



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

October 23, 2024

Licensee

Hope Residential Homes LLC
9800 Morgan Avenue South
Bloomington, MN 55431

RE: Project Number(s) SL34606015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on October 1, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

STATE CORRECTION ORDERS

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

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

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the

resident(s)/employee(s) identified in the correction order.

- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

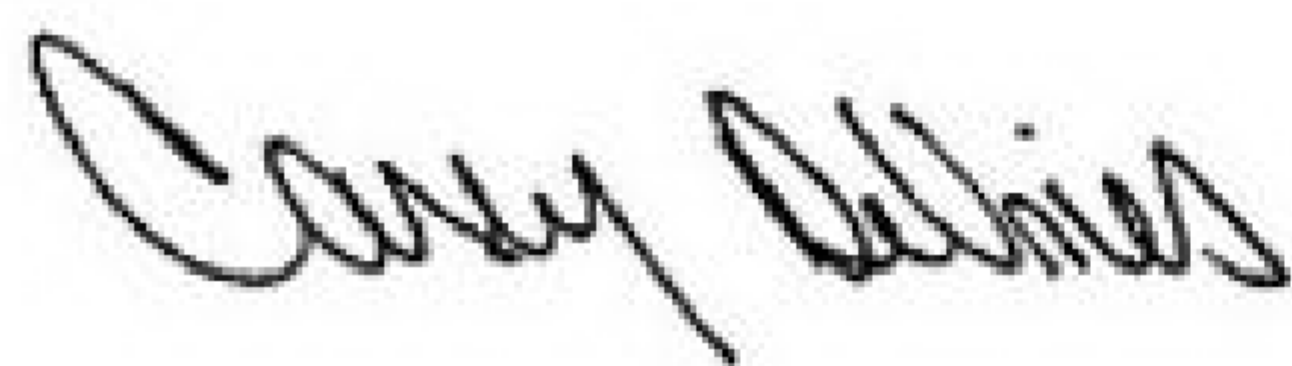
<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **<https://forms.office.com/g/Bm5uQEPhVa>**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,



Casey DeVries, Supervisor

State Evaluation Team

Email: Casey.DeVries@state.mn.us

Telephone: 651-201-5917 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34606	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/01/2024
NAME OF PROVIDER OR SUPPLIER HOPE RESIDENTIAL HOMES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 9800 MORGAN AVENUE SOUTH BLOOMINGTON, MN 55431		
(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: SL34606015-0 On September 30, 2024, through October 1, 2024, 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 residents, all of whom received services under the Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 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 interview and record review, the licensee failed to develop and implement a written staffing plan that included an evaluation completed by the clinical nurse supervisor (CNS) (as indicated in Minnesota Administrative Rule 4659.0180) at least twice a year. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 470			

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0 470	Continued From page 2 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living facility license and was licensed for a capacity of four residents. The licensee's undated Facility Staffing Plan indicated one direct care staff member was needed at the facility for the a.m., p.m., and night shifts seven days per week to meet the needs of the residents. The staffing plan lacked a written evaluation completed by the CNS twice per year. On September 30, 2024, at 11:51 a.m., licensed assisted living director stated they reviewed the staffing plan twice a year, but they did not have documentation to show the staffing plan was reviewed/revised. The licensee's Staffing Plan policy dated December 8, 2023, indicated "The staffing plan shall be evaluated as part of the Quality Management program at least twice per year. The results of the evaluation are documented in the meeting minutes." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470			

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0 680	Continued From page 3	0 680			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 680			

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0 680	Continued From page 4 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's undated emergency disaster preparedness plan lacked evidence of the following required content: - annual update; - quarterly review of missing resident policy; - policies and procedures for shelter in place for residents, staff, and volunteers who remain in the facility; - process for cooperation and collaboration with local, tribal, regional, State and Federal EP to maintain integrated response; - policies and procedures for system to track the location of on-duty staff and sheltered residents; - emergency preparedness plan for relocation of on-duty staff and sheltered and documentation for the specific name/location of the receiving facility or other location; - policies and procedures for volunteers; - policies and procedures for communication plan; - emergency plan (EP) program patient population to include transportation and staff who would assume specific roles in another's absence; - arrangement with other facilities; - contact names and information; - policies and procedures for sharing information on occupancy needs; - emergency officials contact information to include state licensing and certification agency; and	0 680			

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0 680	Continued From page 5 - emergency prep testing requirements. On October 1, 2024, at 8:15 a.m., licensed assisted living director (LALD)-D stated they were not aware of the missing required contents listed above. LALD-D stated "we will fix it, because we like doing things right." The licensee's Emergency Preparedness policy dated December 8, 2023, indicated the licensee would have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services. In addition, a disaster drill would be conducted at the residence at least annually and the results of the drill would be documented. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but	0 780			

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0 780	Continued From page 6 not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that functioned and were interconnected so that the actuation of one alarm caused all alarms in the dwelling unit to actuate. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On September 30, 2024, from 1:35 p.m. to 2:40 p.m., on a facility tour with licensed assisted living director (LALD)-D, the following was observed: There was a hardwired smoke alarm missing in the lower-level common hallway and in bedroom	0 780			

