Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

October 22, 2025

Licensee
Peaceful Heart Health Group LLC
7237 Oliver Avenue North
Brooklyn Center, MN 55430

RE: Project Number(s) SL41110015

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 survey on September 17, 2025, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

The Department of Health 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. The Department of Health documents state 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 . . ."

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
Per 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 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.

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,

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

CLN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41110	A. BUILDING: _____ B. WING _____	09/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACEFUL HEART HEALTH GROUP LLC	7237 OLIVER AVENUE NORTH BROOKLYN CENTER, MN 55430

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER 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: SL41110015-0 On September 15, 2025, through September 17, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were four (4) residents; four receiving services under the Provisional Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 485 SS=C	144G.41 Subdivision 1.a (a) Minimum requirements; required food services	0 485		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41110	A. BUILDING: _____ B. WING _____	09/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACEFUL HEART HEALTH GROUP LLC	7237 OLIVER AVENUE NORTH BROOKLYN CENTER, MN 55430

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 485	Continued From page 1 (a) All assisted living facilities must offer to provide or make available at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes. The facility must not require a resident to include and pay for meals in the resident's contract. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide or make available at least three nutritious meals daily with snacks available seven days per week according to the licensee's posted menu. This had the potential to affect all 4 residents. This practice resulted in a level one violation (a violation that will cause only 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:	0 485		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41110	A. BUILDING: _____ B. WING _____	09/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACEFUL HEART HEALTH GROUP LLC	7237 OLIVER AVENUE NORTH BROOKLYN CENTER, MN 55430

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 485	Continued From page 2 During facility tour with owner/director (O/D)-C on September 15, 2025, at 11:51 a.m., the surveyor observed a chest freezer in the attached garage and observed the freezer to be fairly full and noted a loaf of bread bearing a resident's name. O/D-C stated the items in the freezer was her food, not the facility's food. O/D-C stated the licensee shopped for food weekly. On September 15, 2025, at 1:00 p.m., the surveyor observed R3 and R5 sitting at the kitchen table and lunch served was personal sized round pizza, yogurt, and a beverage (R3 had a bottle of pop, R5's beverage was unknown). On the kitchen counter, there were apples and bananas. On September 16, 2025, at 12:00 p.m., the surveyor observed R4 sitting at the kitchen table putting tartar sauce on fried fish filet accompanied with French fries. The surveyor did not observe any fruit or vegetables of any kind with R4's meal. During interview on September 16, 2025, at 2:53 p.m., R4 stated majority of the foods served were from frozen, high in sodium, high in fat, and processed. R4 stated lunch served for lunch was grilled cheese with tomato soup which cheese caused R4 to get constipated. R4 desired home cooked meals that were healthier such as slow cooker chili, chicken salads, healthier tacos, spaghetti, vegetables and fruits. R4 stated the licensee did not have apples, grapes, plums until a couple of days ago and R4 ends up buying for themselves and keeps it within their room. R4 has expressed a change in the menu but felt nothing had changed. R4 stated if they did not want what was served, the staff would ask what	0 485		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41110	A. BUILDING: _____ B. WING _____	09/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACEFUL HEART HEALTH GROUP LLC	7237 OLIVER AVENUE NORTH BROOKLYN CENTER, MN 55430

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 485	Continued From page 3 they wanted but R4 wouldn't know as they did not know what was available. During interview on September 17, 2025, at 10:30 a.m., R3 stated their favorite foods were burritos and eggs. R3 stated overall they were content with the food served. During interview on September 17, 2025, at 11:00 a.m., R6 stated they were very health conscious, so they bought and made their own foods many times because foods that were served would affect R6's medical condition. R6 stated the licensee did try to provide foods requested, but they were still too high in fat and processed. The licensee's Week 1, Week 2, Week 3, Week 4 menus lacked lunch and dinner varieties, and many items were repeated numerous times: -frozen lasagna served twice a month on a Sunday for dinner; -mashed potato or baked potato with Salisbury steak/gravy served once weekly for dinner; -canned beef stew with rice served twice a month; -pizza served 4 times a month for lunch and dinner; -hot dogs served twice a month for lunch; -corn dogs served once weekly for lunch; -grilled cheese and tomato soup served once weekly for lunch; -pot pie served once weekly for dinner; -BBQ chicken with fries once weekly for dinner; -chicken hot wings with boiled potatoes served once weekly for dinner; -chicken and cheese taquitos (frozen item) served once weekly for lunch; -fried rice with chicken served once weekly for	0 485		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41110	A. BUILDING: _____ B. WING _____	09/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACEFUL HEART HEALTH GROUP LLC	7237 OLIVER AVENUE NORTH BROOKLYN CENTER, MN 55430

