Electronically Delivered

November 14, 2024

Licensee
Hopeville Homes
4925 78th Lane North
Brooklyn Park, MN 55443

RE: Project Number(s) SL36709015

Dear Licensee:

On October 15, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the August 22, 2024, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Tim Hanna, Supervisor
State Engineering Services Section
Email: Tim.Hanna@state.mn.us
Telephone: 507-208-8982 Fax: 1-866-890-9290

HHH

Electronically Delivered

August 26, 2024

Licensee
Hopeville Homes
4925 78th Lane North
Brooklyn Park, MN 55443

RE: Project Number(s) SL36709015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 30, 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.

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.

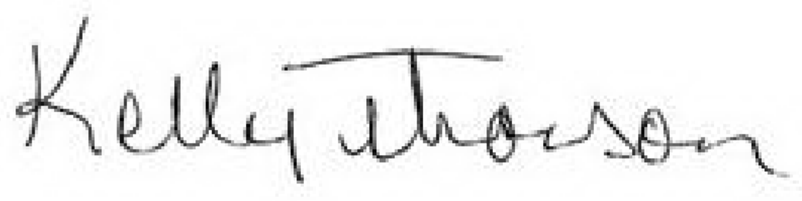
To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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,



Kelly Thorson, Supervisor
State Evaluation Team
Email: Kelly.Thorson@state.mn.us
Telephone: 320-223-7336 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36709	A. BUILDING: _____ B. WING _____	07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPEVILLE HOMES	4925 78TH LANE NORTH BROOKLYN PARK, MN 55443

(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: SL36709015-0 On July 29, 2024, through, July 31, 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 4 resident(s); 4 receiving services under the provider's Assisted Living Facility license. An immediate correction order was identified on July 30, 2024, issued for SL36709015-0, tag identification 0820. At the time of survey exit on July 31, 2024, immediacy remained for immediate correction order 0820. On August 1, 2024, the immediacy of correction order 0820 was removed, however non-compliance remained at an scope and level	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.	

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0 000	Continued From page 1 of G. Surveyor: Spielman, Andrew W.	0 000		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	0 480		

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0 480	Continued From page 2 or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated July 29, 2024 for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 660 SS=D	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 tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which	0 660		

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0 660	Continued From page 3 includes baseline testing for one of two employees unlicensed personnel (ULP)-D. 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). Findings include: The facility TB risk assessment was completed March 13, 2024, and indicated the facility was at a low risk for TB transmission. ULP-D was hired September 29, 2021, to provide direct care services to residents. ULP-D's employee record lacked documentation ULP-D completed a two-step TST or other blood test completed by the licensee upon hire. ULP-D's record included TB Testing Documentation - one step Mantoux dated October 13, 2021, and reading on October 16, 2021, with negative result. ULP-D's record lacked the second step Mantoux with reading. On July 31, 2024, licensed assisted living director (LALD)-A stated the first step TB test was the only one in ULP-D's record and they did not have evidence of a second step. The Minnesota Department of Health's Assisted Living Resources & Frequently Asked Questions (FAQs) dated August 7, 2023, indicated baseline	0 660		

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0 660	Continued From page 4 TB screening includes: - assess for current symptoms of active TB disease; - assess TB history; and - test for the presence of Mycobacterium tuberculosis by administering either a two-step tuberculin skin test (TST) or single TB blood test. A test should be dated with 90 days of hiring is acceptable. The licensee's Tuberculosis Screening/Prevention policy dated August 1, 2021, indicated the Centers for Disease Control (CDC) guidelines (2019) for preventing Mycobacterium tuberculosis transmission in health care settings include the following recommendations: 1) TB screening with an individual risk assessment and symptom evaluation at baseline (preplacement); 2) TB testing with an interferon-gamma release assay (IGRA) or a tuberculin skin test (TST) for persons without documented prior TB disease or latent TB infection (LTBI); 3) no routine serial TB testing at any interval after baseline in the absence of a 1--known exposure or ongoing transmission; 4) encouragement of treatment for all health care personnel with untreated L TBI, unless treatment is contraindicated; 5) annual symptom screening for health care personnel with untreated L TBI; and 6) annual TB education of all health care personnel. Baseline testing completed on hire for all direct care providers and anyone who visited residents (including volunteers). No further information provided.	0 660		

