Electronically Delivered
June 6, 2022

Administrator
Living Hope Homes Brent House
5039 Brent Avenue
Inver Grove Heights, MN 55076

RE: Project Number SL37945015

Dear Administrator:

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 on May 11, 2022, for the purpose of 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.

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, no immediate fines are assessed.

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 general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general 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

Free from Maltreatment reconsideration requests should addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

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,

Matthew Heffron, Supervisor
Health Regulation Division
State Rapid Response Team
85 East Seventh Place, Suite 220
P.O. Box 64970
St. Paul, MN 55164-0970
Email: matthew.heffron@state.mn.us
Phone: 651-201-4221 Fax: 651-215-5963

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37945	A. BUILDING: _____ B. WING _____	05/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVING HOPE HOMES BRENT HOUSE	5039 BRENT AVENUE INVER GROVE HEIGHTS, MN 55076

(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 Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDERS In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL#37945015 On May 9-11, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued: 0460, 0470, 0660, 1520, 1600. At the time of the survey and investigation, there were four (4) residents receiving services under the provider's Provisional Assisted Living Facility 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 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.	
0 460 SS=F	144G.41 Subdivision 1 Minimum requirements	0 460		

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0 460	Continued From page 1 (5) provide a means for residents to request assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide a reliable means for residents to request staff assistance for health and safety needs 24 hours a day, seven days a week. This had the potential to affect all four residents who reside at the facility (R1, R2, R3, and R4). 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) 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). Findings include:	0 460		

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0 460	Continued From page 2 On May 9-11, 2022, the Minnesota Department of Health (MDH) conducted an onsite survey. The facility is a home that contains three bedrooms on one floor, and a fourth bedroom on the basement level. On May 9, 2022, at 3:29 p.m., the MDH surveyor tested R1's call light, but after approximately six minutes no staff responded to the resident's room, even though the room was in close proximity to the nurse's office. R1 stated he had never used his call light, so he did not know whether it worked or not. On May 9, 2022, at 3:35 p.m., the MDH surveyor walked into the nurse's office to inquire about the unanswered call light. Staff members in the office stated no call light came through their system, and started trouble-shooting to figure out why. Over the next few minutes, and during the course of the discussion as to possible reasons why the call light did not work, unlicensed personnel (ULP)-G stated, "I've been saying something since January that it sometimes doesn't work." The MDH surveyor then walked out on the back deck where R4 was sitting in the sun. The surveyor asked R4 how she alerted staff she wanted to return inside, and R4 stated that she had a bell. R4 stated the bell is in her room, and she currently did not have access to it. R4 stated a call pendant that she could have on her person at all times, "would be nice". The surveyor alerted staff that R4 wanted to return inside, and they immediately accommodated her. When the surveyor left the facility for the day, the licensed assisted living director (LALD)-B stated they would immediately correct the call light	0 460		

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0 460	Continued From page 3 issue, as the owner (O-J) of the facility was currently at a store purchasing a call light system. On May 10, 2022, at 10:00 a.m., when the surveyor walked back into the facility, LALD-B stated they had already fixed the call light issue, and performed a demonstration of their new call light system. On May 10, 2022, at 10:22 a.m., R4 stated she received a new call light pendant and was happy she did not have to carry around her bell to alert staff. On May 10, 2022, at 10:30 a.m., R1 stated his call light worked, but that it did not matter, as he never used the call light to summon assistance. R1 stated he did not need to use his call light because the home was so small, all he had to do is call-out, staff would hear him, and usually responded almost immediately. Facility-provided policy, 2.49 Patient Summoning Device, dated August 1, 2021, indicated the licensee "will provide a means for residents to request assistance for health and safety needs 24 hours a day, seven days a week". TIME PERIOD TO CORRECT: Seven (7) days.	0 460		
0 470 SS=C	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable	0 470		