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 485	Continued From page 4 lunch; -baked chicken with macaroni and cheese served twice a month for dinner; -"Inscrustables [sic] Peanut Butter & Jelly Sandwich" served twice a month for lunch; and -baked scalloped potatoes (from freezer) which did not indicate a protein served twice a month for dinner. The menu frequently indicated "salad" as a side dish 42 out of 56 meals (lunch and/or dinner) on the posted menus (4 weeks). During interview and observation on September 17, 2025, at 12:15 p.m., unlicensed personnel (ULP)-B stated R6 preferred foods such as chicken, potatoes, vegetables, and brown rice. If a resident did not want was being served, alternate options were "fruit, sandwich, and salad." The kitchen refrigerator included items such as milk, juice, small number of peppers and cucumber, deli meats, eggs, grapes, and a package of already cut pineapples. Lettuce was not observed anywhere in the refrigerator. The attached freezer had individual sized "Marie Calendar" pot pies, store bought lasagna, bag of meatballs, hashbrowns, one bag of portioned raw white fish (probably enough for one meal for all residents), small sandwich sized Ziplock bag of raw chicken (would not be enough for 4 adults), and minimal frozen vegetables. The surveyor did not observe any other types of frozen meats such as beef or pork. The cupboards within the kitchen contained items such as canned beef stew "Dinty Moore," box of scalloped potatoes, boxes of macaroni and cheese, jar of marinara sauce, one packet of taco seasoning, canned beanless chili, cans of plain beans, canned chicken noodle soup, cereals (Honey Bunches of Oats, Fruit Loops, and Honey Nut Cheerios), canned tuna,	0 485		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41110	A. BUILDING: _____ B. WING _____	09/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACEFUL HEART HEALTH GROUP LLC	7237 OLIVER AVENUE NORTH BROOKLYN CENTER, MN 55430

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 485	Continued From page 5 container of rolled oats, and a box of individually packaged oatmeal with different flavors. The surveyor asked what was going to be served for lunch, ULP-B stated "corn dogs." On the countertop of the kitchen included apples, oranges, and bananas. R3's signed Attachment C Meal Plan Options (addendum to contract) dated March 1, 2025, indicated licensee would offer at least three nutritious meals daily with snacks available seven days per week in accordance with the recommended dietary allowances in the USDA (United States Department of Agriculture) guidelines, including seasonal fresh fruit and fresh vegetables. The USDA MyPlate website recommended eating a variety of protein foods to get more of the nutrients a body needs. Meat and poultry choices should be lean or low-fat, like 93% lean ground beef, pork loin, and skinless chicken breasts. Choose seafood options that are higher in healthy fatty acids and lower in methylmercury, such as salmon, anchovies, and trout. MyPlate also recommended two to four cups of vegetables a day depending on gender/age. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 800 SS=E	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	0 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41110	A. BUILDING: _____ B. WING _____	09/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACEFUL HEART HEALTH GROUP LLC	7237 OLIVER AVENUE NORTH BROOKLYN CENTER, MN 55430

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 800	Continued From page 6 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. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On September 16, 2025, from 10:30 a.m. to 12:30 p.m., the surveyor toured the facility with owner/director (O/D)-C. The following was observed. EGRESS WINDOWS: The egress windows in basement bedrooms 4 and 5 were obstructed by plastic covers that limited the amount the window could be opened for immediate exit in the case of a fire or similar	0 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41110	A. BUILDING: _____ B. WING _____	09/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACEFUL HEART HEALTH GROUP LLC	7237 OLIVER AVENUE NORTH BROOKLYN CENTER, MN 55430

