



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

July 21, 2025

Licensee

Divine Mercy Homes LLC

6325 Xerxes Avenue North

Brooklyn Center, MN 55430

RE: Project Number(s) SL37828016

Dear Licensee:

On May 22, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on February 20, 2025. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink that reads 'Casey DeVries'.

Casey DeVries, Supervisor

State Evaluation Team

Email: casey.devries@state.mn.us

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

JMD



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

March 12, 2025

Licensee

Divine Mercy Homes LLC
6325 Xerxes Avenue North
Brooklyn Center, MN 55430

RE: Project Number(s) SL37828016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on February 20, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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 . . ."

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 may be 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.

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

St - 0 - 0470 - 144g.41 Subdivision 1 - Minimum Requirements - \$3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$3,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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>

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

To submit a hearing request, please visit:

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

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. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at

Divine Mercy Homes LLC

March 12, 2025

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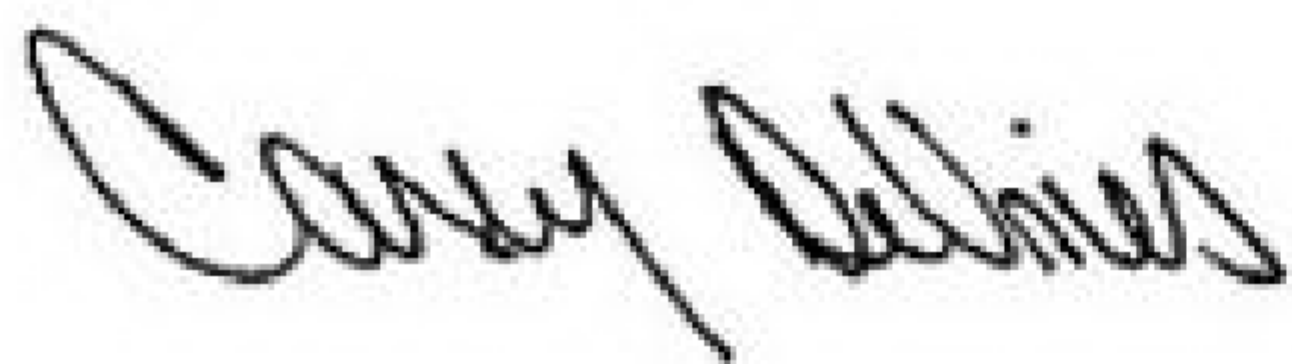
the website listed above.

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,

A handwritten signature in black ink that reads "Casey DeVries". The signature is written in a cursive, flowing style.

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: 37828	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/20/2025
NAME OF PROVIDER OR SUPPLIER DIVINE MERCY HOMES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 6325 XERXES 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 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: SL37828016-0 On February 18, 2025, through February 20, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were four residents all of whom received services under the Assisted Living Facility license. An immediate order for correction was identified on February 20, 2025, for SL37828016-0, tag identification 0470. During the survey, the licensee took action to mitigate the immediate risk. However, noncompliance remained, and the scope and level remain unchanged.	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.		
0 470 SS=I	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	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 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 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 ensure they always had sufficient staffing 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 for one of one resident (R3), who required two-person transfers with a mechanical lift.	0 470			

Minnesota Department of Health

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0 470	Continued From page 2 This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R3 was admitted to licensee for assisted living services on April 7, 2022. R3's diagnoses included type II diabetes mellitus without complication, hypertension, and history of transient ischemic attack (stroke). R3's Service Plan dated November 25, 2022, indicated R3 received the following services: hands on assistance with transfers and mobility, medication administration, assistance with bathing, prepare modified diets, assistance with eating, laundry, housekeeping and linen change, and treatments and exercises. R3's 90-day Assessment dated February 7, 2025, indicated R3 was bed and wheelchair bound, needed help to be turned and repositioned, and always needed assist of two for all cares and for Hoyer lift transfers (type of mechanical lift, a device designed to assist caregivers in safely transferring patients or individuals with limited mobility). The licensee's Facility Staffing Plan dated December 20, 2024, indicated staffing requirements for each shift Sunday through Saturday: day shift 7:00 a.m. - 3:00 p.m., two	0 470			

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0 470	Continued From page 3 unlicensed staff required, evening shift 3:00 p.m. - 11:00 p.m., two unlicensed staff required, and night shift 11:00 p.m. - 7:00 a.m., one staff required. The licensee's posted staff schedule dated February 15, 2025, through March 14, 2025, indicated two staff were available for morning shift, two staff were available for evening shift, and one staff was available for night shift. On February 19, 2025, at 2:35 p.m., the surveyor requested how the resident was transferred at night and in case of an emergency. Clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated R3 had never called for assistance at night and in the event of an emergency, the staff would call paramedics. When the surveyor asked if they would be calling paramedics to assist for other cares, CNS/LALD-A stated that was their only option. Minnesota Administrative Rule 4659.0180, Subpart 5 dated August 11, 2021, indicated "A minimum of two direct-care staff must be scheduled and available to assist at all times whenever a resident requires the assistance of two direct-care staff for scheduled reasonably foreseeable and unscheduled needs, as reflected in the resident's assessments and service plan." Although the licensee asserted to the surveyor they had policies on mechanical lift transfer, the licensee was unable to locate or produce the policies for the surveyor to review at the time the immediate order for correction was issued on February 20, 2025, at approximately 12:00 p.m. No further information was provided.	0 470			