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0 470	Continued From page 4 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 observation, interview and record review, the licensee failed to ensure a clinical nurse supervisor developed and implemented a staffing plan for determining its staffing levels. This had the potential to affect all four residents, staff, and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).	0 470		

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0 470	Continued From page 5 The findings include: On May 9-11, 2022, the Minnesota Department of Health (MDH) conducted an onsite survey. The facility is a home that contains three bedrooms on one floor, and a fourth bedroom on the basement level. During an entrance conference on May 9, 2022, at 12:15 p.m., the licensed assisted living director (LALD)-B stated the facility does not have a staffing plan. LALD-B stated the licensee is a very small facility, does not have any issues with staffing levels, and that one aide is staffed per shift to meet the four residents' needs. During the onsite visit, LALD-B verified the facility is licensed to provide assisted living services to five residents, but they rarely have five residents in the home. LALD-B stated that during normal weekday business hours, the licensee's housing manager (HM)-A, registered nurse (RN)-D, and licensed assisted living director (LALD)-C, (who is in training), also spend time at the home. A licensee-proved staff schedule indicated one staff member was scheduled per shift, for the months of April and May 2022. The licensee policy 2.02 Acceptance of Residents, dated August 1, 2021, indicated, "[Licensee Name] will only accept a resident if the facility has staff, sufficient in qualifications, competency, and numbers, to adequately provide the services agreed to in each resident's Assisted Living Contract ...". TIME PERIOD FOR CORRECTION: Twenty-one (21) Days.	0 470		

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0 660	Continued From page 6	0 660		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a comprehensive tuberculosis infection control (TBIC) program according to the most current TBIC guidelines issued by the Centers for Disease Control (CDC), and failed to maintain written evidence of compliance of such. The licensee's prior registered nurse (RN)-I, also allowed unlicensed personnel (ULP)-G to work in the facility with an expired TB test. This had the potential to affect all four residents receiving assisted living services, as well as other 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	0 660		

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0 660	Continued From page 7 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: FACILITY TBIC RISK ASSESSMENT On May 9-11, 2022, the Minnesota Department of Health (MDH) conducted an onsite survey. The facility is a home that contains three bedrooms on one floor, and a fourth bedroom on the basement level. During the entrance conference on May 9, 2022, at 10:25 a.m., the MDH surveyor requested the licensee's TBIC Risk Assessment. Per the licensed assisted living director (LALD)-B, the licensee does not have one. LALD-B stated the responsibility of this documents was that of the licensee's former registered nurse (RN)-I, who was terminated on May 3, 2022, after discovery she (RN-I) had not completed, or only half-completed, required documentation to maintain their 144G licensure compliance. EMPLOYEE SCREENING AND EMPLOYEE TB TESTING RESULTS One of four employee files reviewed lacked an updated TB screening and TB test results. Unlicensed personnel (ULP)-G was hired by the licensee on January 3, 2022. ULP-G's Baseline TB Screening Tool for Health Care Workers, indicated a two-step Tuberculin skin test (TST): "8/10/21 @ 4:30pm, R forearm", and was read on "8/13/21 @ 10am, Negative".	0 660		

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0 660	Continued From page 8 "8/23/21 @ 4pm, R forearm", and was read on "8/26/21 2p, Negative". During an interview on May 9, 2022, at 3:53 p.m., ULP-G stated that during her hiring process, RN-I advised her that the above TST information would suffice for the TB testing requirements, and that she (ULP-G) did not have to get another TB test. Facility-provided policy 8.16 Tuberculosis Screening, dated August 1, 2021, indicated the licensee "will establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis control guidelines issued by ...the Centers for Disease Control (CDC)", "Staff whose essential job functions require work within the same air space of home care clients will be screened and tested for tuberculosis prior to the staff being exposed to clients", and "New staff will be screened for active signs of TB ...". TIME PERIOD FOR CORRECTION: Seven (7) days.	0 660		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire	0 790		