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 800	Continued From page 7 emergency. Emergency escape and rescue openings are required to be maintained clear of obstructions that prevent its full and immediate use in the event of a fire or similar emergency. GENERAL MAINTENANCE: The gate to exit the fenced in backyard was held in place by a large brick paver placed on the exterior side of the gate. O/D-C could not open the gate completely at the time of survey due to the brick paver, weight of the gate, and damaged to the wood securing the hinges in place. The wood swing in the front yard was broken and held together using a rope. There were screws and bolts protruding from the seat and arms at the broken connection points. These deficient conditions were visually verified at the time of discovery by O/D-C accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41110	A. BUILDING: _____ B. WING _____	09/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACEFUL HEART HEALTH GROUP LLC	7237 OLIVER AVENUE NORTH BROOKLYN CENTER, MN 55430

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	Continued From page 8 which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41110	A. BUILDING: _____ B. WING _____	09/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACEFUL HEART HEALTH GROUP LLC	7237 OLIVER AVENUE NORTH BROOKLYN CENTER, MN 55430

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	Continued From page 9 resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident assessment to include all areas required on the uniform assessment tool for one of three residents (R6). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R6 was admitted for services on July 10, 2025, and had diagnoses including multiple sclerosis (breakdown of protective covering of nerves), generalized anxiety disorder, irritability and anger, and tobacco use. R6's Service Plan-Modification signed July 10, 2025, indicated the following services: -daily transportation assistance; -recording pain three times per day; -safety check nine (9) times per day; and -managing behaviors multiple times daily. R6's admission assessment dated July 10, 2025, assessed R6 was independent with mobility and did not require the use of a wheelchair. Under the physical section of the assessment, it indicated	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41110	A. BUILDING: _____ B. WING _____	09/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACEFUL HEART HEALTH GROUP LLC	7237 OLIVER AVENUE NORTH BROOKLYN CENTER, MN 55430

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	Continued From page 10 R6 had leg spasms everyday with a baseline of 6 drinking water to stay hydrated. No further details were provided. Under the safety section of the assessment, clinical nurse supervisor (CNS)-A did not note if R6 was safe to smoke, but indicated R6 was vulnerable due to marijuana use. R6's Service Recap Summary dated September 1-16, 2025, noted staff initials daily at AM (morning), PM (evening), and overnight for a service titled "Record-Pain." Throughout the survey between September 15, through September 17, 2025, the surveyor observed R6 walk independently up and down the stairs and around the house using a single cane. The surveyor also observed a designated smoking area in front of the garage near the corner. R6's records lacked uniform assessment tool content under Minnesota Rule 4659.0150, subpart 2. The assessment lacked the follow required content: - safe smoking - Pain - assistive device use During facility tour on September 15, 2025, at 11:51 a.m., owner/director (O/D)-C stated three of the four current residents smoked and indicated R5 did not smoke. All residents were compliant with smoking in designated area outside. During interview on September 17, 2025, at 2:03 p.m., CNS-A stated staff would ask the resident if they were having pain, but could not provide a	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41110	A. BUILDING: _____ B. WING _____	09/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACEFUL HEART HEALTH GROUP LLC	7237 OLIVER AVENUE NORTH BROOKLYN CENTER, MN 55430

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	Continued From page 11 reason why the assessment lacked further details about R6's pain and stated she cared about the resident's and was new this this role and was still learning. The licensee's Nursing Assessment and Reassessment of Residents policy dated August 12, 2024, indicated a nursing assessment would include but not limited to the requirements outlined in Minnesota Rules. Minnesota Rules 4659.0140 Subdivision 2, regarding nursing assessments, indicates a nursing assessment or reassessment must address the Uniform Assessment Tool parts A through N and be in writing. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01620		
01760 SS=E	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan.	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41110	A. BUILDING: _____ B. WING _____	09/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACEFUL HEART HEALTH GROUP LLC	7237 OLIVER AVENUE NORTH BROOKLYN CENTER, MN 55430