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0 660	Continued From page 5 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
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 develop a written emergency preparedness (EP) plan with all the required content. This had the potential to affect all residents, employees, and visitors to the facility.	0 680		

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0 680	Continued From page 6 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: The licensee's emergency preparedness plan (EPP) lacked the required content: - annual review; - develop and maintain the EPP; - missing resident quarterly review; - description of the population served by licensee; - a process for emergency preparedness (EP) collaboration with state and local EP officials/organizations; - the development of policies/procedures to address: - subsistence needs for staff and residents; - procedures for tracking staff and residents; - procedures for medical documents; - use of volunteers; and - roles under a waiver declared by Secretary. - names and contact information for staff, entities providing services, resident physicians, other facilities, and volunteers; - methods for sharing medical documentation for residents under the facility's care, as necessary, with other health care providers to maintain continuity of care; - means to providing information about the facility's occupancy, needs, and it's ability to provide assistance, to the authority having jurisdiction, the incident command center, or designee;	0 680		

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0 680	Continued From page 7 - develop and maintain EP training and testing program; and - must conduct exercises to test the EP at least twice per year, including unannounced staff drills using the EP. On July 29, 2024, licensed assisted living director (LALD)-A stated he agreed that the EPP did not have an annual review, the missing person policy had not been reviewed quarterly, and the EPP was missing some of the required content due to being unaware. The licensee's Emergency Preparedness policy dated August 1, 2021, indicated the facility will have 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. The emergency preparedness plan/program will be reviewed/updated at least annually. The licensee's Missing Resident policy dated August 1, 2021, indicated the missing resident procedure will be reviewed by the Director and Clinical Nurse Supervisor at least quarterly. Per Assisted Living Facilities: Minnesota Rules Chapter 4659, 4659.0110, Subp. 4. Review missing resident plan. The assisted living director and clinical nurse supervisor must review the missing person plan at least quarterly and document any changes to the plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		

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0 800	Continued From page 8	0 800		
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 facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: During facility tour on July 30, 2024, from 11:00 a.m. through 11:45 a.m., with licensed assisted living director, (LALD)-A the surveyor made the following observations: The door into resident room 2 was damaged and had holes in it.	0 800		

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0 800	Continued From page 9 The floor outside resident room 2 had cracked and damaged flooring and there was a hump in the floor. LALD-A stated the floor was damaged from a wheelchair. The surveyor explained that the cracked flooring and hump could create a trip hazard. The wall across the hall from resident room 2 had a metal kick plate at the bottom of the wall. The kick plate was loose along the top edge. LALD-A stated the kick plate was installed because a wheelchair was damaging the drywall. The surveyor explained that the kick plate must be fastened in place to prevent loose, sharp edges. The light in the basement laundry room had a broken fixture, exposing the electrical wires and connections. Electrical components must be covered and concealed to prevent fire and electric shock. There was paint peeling above the sink in the basement bathroom. Peeling paint could be a sign of water damage or excess humidity. LALD-A visually verified these deficient findings at the time of discovery. 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	0 810		

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0 810	Continued From page 10 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 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. 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	0 810		

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0 810	Continued From page 11 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: During facility tour on July 30, 2024, from 11:00 a.m. through 11:45 a.m., with licensed assisted living director, (LALD)-A the surveyor observed the evacuation diagram posted in the basement of the facility showed the layout of the main floor. Each floor of a facility must have an evacuation diagram that shows evacuation routes for the floor level it is posted in. During same tour the surveyor observed the evacuation diagram posted on the main floor did not show the location and number of sleeping rooms. The diagram had room names listed but did not show walls, room numbers or evacuation routes accurate to the building layout. The evacuation diagram showed an emergency exit at the door leading from the facility into the attached garage. Emergency exits cannot lead through a higher hazard area. On July 30, 2024, at 12:20 p.m. LALD-A provided documentation 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 and Evacuation Plan", revised 4/8/2024 failed to include the following:	0 810		