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0 790	Continued From page 9 Code; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to locate and maintain fire extinguishers in accordance with the State Fire Code as required by MN Statute 144G.45 subd.2(a)(2). This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On May 9, 2022, from approximately 1:20 p.m. to 2:30 p.m., survey staff toured the home with the licensed assisted living director (LALD)-C and housing manager (HM)-A. During the tour, survey staff observed the following: LOCATION The portable fire extinguishers were improperly located for ready access and visible locations. Survey staff observed the extinguishers were located inside the food pantry closet behind closed doors on the main floor and inside the laundry room on the lower level. MONTHLY INSPECTION The portable fire extinguishers both had a tag	0 790		

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0 790	Continued From page 10 indicating the last annual service date of August 2021 but lacked the required monthly visual inspection records. Staff explained to the LALD-C and the HM-A that all portable fire extinguishers must be inspected monthly by an assigned staff at the home to ensure the extinguishers were at designated locations, verification that the extinguishers had not been tampered with, or condition of the extinguishers to prevent operation. On May 9, 2022, at approximately 3:20 p.m., the LALD-C and the HM-A acknowledged the findings during the exit interview. No other information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
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	0 810		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 810	Continued From page 11 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 activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on document review and interview, the licensee failed to provide the required content of documentation on the fire safety and evacuation plan, required training documentation for employees and residents on the fire safety and evacuation plan, and required documentation of fire and evacuation drills performed by employees. This has the potential to directly affect the safety of visitors, staff, and all residents receiving assisted living care. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37945	A. BUILDING: _____ B. WING _____	05/11/2022

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0 810	Continued From page 12 On May 9, 2022, at approximately 2:30 p.m., survey staff received the home's fire safety and evacuation plan documentation and related documentation for review. The documentation review indicated the following: FIRE SAFETY AND EVACUATION PLAN: - The home's fire policy, dated August 1, 2021, lacked site-specific fire protection procedures as the documentation incorrectly showed the home was provided with a fire sprinkler system by indicating that sprinklers will be activated when fire alarms were pulled. In addition, the procedures also referred to magnetic holders for fire doors which the home did not have. - The plan documentation lacked site-specific procedures necessary for addressing resident movement, evacuation, and relocation including any unique resident-specific situations during an evacuation. Unique situations during an evacuation may be residents who have mobility limitations, cognitive impairment, or needing assistance during an evacuation and must be addressed in the fire safety and evacuation plan documentation. During the tour, survey staff observed wheelchair-bound residents and others that may need assistance during an evacuation. -The plan documentation lacked documentation of fire protection procedures for residents. -The floor plan of the lower level lacked an exit route by means of the stairway to the upper main floor. The exit route to the back patio if used must be provided with for proper means of weathered walkways to the front of the house. TRAINING -The review of the fire policy dated August 1, 2021, showed the correct frequency of employee training on the fire safety and evacuation plan	0 810		

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0 810	Continued From page 13 was adopted but the licensee lacked records to show that the employee training on the fire safety and evacuation plan had been completed. FIRE AND EVACUATION DRILLS - The review of the fire policy dated August 1, 2021, showed the correct minimum number of fire and evacuation drills to be performed as required but the licensee lacked records to show that the employee training on the fire safety and evacuation plan had been completed. The housing manager (HM)-A stated that they have the forms to document the drills but they have not performed any employee evacuation drills to date. On May 9, 2022, at approximately 3:20 p.m., the licensed assisted living director-C and the HM-A acknowledged the findings during the exit interview. No other information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days	0 810		
01520 SS=F	144G.63 Subd. 7 Verification and documentation of orientation The assisted living facility shall retain evidence in the employee record of each staff person having completed the orientation and training required by this section. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to retain evidence in the registered nurse's (RN)-D personnel file that she completed the orientation required by this section. This had	01520		