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0 780	Continued From page 7 #4. Smoke alarms are required to be maintained as hardwired (receiving power from the building electrical system) as installed at the time of construction in accordance with current Minnesota State Fire Code. On September 30, 2024, at 2:35 p.m., LALD-D stated they understood the above-listed deficient condition. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780			
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, 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. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	0 800			

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0 800	Continued From page 8 cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On September 30, 2024, from 1:35 p.m. to 2:40 p.m., on a facility tour with licensed assisted living director (LALD)-D, the following was observed. SMOKING AREAS: There was a non-designated smoking area on the rear deck that was being used for smoking. LALD-D Stated that the deck in not a designated smoking area and that they have instructed residents and staff that the deck is not a designated smoking area. There were multiple cigarettes scattered under the deck in the yard. LALD-D was advised that smoking should be done safely and that cigarettes should be disposed of in approved non-combustible receptacles. GENERAL MAINTENANCE: The fire wall in the garage had two holes in it. LALD-D stated that they would have it repaired. The rear deck boards, handrail, and balustrades were weather worn and were starting to splinter. The wooden fence and fence gates around the back yard were damaged. The gates no longer operated normally, and the fence was leaning and missing pickets in spots. LALD-D stated that they would speak to their landlord and see if they will repair it. The foundation under the service door from the garage leading into the back yard was deteriorating. LALD-D stated that they will have it repaired. During interview on September 30, 2024, at 2:35	0 800			

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0 800	Continued From page 9 p.m., LALD-D acknowledged and stated they understood the above listed deficient conditions. 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 twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system	0 810			

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0 810	Continued From page 10 activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On September 30, 2024, licensed assisted living director (LALD)-D provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP, titled "Fire Safety", dated December 8, 2023, failed to include the following: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The provided FSEP was from a third-party provider and had not	0 810			

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0 810	Continued From page 11 been updated to the specific facility. The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation nor did it include instructions for staff to follow in case of relocation. TRAINING: The licensee failed to provide evacuation training to residents at least once per year. LALD-D stated that they are doing required training, but they are not documenting. LALD-D stated that they will begin documenting training. DRILLS: The licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. Record review of licensee's evacuation drill log, indicated evacuation drills were conducted on January 2, 2024, March 1, 2024, May 2, 2024, and July 1, 2024. Records indicated that all fire drills were conducted on first shift only. No other documentation was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810			

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER HOPE RESIDENTIAL HOMES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 9800 MORGAN AVENUE SOUTH BLOOMINGTON, MN 55431		
(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
01060	Continued From page 12	01060			
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not	01060			

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01060	Continued From page 13 returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with required content for an emergency relocation for one of one resident (R3) with records reviewed. 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: R3 was admitted to the licensee on February 27, 2023. R3's diagnosis included diabetes type I, major depressive disorder, persistent mood disorder, and anxiety disorder. R3's signed service plan (Waiver)-Addendum to Contract, dated October 1, 2024, indicated R3 received assistance with medication administration, bathing reminder, grooming, housekeeping, laundry, meals assistant, manager behaviors, and record vital signs. R3's record included a hospital After Visit Summary dated May 21, 2024, which indicated R3 was hospitalized on May 18, 2024, and	01060			

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01060	Continued From page 14 discharged from the hospital on May 21, 2024. R3's record lacked evidence a written notice was provided that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the Office of Ombudsman for Long-Term Care; - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. On October 1, 2024, at 2:07 p.m., licensed assisted living director (LALD)-D, stated they were not aware of the requirement to provide a written notice with required contents for an emergency relocation. On October 1, 2024, at 2:18 p.m., clinical nurse supervisor (CNS)-C stated they were not aware of the requirement to provide a written notice with required contents for an emergency relocation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060			
01500 SS=D	144G.63 Subd. 5 Required annual training	01500			

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01500	Continued From page 15 (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual 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	01500			

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01500	Continued From page 16 based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an employee received at least eight hours of annual training for each 12 months of employment for one of three employees (unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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: ULP-B was hired on September 30, 2021, to provide direct services to residents.	01500			

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01500	Continued From page 17 ULP-B's employee record lacked the following topics of annual trainings: - assisted living bill of rights; and - principles of person-centered planning/service delivery. On October 1, 2024, at approximately 10:45 a.m., clinical nurse supervisor (CNS)-C stated the above-mentioned training topics were assigned to ULP-B and ULP-B did not complete the training. Licensed assisted living director (LALD)-D stated going forward the plan was to take ULP-B off the schedule until they completed their training. The licensee's Staff Orientation and Education policy dated December 8, 2023, indicated "All staff providing assisted living services will complete at least eight (8) hours of education for every twelve (12) months of employment." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500			
01620 SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs	01620			

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01620	Continued From page 18 and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective 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 and reassessment, not to exceed 90 calendar days from the last date of the assessment for two of three residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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: R1 R1 was admitted to the licensee on December 23, 2020, and began receiving assisted living services.	01620			