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0 810	Continued From page 12 The FSEP did not include an evacuation map with a floor plan accurate to the building layout that showed the location and number of resident sleeping rooms. There was no evacuation map included in the FSEP. During interview on July 30, 2024, at 12:35 p.m., LALD-A stated they would update the diagram, post one on each level of the facility and insert one in the FSEP. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 820 SS=G	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide facilities that were not a distinct hazard to life. This had the potential to directly affect a limited number of residents and staff.	0 820	This immediate correction order identified on July 30, 2024, has had the immediacy lifted as of August 1, 2024, however non-compliance remained a scope and level of G.	

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	36709	A. BUILDING: _____ B. WING _____	07/30/2024

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0 820	Continued From page 13 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 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: During facility tour on July 30, 2024, from 11:00 a.m. through 11:45 a.m. with licensed assisted living director (LALD)-A, it was observed that compliant emergency escape and rescue openings were not provided in resident sleeping room 2. Occupied Resident Rooms Resident sleeping room 2, located on the main floor, occupied by R1, emergency escape and rescue clear window opening measurements are 17 inches wide, 39 inches in height and 663 square inches in openable area. LALD-A opened the window and it was measured with LALD-A, and the surveyor. The window did not meet the minimum requirements for clear opening width. TIME PERIOD FOR CORRECTION: Immediate.	0 820		
01500 SS=F	144G.63 Subd. 5 Required annual training (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	01500		

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01500	Continued From page 14 provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must 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	01500		

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01500	Continued From page 15 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 observation, interview, and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment for two of two employees (housing manger (HM)-C and unlicensed personnel (ULP)-D). 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: HM-C HM-C was hired on October 18, 2021, to provide direct care services to residents. On July 31, 2024, at 8:15 a.m., the surveyor observed HM-C administer R2's medications.	01500		

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01500	Continued From page 16 HM-C's record lacked documentation of annual training to include: - Review of provider's policies and procedures. ULP-D ULP-D was hired on September 29, 2021, to provide direct care services to residents. ULP-D's record lacked documentation of annual training to include: - Review of provider's policies and procedures; and - Assisted Living Bill of Rights. On July 31, 2024, at 9:45 a.m., licensed assisted living director (LALD)-A stated they did not have evidence of the review of the policies and procedures for any of the staff's annual training. LALD-A stated ULP-D's record was also missing evidence of missing the Assisted Living Bill of Rights. The licensee's Staff Orientation and Education policy dated August 1, 2021, indicated all staff providing assisted living services will complete at least eight (8) hours of education for every twelve (12) months of employment. Education topics will include, but not be limited to, the following: - Review of the organizations policies and procedures related to provision of assisted living services and how to implement them; and - Review of Assisted Living Bill of Rights and staff responsibilities related to ensuring the exercise and protection of those rights. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		

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01530	Continued From page 17	01530		
01530 SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure all direct care staff received at least eight hours of initial dementia care training within the first 160 working hours of employment for direct care employees as required for two of two employees (housing manager (HM)-C and unlicensed personnel	01530		

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01530	Continued From page 18 (ULP)-D). 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: HM-C HM-C was hired on October 18, 2021, to provide direct care services to residents. On July 31, 2024, at 8:15 a.m., the surveyor observed HM-C administer R2's medications. HM-C's employee record indicated HM-C completed 7.00 hours of dementia training, thus did not contain documentation HM-C completed the initial eight hours of training required related to dementia care, within 160 working hours of HM-C's employment start date. ULP-D ULP-D was hired on September 29, 2021, to provide direct care services to residents. ULP-D's employee record indicated ULP-D completed 0.75 hours of dementia training, thus did not contain documentation ULP-D completed the initial eight hours of training required related to dementia care, within 160 working hours of ULP-D's employment start date. On July 31, 2024, at 9:50 a.m., licensed assisted living director (LALD)-A, confirmed HM-C's record	01530		