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01520	Continued From page 14 the potential to affect all four residents who reside at 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) 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). Findings include: On May 9-11, 2022, the Minnesota Department of Health (MDH) conducted an onsite survey. The facility is a home that contains three bedrooms on one floor, and a fourth bedroom on the basement level. During an interview on May 10, 2022, at 10:50 a.m., RN-D stated she started work at the facility on April 13, 2022. RN-D stated she was advised she would train on Assisted Living Facility licensure for six weeks under registered nurse (RN)-I, who was already employed by the licensee. RN-D stated that on May 3, 2022, RN-I was terminated. During the exit conference on May 11, 2022, at 10:00 a.m., the facility owner (O-J) stated that she reached out to RN-I several times to get RN-D's orientation-training paperwork, but RN-I did not respond. Facility administrative staff forwarded this surveyor several email strings between licensee/owners/administrative staff and RN-I, in which they requested documents, but RN-I did not provide any documents (to include RN-D's training file).	01520		

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01520	Continued From page 15 During a phone interview on May 17, 2022, at 10:50 a.m., RN-I stated she still had RN-D's orientation file and would email it to me. RN-I stated she and RN-D had gotten through about ½ of the orientation documentation. As of the writing of this correction order, RN-I still had not yet emailed the requested documentation. Licensee-provide policy 5.01 Orientation of Staff and Supervisors & Content, dated August 1, 2021, indicated, "All staff of [facility name] providing and supervising direct services must complete an orientation to Assisted Living facility licensing requirements and regulations before providing assisted living services to residents". TIME PERIOD TO CORRECT: Seven (7) days.	01520		
01600 SS=F	144G.70 Subdivision 1 Acceptance of residents An assisted living facility may not accept a person as a resident unless the facility has staff, sufficient in qualifications, competency, and numbers, to adequately provide the services agreed to in the assisted living contract. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure staff were available, sufficient in numbers, to adequately provide the services agreed to in the assisted living contract for one of four residents who resided in the Assisted Living Facility (ALF). 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	01600		

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01600	Continued From page 16	01600		

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).

The findings include:

On May 9-11, 2022, the Minnesota Department of Health (MDH) conducted an onsite survey. The facility is a home that contains three bedrooms on one floor, and a fourth bedroom on the basement level.

During the initial conference on May 9, 2022, at 12:15 p.m., licensed assisted living director (LALD)-B stated the facility was staffed with one unlicensed personnel (ULP) during the day, evening, and midnight shifts. LALD-B stated that during normal business hours, one or more of the following staff were also present: housing manager (HM)-A, licensed assisted living director (LALD)-C (in training), and registered nurse (RN)-D.

R2's medical record was reviewed. R2's diagnoses included Spinal Muscle Atrophy Type 2. R2's unsigned service plan indicated she received services for assistance with transfers and mobility, activities of daily living, and safety checks. R2's Face Sheet indicated she moved into the facility October 14, 2021.

R2's Individual Review Assessment, date April 22, 2022, indicated R2 required a mechanical lift for all transfers, as well as an electric wheelchair for mobility.

During an onsite interview on May 10, 2022, at 2:21 p.m., ULP-H stated she sometimes worked

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01600	Continued From page 17	01600		

alone. ULP-H stated she used a mechanical lift to transfer R2. ULP-H stated R2 sometimes refused the mechanical lift to be used, so ULP-H physically lifted R2 from her bed to her wheelchair.

The licensee's staffing schedule, dated May 9-15, 2022, indicated one staff member worked per shift, during the day, evening, and midnight hours.

During the exit conference on May 11, 2022, at 10:00 a.m., HM-A stated the staff schedule was updated to reflect two staff members in the facility at all times, for the next week. HM-A stated she will continue to work on the staff schedule (past the next week), to ensure that two staff members are always present in the facility. During the conference LALD-D also stated that the licensee's prior registered nurse admitted R2 to the facility, not the current registered nurse.

