fahrenheit - Location: refrigerator

Violation Issued: No

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

Conducted food services inspection in conjunction with an HRD survey for the ALF, Hopeville Homes, located at 4034 Lake Road Avenue, Robbinsdale, MN 55422. Conducted inspection in the presence of Joey Kortuem, Manager, and other staff members. Establishment serves a highly susceptible population. Joey had his ServSafe certification but had not obtained the CFPM certification. Staff produced a laptop and we navigated to the MDH website where I showed them how to obtain a CFPM certification. Employee illness reporting and exclusion procedures were discussed in addition to foodborne illness organisms and general food safety practices.

The kitchen area had painted textured ceilings with no buildup of any kind, smooth painted walls, tile backsplash, granite-esque stone countertops, wood/faux-wood cabinetry and drawers with durable laminate coverings, and faux-wood luxury vinyl plank flooring. The kitchen was in good condition. Establishment used a dishwasher that was NSF 184 for sanitizing.

Type: Full
Date: 01/30/23
Time: 12:00:55
Report: 1029231015
Hopeville Homes

Food and Beverage Establishment Inspection Report

Page 2

All findings conveyed to lead HRD surveyor and Rapid Response Evaluator, Lissa Lin, RN.

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection
report number 1029231015 of 01/30/23.

Certified Food Protection Manager: Vacant

Certification Number: _____ Expires: ____/____/____

Signed: _____

Joey Kortuem
Manager

Signed:  _____

Trevor McCliment
Public Health Sanitarian
Metro District Office
651-201-3957
trevor.mccliment@state.mn.us

Report #: 1029231015

Food Establishment Inspection Report



Minnesota Department of Health
Food, Pools, and Lodging Services
625 Robert Street North
St. Paul

No. of RF/PHI Categories Out

1

Date 01/30/23

No. of Repeat RF/PHI Categories Out

0

Time In 12:00:55

Legal Authority MN Rules Chapter 4626

Time Out

Hopeville Homes

Address

4034 Lake Road Avenue

City/State

Robbinsdale, MN

Zip Code

55422

Telephone

License/Permit #
0041056

Permit Holder

Purpose of Inspection
Full

Est Type

Risk Category

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item

Mark "X" in appropriate box for COS and/or R

IN=in compliance

OUT=not in compliance

N/O=not observed

N/A=not applicable

COS=corrected on-site during inspection

R=repeat violation

Compliance Status		COS	R
Supervision			
1	IN OUT		
2	IN OUT N/A		
Employee Health			
3	IN OUT		
4	IN OUT		
5	IN OUT		
Good Hygienic Practices			
6	IN OUT N/O		
7	IN OUT N/O		
Preventing Contamination by Hands			
8	IN OUT N/O		
9	IN OUT N/A N/O		
10	IN OUT		
Approved Source			
11	IN OUT		
12	IN OUT N/A N/O		
13	IN OUT		
14	IN OUT N/A N/O		
Protection from Contamination			
15	IN OUT N/A N/O		
16	IN OUT N/A		
17	IN OUT		

Compliance Status		COS	R
Time/Temperature Control for Safety			
18	IN OUT N/A N/O		
19	IN OUT N/A N/O		
20	IN OUT N/A N/O		
21	IN OUT N/A N/O		
22	IN OUT N/A		
23	IN OUT N/A N/O		
24	IN OUT N/A N/O		
Consumer Advisory			
25	IN OUT N/A		
Highly Susceptible Populations			
26	IN OUT N/A		
Food and Color Additives and Toxic Substances			
27	IN OUT N/A		
28	IN OUT		
Conformance with Approved Procedures			
29	IN OUT N/A		

Risk factors (RF) are improper practices or procedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions (PHI)** are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is **not** in compliance

Mark "X" in appropriate box for COS and/or R

COS=corrected on-site during inspection

R=repeat violation

Compliance Status		COS	R
Safe Food and Water			
30	IN OUT N/A		
31	Water & ice obtained from an approved source		
32	IN OUT N/A		
Food Temperature Control			
33	Proper cooling methods used; adequate equipment for temperature control		
34	IN OUT N/A N/O		
35	IN OUT N/A N/O		
36	Thermometers provided & accurate		
Food Identification			
37	Food properly labeled; original container		
Prevention of Food Contamination			
38	Insects, rodents, & animals not present		
39	Contamination prevented during food prep, storage & display		
40	Personal cleanliness		
41	Wiping cloths: properly used & stored		
42	Washing fruits & vegetables		

Compliance Status		COS	R
Proper Use of Utensils			
43	In-use utensils: properly stored		
44	Utensils, equipment & linens: properly stored, dried, & handled		
45	Single-use/single service articles: properly stored & used		
46	Gloves used properly		
Utensil Equipment and Vending			
47	Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48	Warewashing facilities: installed, maintained, & used; test strips		
49	Non-food contact surfaces clean		
Physical Facilities			
50	Hot & cold water available; adequate pressure		
51	Plumbing installed; proper backflow devices		
52	Sewage & waste water properly disposed		
53	Toilet facilities: properly constructed, supplied, & cleaned		
54	Garbage & refuse properly disposed; facilities maintained		
55	Physical facilities installed, maintained, & clean		
56	Adequate ventilation & lighting; designated areas used		
57	Compliance with MCIAA		
58	Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature)

Date: 01/31/23

Inspector (Signature)