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0 470	Continued From page 4 TIME PERIOD FOR CORRECTION: Immediate	0 470			
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.	0 680			

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0 680	Continued From page 5 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's emergency disaster preparedness plan dated December 1, 2023, lacked evidence of the following required content: - hazard vulnerability risk assessment not completed; - EPP program patient population; - process for EPP collaboration; - subsistence needs for staff and residents including sewage and waste disposal; - policies and procedures for evacuation including transportation; - procedures for tracking of staff and patients; - policies and procedures for sheltering; - policies and procedures for medical documents; - policies and procedures for volunteers; - arrangement with other facilities; - roles under a waiver declared by secretary; - development of communication plan; - names and contact information; - emergency officials contact information. - methods for sharing information; - sharing information on occupancy/needs; and - LTC family notifications. On February 18, 2025, at 10:36 a.m., the surveyor showed clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A a blank hazard vulnerability	0 680			

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0 680	Continued From page 6 assessment. CNS-LALD-A stated the licensee had not completed one. CNS/LALD-A stated during an emergency, employees would utilize their personal vehicle to transport residents; however, the EPP lacked this information. CNS/LALD-A stated the licensee was working on transitioning the EPP into RTasks (a documenting software program) which contained more information than the current EPP; however, what was provided was what the licensee currently had. The licensee's Disaster Planning and Emergency Preparedness policy dated January 26, 2022, indicated the licensee would develop a written emergency disaster plan that included a detailed strategy for evacuation, address all elements during a disaster or emergency. This plan would incorporate all the necessary elements outline in Appendix Z. 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 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 not including crawl spaces and unoccupied attics;	0 780			

Minnesota Department of Health

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0 780	Continued From page 7 (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 provide interconnected smoke alarms. 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 February 19, 2025, at approximately 9:00 a.m., the surveyor toured the facility with clinical nurse supervisor/licensed assisted living director (CNS-LALD)-A. During the tour, the surveyor observed the smoke alarms were tested for interconnection by the licensee, the dwelling unit	0 780			

Minnesota Department of Health

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0 780	Continued From page 8 smoke alarms were not interconnected as required by state statute. During the facility tour interview on February 19, 2025, CNS-LALD-A acknowledged the observation while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780			
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 Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the portable fire extinguishers. 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) 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	0 790			

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0 790	Continued From page 9 of the residents). The findings include: On February 19, 2025, at approximately 9:00 a.m., the surveyor toured the facility with clinical nurse supervisor/licensed assisted living director (CNS-LALD)-A. The portable fire extinguishers throughout the facility lacked records to show monthly visual inspections were complete. On February 19, 2025, the surveyor explained to CNS-LALD-A that the portable fire extinguishers must be provided annual certification tags and also monthly visual inspections or "quick checks" of each extinguisher by their employees to ensure all portable extinguishers are readily available, fully charged, and operable at their designated location with no obvious physical damage or condition to the extinguisher that would prevent their operation when needed. CNS-LALD-A stated they understood the requirements. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790			
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.	0 800			

Minnesota Department of Health

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0 800	Continued From page 10 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On February 19, 2025, at approximately 9:00 a.m., the surveyor toured the facility with clinical nurse supervisor/licensed assisted living director (CNS-LALD)-A. The following was observed. GENERAL MAINTENANCE: The water closet in lower-level bathroom had caulking that was peeling, missing, and was not properly sealed to the floor allowing the potential of water damage and unsanitary conditions. The lower-level bathroom sink had caulking that was peeling, missing, and was not properly sealed to the floor allowing the potential of water damage and unsanitary conditions. On February 19, 2025, at 10:30 a.m.,	0 800			

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER DIVINE MERCY HOMES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 6325 XERXES 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 11 CNS-LALD-A stated they understood the above-listed deficiencies. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800			
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.	0 810			

Minnesota Department of Health

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0 810	Continued From page 12 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. 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 February 19, 2025, at approximately 10:30 a.m., the surveyor observed the bedroom identification did not match the exit plan diagrams outlined in the FSEP. The exit plan diagrams must be correctly labeled to reduce confusion in a fire or similar emergency. On February 19, 2025, clinical nurse supervisor/licensed assisted living director (CNS-LALD)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP, failed to include the following:	0 810			

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0 810	Continued From page 13 The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine and Extinguish or Evacuate) but failed to include procedures for how staff are to complete each step. 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. On February 19, 2025, CNS-LALD-A stated they understood the areas of their policy that were incomplete and would work on bringing them into compliance. TIME PERIOD FOR CORRECTION: Seven (7) days	0 810			
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name	0 910			