The licensee's 6.31 Hoyer Use Policy, dated August 1, 2021, indicated, "Hoyer lists are to be operated with two staff members present at all times", and "One staff is to operate and movement of lift [sic], the other is primarily responsible for safe positioning of individual in sling during transfer".

The licensee's 2.02 Acceptance of Residents policy, dated August 1, 2021, which indicated, "[Licensee Name] will only accept a resident if the facility has staff, sufficient in qualifications, competency, and numbers, to adequately provide the services agreed to in each resident's Assisted Living Contract ...".

TIME PERIOD TO CORRECT: Seven (7) days.

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

Type: Full
Date: *05/09/22*
Time: 11:37:36
Report: 1004221115

Food and Beverage Establishment Inspection Report

Location:
Living Hope Homes Brent House
5039 Brent Avenue
Inver Grove Heights, MN55076
Dakota County, 19

Establishment Info:
ID #: 0037550
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6514247163
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.

3-300B Protection from Contamination: cross-contamination, eggs

3-302.11A(1) ** Priority 1 **

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

RAW CHICKEN AND RAW SHELL EGGS FOUND STORED ON THE TOP SHELF OF THE REFRIGERATOR. ENSURE ALL RAW ANIMAL FOODS ARE STORED BELOW AND SEPARATELY FROM READY-TO-EAT ITEMS AND PRODUCE.

Comply By: 05/09/22

4-700 Sanitizing Equipment and Utensils

4-702.11 ** Priority 1 **

MN Rule 4626.0900 Sanitize utensils and food contact surfaces of equipment before use, after cleaning.

EMPLOYEE STATED SOME ITEMS (LARGE POTS/PANS) ARE NOT SANITIZED AFTER WASHING. IF ITEMS ARE NOT PUT THROUGH DISH MACHINE FOR SANITIZING, THEY MUST BE SANITIZED USING APPROVED CHEMICAL SANITIZER AFTER WASHING. (WASH, RINSE WITH CLEAN WATER, THEN SANITIZE)

Comply By: 05/09/22

4-700 Sanitizing Equipment and Utensils

4-703.11B ** Priority 1 **

MN Rule 4626.0905B Sanitize food contact surfaces of equipment and utensils after cleaning by using mechanical hot water operations that achieve a utensil surface temperature of 160 degrees F (71 degrees C) and are set up and maintained in accordance with the specifications of NSF International and the manufacturer's data plate.

UTENSIL SURFACE TEMPERATURE IN THE DISH MACHINE MEASURED AT 121*F. ENSURE UTENSIL SURFACE TEMPERATURE REACHES A MINIMUM OF 160*F FOR REQUIRED

SANITIZING. *USE CHEMICAL SANITIZER UNTIL UNIT IS REPAIRED AND VERIFIED TO BE ABLE TO REACH AT LEAST 160*F.

Comply By: 05/10/22

4-300 Equipment Numbers and Capacities

4-302.12B ** Priority 2 **

MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.

THERMOMETER ON SITE DOES NOT HAVE A SMALL DIAMETER PROBE. PROVIDE AND USE FOR ACCURATE TEMPERATURE TESTING OF THIN FOODS.

Comply By: 05/09/22

4-300 Equipment Numbers and Capacities

4-302.14 ** Priority 2 **

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

NO SANITIZER TEST KITS ON SITE. PROVIDE AND USE FREQUENTLY TO ENSURE SANITIZER CONCENTRATIONS ARE WITHIN REQUIRED RANGE (50-100PPM FOR CHLORINE BLEACH FOR FOOD CONTACT SURFACES).

Comply By: 05/09/22

5-200A Plumbing: approved materials/design

5-203.11A ** Priority 2 **

MN Rule 4626.1070A Provide at least 1 handwashing sink, or the number of handwashing sinks necessary to allow for the convenient use by employees during food preparation, food dispensing, and warewashing; and in or adjacent to toilet rooms.