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01620	Continued From page 19 R1's diagnosis included schizoaffective disorder, delusions, psychosis, anxiety disorder, intellectual disability, paranoia, post-traumatic stress disorder, and obsessive-compulsive disorder. R1's Service Plan (Waiver) - Addendum to Contract form dated August 23, 2024, indicated R1 received assistance with medication setup, medication administration, grooming, housekeeping, laundry, meal assistance, socialization, managing symptom, managing behaviors, and bed making. R1's record included 90-day nursing assessments dated April 21, 2024, and July 29, 2024. The assessment completed on July 29, 2024, was late by nine days. R2 R2 was admitted to the licensee on October 6, 2021, and began receiving assisted living services. R2's diagnosis included diabetes type II, bipolar disorder, major depressive disorder recurrent severe with psychotic features, and anxiety disorder unspecified. R2's Service Plan (Waiver) - Addendum to Contract form dated October 1, 2024, indicated R2 received assistance with medication setup, medication administration, grooming, housekeeping, laundry, meal assistance, socialization, managing symptom, managing behaviors, and bed making. R2's record included 90-day nursing assessments dated January 14, 2024, April 19, 2024, and July 30, 2024. The assessment completed on April 19, 2024, was late by six days.	01620			

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01620	Continued From page 20 The assessment completed on July 29, 2024, was late by 11 days. On October 1, 2024, at 10:40 a.m., clinical nurse supervisor (CNS)-C stated the assessments were not done on time. CNS-C stated they were overlooked. The licensee's Comprehensive Nursing Assessment dated December 8, 2023, read "Policy Statement: The Registered Nurse (RN) will conduct and document a comprehensive assessment for all residents admitted to [licensee's name] to determine the services required and to develop an individualized care plan for staff to implement. The assessment addresses the resident's physical, mental and cognitive needs." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620			



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

Type: Full
Date: 10/01/24
Time: 10:45:00
Report: 1005241245

Food and Beverage Establishment Inspection Report

Page 1

Location:

Hope Residential Homes Llc
9800 Morgan Avenue South
Bloomington, MN55431
Hennepin County, 27

Establishment Info:

ID #: 0039060
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6125980893
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.

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Utensil Surface Temp.: = at 161 Degrees Fahrenheit
Location: DISHWASHER
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Hold/CUT WATERMELON
Temperature: 41 Degrees Fahrenheit - Location: KENMORE KITCHEN REFRIGERATOR
Violation Issued: No

Process/Item: Cold Hold/CHEESE
Temperature: 40 Degrees Fahrenheit - Location: KENMORE KITCHEN REFRIGERATOR
Violation Issued: No

Process/Item: Cold Hold/MILK
Temperature: 39 Degrees Fahrenheit - Location: KENMORE KITCHEN REFRIGERATOR
Violation Issued: No

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

INSPECTION COMPLETED WITH OPERATOR AND REVIEWED WITH HRD NURSING EVALUATOR DEE MOSISSA.

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

OPERATOR HAD RECENTLY RUN THEIR MAXIMUM REGISTERING THERMOMETER THROUGH THEIR DISHWASHER, WHICH RECORDED A MAXIMUM TEMPERATURE OF 161

Type: Full
Date: 10/01/24
Time: 10:45:00
Report: 1005241245
Hope Residential Homes Llc

Food and Beverage Establishment Inspection Report

Page 2

DEGREES F.

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

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

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

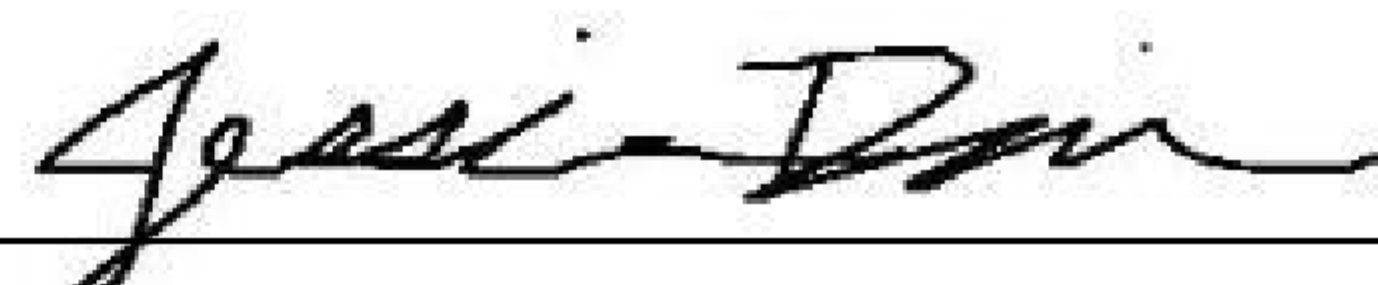
I acknowledge receipt of the Minnesota Department of Health inspection report number 1005241245 of 10/01/24.

Certified Food Protection Manager ASHA H. WARFA

Certification Number: FM113322 Expires: 09/22/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
ZAMZAM FARAH

Signed:  _____
Jessica Davis
Public Health Sanitarian III
651-201-3961
jessica.davis@state.mn.us