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01760	Continued From page 12 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered as ordered for two of three residents (R5, R3) receiving medication services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R5 R5 was admitted for assisted living services on March 6, 2025, with diagnoses including bipolar disorder (extreme mood swings), anti-social personality disorder (persistent pattern of disregard for social norms, laws, and rights of others), and malignant neoplasm of prostate (tumor in prostate). R5's Service Plan dated March 6, 2025, indicated R5 received assistance with medication administration twice daily. R5's prescriber order signed April 10, 2025, indicated Artificial Tears drops-one drop in each eye twice a day as needed for dry eye. On September 16, 2025, at 9:51 a.m., the	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41110	A. BUILDING: _____ B. WING _____	09/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACEFUL HEART HEALTH GROUP LLC	7237 OLIVER AVENUE NORTH BROOKLYN CENTER, MN 55430

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01760	Continued From page 13 surveyor observed unlicensed personnel (ULP)-B assist R5 to the kitchen table and obtained blood pressure, temperature, and pulse. ULP-B sat down at the desk and began setting up R5's medications using the electronic medication administration record (EMAR). ULP-B accessed the as needed (PRN) medication list on the EMAR and clicked on Artificial Tears-one drop to each eye twice daily as needed and stated to the surveyor that R5 requested the eye drops. After setting up the rest of R5's medications, ULP-B brought the medications to the kitchen table where R5 was seated. ULP-B instructed R5 to tilt his head back which he did as far as he could. ULP-B placed a drop at the medial commissure (canthus-inner most part of the eye) of both eyes which some of each drop did not make it inside the eye. R5 then wiped away the drop with a tissue paper. ULP-B stated, "it is very important to give eye drops every morning and night." ULP-B stated clinical nurse supervisor (CNS)-A trained her on medication administration. On September 17, 2025, at 2:03 p.m., the surveyor asked why Artificial Tears was not scheduled when it was being given twice daily. CNS-A stated she would need to follow up on that. CNS-A explained staff were trained to wash hands, apply gloves, practice 6 rights of medication administration (right person, right medication, right time, right route, right, dose, and right reason) including right eye, then tilt the resident's head back and pull the lower eye lid down creating a pocket and administer a drop into the pocket. CNS-A stated ULP-B administered the eye drop incorrectly and would provide re-education. R3	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41110	A. BUILDING: _____ B. WING _____	09/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACEFUL HEART HEALTH GROUP LLC	7237 OLIVER AVENUE NORTH BROOKLYN CENTER, MN 55430

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01760	Continued From page 14 On September 16, 2025, at 8:37 a.m., the surveyor met R3 at the outside designated smoking area where R3 was sitting on a chair. R3 explained she sustained a traumatic brain injury by falling down the stairs resulting in many broken bones and fractured skull. That incident has left her with years of pain in different parts of her body. At 8:51 a.m., R3 was back inside the facility and ULP-B stated R3 had refused Miralax (used to relieve constipation) during the morning medication pass and wanted to take it now so ULP-B set it up and administered it to R3. R3 was admitted for assisted living services on March 1, 2025, with diagnoses including major depressive disorder, chronic pain syndrome, radiculopathy in cervical region (compressed nerve roots), and history of traumatic brain injury. R3's Addendum to Contract-Waiver-MN (service plan) dated on May 1, 2025, indicated R3 received assistance with medication reminder three times per day, and medication administration four times per day. R3's prescriber orders signed May 9, 2025, indicated acetaminophen extra strength (ES) 500 milligrams (mg), two tablets by mouth twice daily as needed for pain. Max of 4000 mg acetaminophen in 24 hours. R3's EMAR dated September 1-15, 2025, indicated R3 had scheduled medications at 7:00 a.m., 1:00 p.m., 2:00 p.m., and 9:00 p.m. The EMAR indicated on September 8, 2025, ULP-E administered PRN acetaminophen ES 500 mg at 8:32 p.m., for pain. On September 9, 2025, at 8:24 a.m., ULP-B administered acetaminophen ES 500 mg for pain.	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41110	A. BUILDING: _____ B. WING _____	09/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACEFUL HEART HEALTH GROUP LLC	7237 OLIVER AVENUE NORTH BROOKLYN CENTER, MN 55430