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0 910	Continued From page 14 and the health facility identification of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for one of one resident (R1). 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). The findings include: R1 was admitted to the licensee on December 4, 2023, and received assisted living services. R1's Housing with Service Lease/Contract signed on December 4, 2023, lacked the following required content: - in a conspicuous place and manner on the contract the Health Facility Identification number (HFID#) of the facility. On February 19, 2025, at 11:40 a.m., clinical	0 910			

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0 910	Continued From page 15 nurse supervisor/licensed assisted living director (CNS/LALD)-A stated the licensee was not aware of the HFID# requirement. CNS/LALD-A further stated that all the licensee's resident contracts would be missing the HFID#. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 910			
0 950 SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding	0 950			

Minnesota Department of Health

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0 950	Continued From page 16 subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to offer the opportunity to identify a designated representative for one of one resident (R1). 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 potential to affect a large portion or all the residents). The findings include: R1 was admitted to the licensee on December 4, 2023, and received assisted living services. R1's Housing with Service Lease/Contract signed on December 4, 2023, lacked the opportunity to designate a representative and the verbatim "right to designate a representative for certain purposes" notice. On February 18, 2025, at 11:40 a.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated the licensee was not aware of the designated representative notice and that none of the residents would have the notice in their contracts. No further information was provided.	0 950			

Minnesota Department of Health

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0 950	Continued From page 17	0 950			
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	01060			

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01060	Continued From page 18 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation to the resident, legal representative, or designated representative and failed to provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC) of the emergency relocation greater than four days for one of one resident (R3). 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). The findings include: R3 was admitted to the licensee and began to receive assisted living services on April 7, 2022. R3's Service Plan dated November 25, 2022, indicated R3 received the following services: hands on assistance with transfers and mobility, medication administration, assistance with	01060			

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01060	Continued From page 19 bathing, prepare modified diets, assistance with eating, laundry, housekeeping and linen change, and treatments and exercises. R3's After Visit Summary notes printed on January 24, 2025, indicated R3 was in hospital from January 13, 2025, through January 24, 2025. R3's record lacked evidence a written notice, with the required statutory content, was provided to resident, or resident representative. On February 19, 2025, at 10:45 a.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated the licensee was not aware of the requirement. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060			
01970 SS=F	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to ensure there was a signed	01970			

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01970	Continued From page 20 prescriber's order for treatments for one of one resident (R3) who received blood glucose monitoring. 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). The findings include: R3's diagnoses included type II diabetes mellitus without complication, hypertension, and history of transient ischemic attack (stroke). R3's Service Plan dated November 25, 2022, indicated R3 received the following services: hands on assistance with transfers and mobility, medication administration, assistance with bathing, prepare modified diets, assistance with eating, laundry, housekeeping and linen change, and treatments and exercises. On February 19, 2025, at 8:05 a.m., the surveyor observed unlicensed personnel (ULP)-B perform blood glucose monitoring for R3. R3's unsigned Provider Orders printed February 19, 2025, indicated check blood glucose and record, notify registered nurse (RN) if blood glucose less than 70 milligrams/deciliter (mg/dL) or greater than 300 mg/dL. R3's Vital Signs - One Resident blood glucose log dated between February 1, 2025, and February 19, 2025, indicated R3's blood glucose ranges	01970			

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01970	Continued From page 21 between 79 mg/dL and 90 mg/dL. On February 20, 2025, at 1:45 p.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated they had sent the orders to be signed but they had not received them back. The surveyor requested for the licensee's fax correspondence with the provider, but none was provided. CNS/LALD-A also stated they had called the clinic several times but still had not received the orders. The licensee's Medication & Treatment Orders - Renewal policy dated January 26, 2022, indicated all orders must be current and consistent with the nursing assessment. Also, the policy indicated treatment orders must be renewed at least every 12 months or more frequently as required. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970			



Minnesota Department of Health

3333 Division St #212
St. Cloud
320 223-7300

Type: Full
Date: 02/18/25
Time: 10:30:00
Report: 1051251039

Food and Beverage Establishment Inspection Report

Page 1

Location:

Divine Mercy Homes LLC
6325 Xerxes Ave North
Brooklyn Center, MN55430
Hennepin County, 27

Establishment Info:

ID #: 0040868
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/22

Operator:

Phone #:
ID #:

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

No NEW orders were issued during this inspection.

Food and Equipment Temperatures

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

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

MET WITH NURSE EVALUATOR, BENARD NYANGENA.

DISCUSSED THE FOLLOWING WITH THE MANAGER, PATRICIA:

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

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

Type: Full
Date: 02/18/25
Time: 10:30:00
Report: 1051251039
Divine Mercy Homes LLC

Food and Beverage Establishment Inspection Report

Page 2

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 1051251039 of 02/18/25.

Certified Food Protection Manager Patricia C. Amajuoyi

Certification Number: FM108723 Expires: 12/05/27

Inspection report reviewed with person in charge and emailed.

Signed: _____

Patricia C. Amajuoyi
Manager

Signed: 

Kai Yang
Public Health Sanitarian 1
St. Cloud
320 640-3532
Kai.Yang@state.mn.us