KITCHEN HAS A 2-BASIN SINK. ONE BASIN MUST BE DESIGNATED AS THE HANDWASHING SINK AND USED ONLY FOR HANDWASHING PURPOSES.

Comply By: 05/09/22

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

NO STATE CERTIFIED FOOD PROTECTION MANAGER. EMPLOYEE HAS TAKEN AN APPROVED FOOD SAFETY COURSE BUT HAS NOT APPLIED WITH THE STATE FOR STATE CERTIFICATION. APPLICATION WAS EMAILED TO ESTABLISHMENT.

Comply By: 05/09/22

4-500 Equipment Maintenance and Operation

4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

HOT WATER SANITIZING DISH MACHINE WAS UNABLE TO REACH A UTENSIL SURFACE TEMPERATURE OF AT LEAST 160*F FOR REQUIRED SANITIZING. HAVE UNIT REPAIRED/ADJUSTED.

Comply By: 05/10/22

6-300 Physical Facility Numbers and Capacities

6-301.14A

MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands

NO HANDWASHING SIGN OR POSTER AT KITCHEN HAND SINK. PROVIDE AND MAINTAIN AT ALL HANDWASHING SINKS USED BY EMPLOYEES THAT HANDLE FOOD (INCLUDING HANDWASHING SINK IN RESTROOMS).

Comply By: 05/09/22

Surface and Equipment Sanitizers

Utensil Surface Temp.: = at 121 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: Yes

Food and Equipment Temperatures

Process/Item: MILK
Temperature: 41 Degrees Fahrenheit - Location: REFIGERATOR
Violation Issued: No

Process/Item: HEAVY CREAM
Temperature: 40 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: No

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

INSPECTION WAS CONDUCTED BY MOLLY DOUGHERTY (FPLS) IN CONJUNCTION WITH A HEALTH REGULATIONS DIVISION (HRD) SURVEY CONDUCTED BY SHANNAN STOLTZ.

DISCUSSED:
-EMPLOYEE ILLNESS POLICY AND LOG
-HANDWASHING
-PREVENTING BAREHAND CONTACT
-SANITIZER USE AND TEST KITS
-CLEANING/SANITIZING FOOD CONTACT SURFACES AND UTENSILS
-DISH MACHINE SANITIZING TEMPERATURE VERIFICATION
-DATE MARKING PROCEDURES
-THERMOMETER USE AND CALIBRATION
-SERVING A HIGHLY SUSCEPTIBLE POPULATION (NO RAW/UNDERCOOKED ANIMAL FOODS, NO UNPASTEURIZED JUICE, MILK, ETC)
-VOMIT/FECAL INCIDENT CLEAN UP PROCEDURES
-FOOD SOURCE
-RECEIVING DELIVERIES PROCEDURES
-FOOD SERVICE PROCEDURES (SAME DAY PREPARE AND SERVE)
-PEST CONTROL
-PHYSICAL FACILITIES AND MAINTENANCE

*FLOORS ARE VINYL AND CEILING IS TEXTURED. COUNTERTOPS ARE STONE AND CABINETS ARE HALLOW BASE 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.

*IF ANY RESIDENT COMPLAINS OF ILLNESS, CONTACT THE MINNESOTA DEPARTMENT OF HEALTH AND PROVIDE THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER TO THE RESIDENT, OR CALL ON THEIR BEHALF. THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER IS 1-877-366-3455.

*REPORT WAS DISCUSSED WITH THE HOUSE MANAGER, MULTIPLE EMPLOYEES ON SITE, AND WITH THE NURSE EVALUATOR, SHANNAN.

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 1004221115 of 05/09/22.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Signed:_____
DASON MATTHIESON
ULP MORNING LEAD

Signed: Molly Dougherty
Molly Dougherty
Public Health Sanitarian
Metro District Office
651-201-3978
molly.dougherty@state.mn.us