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01760	Continued From page 15 R3's progress notes dated September 10, 2025, at 9:20 a.m., ULP-B documented an incident for September 9, 2025, indicating staff checked R3's vital signs and was preparing to administer her morning medications when R3 requested her PRN acetaminophen. R3 reviewed the EMAR and informed R3 that it had only been 9 hours since her last dose, and would need to wait the full 12 hours before receiving another dose. R3 became upset and she would not take her morning medications until the PRN was due. When it had been 12 hours, ULP-B administered the acetaminophen at 8:24 a.m. On September 17, 2025, at 2:03 p.m., CNS-A stated she had contacted the pharmacy for the acetaminophen frequency and provided education to ULP-B. ULP-B's competency form dated April 6, 2025, indicated CNS-A observed ULP-B completing medication administration routes correctly. The licensee's blank Skill Competency Medication Administration-Routes form dated 2017, indicated eye drop procedure was to position the resident sitting with chin up, looking up. With forefinger, gently pull-down lower lid, creating a little pouch. Place one drop into center of pouch. The licensee's Medication Management Services policy dated August 12, 2024, indicated the registered nurse during the resident monitoring visit, verify that staff were administering the medications as prescribed and is documenting the administration appropriately with authentication by each staff person by discipline	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41110	A. BUILDING: _____ B. WING _____	09/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACEFUL HEART HEALTH GROUP LLC	7237 OLIVER AVENUE NORTH BROOKLYN CENTER, MN 55430

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01760	Continued From page 16 or title. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
02340 SS=F	144G.91 Subd. 6 Participation in care and service planning Residents have the right to actively participate in the planning, modification, and evaluation of their care and services. This right includes: (1) the opportunity to discuss care, services, treatment, and alternatives with the appropriate caregivers; (2) the right to include the resident's legal and designated representatives and persons of the resident's choosing; and (3) the right to be told in advance of, and take an active part in decisions regarding, any recommended changes in the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide individualized person-centered care plans for each resident receiving services. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	02340		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41110	A. BUILDING: _____ B. WING _____	09/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACEFUL HEART HEALTH GROUP LLC	7237 OLIVER AVENUE NORTH BROOKLYN CENTER, MN 55430

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02340	Continued From page 17 The findings include: R6's SERVICE PLAN R6 was admitted for services on July 10, 2025, and had diagnoses including multiple sclerosis (breakdown of protective covering of nerves), generalized anxiety disorder, irritability and anger, and tobacco use. R6's Service Plan-Modification signed July 10, 2025, indicated R6 received assistance with the following services: -daily transportation assistance; -recording pain three times per day; -safety check nine (9) times per day; and -managing behaviors multiple times daily. R6's Assessment (admission assessment) dated July 10, 2025, indicated R6 was independent with bathing, dressing, eating, mobility, toileting, financial, laundry, transportation (able to drive himself around in his own vehicle), medication administration, emergency evacuation, phone use, and no difficulty with language comprehension or expression. The assessment also indicated R6 had a history of falls, but was not a risk for falls. The assessment indicated R6 had leg spasms and staying hydrated helped but did not offer additional interventions should R6 report pain. R6's Service Recap Summary dated September 1-16, 2025, included staff initials on the following services: -Record-pain at AM (morning), PM (evening), and overnight, staff documented "declined" 6 out of 48 times; -Safety check at 12:00 AM, 2:00 AM, 4:00 AM,	02340		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41110	A. BUILDING: _____ B. WING _____	09/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACEFUL HEART HEALTH GROUP LLC	7237 OLIVER AVENUE NORTH BROOKLYN CENTER, MN 55430

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02340	Continued From page 18 9:00 AM, 11:00 AM, 2:00 PM, 4:00 PM, 6:00 PM, and 8:00 PM, staff documented "declined" 56 out of 144 times; and -Transportation assistance daily for AM, staff documented "declined" 9 out of 16 days. R3, R4, R5 DAILY VITAL SIGN CHECK R3, R4, R5 were admitted to licensee on March 1, 2025, July 31, 2025, and March 6, 2025, respectively. On September 16, 2025, between 9:15 a.m., and 9:51 a.m., unlicensed personnel (ULP)-B administered medication to R3, R4, and R5, and checked vital signs (blood pressure, pulse, temperature, oxygen saturation, respirations, and weight) on R4 and R5. R3 and R5's nursing assessment dated September 10, 2025, and September 16, 2025, respectively, did not indicate R3 and R5 required daily vital sign check. R3 and R5's service plan dated May 1, 2025, and April 1, 2025, respectively, indicated daily check of blood pressure, oxygen saturation, pulse, respiration, temperature, and weight. The service plans also indicated the registered nurse (RN) would supervise the vital signs once weekly. R4's vital signs record dated September 3 through 17, 2025, noted results of daily blood pressure, pulse, temperature, oxygen saturation, respiration, and weight. During interviews on September 17, 2025, at 2:03 p.m., clinical nurse supervisor (CNS)-A believed while completing a resident's comprehensive assessment, Residex (online	02340		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41110	A. BUILDING: _____ B. WING _____	09/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACEFUL HEART HEALTH GROUP LLC	7237 OLIVER AVENUE NORTH BROOKLYN CENTER, MN 55430

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02340	Continued From page 19 electronic health record) populated a frequency automatically which was why residents were getting daily vital sign (blood pressure, pulse, temperature, oxygen saturation, and respirations) and weight checks. Owner/director (O/D)-C stated due to R6's history with falls, they felt it was necessary to have that many safety checks based on their previous job experience and other licensee's survey results. O/D-C was fearful of falls and wanted to make sure they were doing everything they could to prevent falls for each resident. The surveyor asked CNS-A what "record pain" meant, she stated she cared about the residents but could not provide an explanation why that service was included in a resident's service plans when the nursing assessment did not indicate R6 required assistance with pain intervention. O/D-C stated safety checks were implemented on all residents, and stated these blanket services were not providing person-centered planning. The Minnesota Assisted Living Resident Bill of Rights dated November 8, 2022, indicated residents have the right to actively participate in the planning, modification, and evaluation of their care and services. This right includes the opportunity to discuss care, services, treatment and alternatives with the appropriate caregivers in advance of changes. The licensee's Service Plan policy dated August 12, 2024, indicated the service plan was developed with the resident/representative and is based on resident needs and preferences. The policy also noted the service plan was based on the assessment and resident preferences and was consistent with accepted standards of practice for professional nursing or other relevant	02340		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41110	A. BUILDING: _____ B. WING _____	09/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACEFUL HEART HEALTH GROUP LLC	7237 OLIVER AVENUE NORTH BROOKLYN CENTER, MN 55430

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02340	Continued From page 20 standards. No further information available. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02340		

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

PEACEFUL HEART HEALTH GROUP LL
7237 OLIVER AVENUE NORTH
Brooklyn Center, MN 55430
Hennepin County
Parcel:

Phone:

License Info

License: HFID 41110

Risk:
License:
Expires on:
CFPM: Sukurat Oparemi
CFPM #: 125149; Exp: 06/13/2027

Inspection Info

Report Number: F1051251106
Inspection Type: Full - Single
Date: 9/15/2025 Time: 11:00:00 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 THE NURSE EVALUATOR, ANNA BOHNEN.

DISCUSSED THE FOLLOWING WITH THE KITCHEN MANAGER, SUKURAT:

EMPLOYEE ILLNESS LOG
VOMIT CLEAN-UP PROCEDURES
HANDWASHING & GLOVE USE/DISPOSAL

THE KITCHEN HAS VINYL PLANK FLOORING, A SMOOTH TEXTURE CEILING, STONE MATERIAL COUNTERTOPS WITH HOLLOW BASES, LAMINATE CABINETS, AND A NSF 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 F1051251106 from 9/15/2025

Sukurat Oparemi
Kitchen Manager

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

PEACEFUL HEART HEALTH GROUP LL
Brooklyn Center
County/Group: Hennepin County

Inspection Info

Report Number: F1051251106
Inspection Type: Full
Date: 9/15/2025
Time: 11:00:00 AM

Equipment Temperature: Product/Item/Unit: AMBIENT**; Temperature Process:** Ambient Air
Location: Upright Cooler at 39 Degrees F.
Comment:
Violation Issued?: No