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01530	Continued From page 19 only indicated 7 hours of dementia training for orientation and it must have been an oversight when assigning the classes. On July 31, 2024, at 10:10 a.m., clinical nurse supervisor (CNS)-B confirmed ULP-D's record only indicated 0.75 hours of dementia training for orientation and the classes must not have been assigned correctly upon hire. The licensee's Dementia Education policy, dated August 1, 2021, indicated direct care employees must have completed at least eight (8) hours of initial education within 160 working hours of the employment start date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01530		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration;	01940		

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01940	Continued From page 20 (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of one resident (R1). 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: R1 was admitted to the licensee on July 29, 2021, and began receiving assisted living services on August 1, 2021.	01940		

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01940	Continued From page 21 R1's diagnoses included cerebral palsy, epilepsy, anxiety, depression, and moderate intellectual disorder. R1's Service Plan dated May 24, 2024, indicated R1 received services to include dressing assistance, bathing assistance, drinking assistance, mobility assistance, grooming, hearing aids, housekeeping, laundry, meal reminder, medication administration, reposition, toileting, and transfer assistance. R1's Master Care Plan dated May 24, 2024, indicated R1 received assistance with mechanical altered diet and specialized dressing needs for brace. R1's Service Recap Summary dated July 2024, included meal assistance three times daily and dressing assistance twice daily. R1's Individualized Treatment or Therapy Management Plan, failed to include the following required content: - Documentation of specific resident instructions relating to the treatments or therapy administration; - Identification of treatment or therapy tasks that will be delegated to unlicensed personnel; and - Procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services. On July 31, 2024, at 8:00 a.m., the surveyor observed housing manager (HM)-C assist R1 with eating her modified diet and it was noted R1 was wearing her orthotic braces on both lower extremities.	01940		

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01940	Continued From page 22 On July 29, 2024, at 2:15 p.m., clinical nurse supervisor (CNS)-B stated R1's treatment plan for modified diet and orthotic braces was missing some of the required information but the staff have all been trained in these treatments for R1. The licensee's Treatment and Therapy Management policy dated August 1, 2021, indicated the registered nurse or licensed professional will prepare an individualized treatment or therapy management plan for each resident receiving ordered or prescribed treatments or therapy services, which addresses: - Type of services that will be provided; - Procedures for documenting treatments or therapies; - Procedures for monitoring treatments or therapies to prevent possible complications or adverse reactions; - Identification of treatment or therapy tasks delegated to unlicensed personnel; and - Procedures for notifying the RN or licensed health professional when a problem arises related to the treatment or therapy service. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01950 SS=F	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the	01950		

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01950	Continued From page 23 appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure training and competency was completed for two of two employees (housing manager (HM)-C and unlicensed personnel (ULP)-D) when providing assistance with orthotic lower leg braces. 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: HM-C HM-C was hired on October 18, 2021, to provide direct care services to residents. HM-C's record lacked documentation of competency evaluation to include:	01950		

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01950	Continued From page 24 -Orthotic braces. On July 31, 2024, at 8:00 a.m., the surveyor observed housing manager (HM)-C assist R1 with eating her modified diet and it was noted R1 was wearing her orthotic braces on both lower extremities. ULP-D ULP-D was hired on September 29, 2021, to provide direct care services to residents. ULP-D's record lacked documentation of competency evaluation to include: -Orthotic braces. On July 31, 2024, at 10:30 a.m., clinical nurse supervisor (CNS)-B confirmed the staff do not have evidence of competency evaluation for orthotic braces for R1, but they have all been trained on how to properly apply and remove the braces. The licensee's Delegation of Assisted Living Tasks dated August 1, 2021, indicated the clinician may delegate procedures according to the following: - The clinician instructed the home health aide in the proper methods to perform the procedure with respect to each resident; - The clinician provided the home healthy with written instructions specific to the resident; - The home health they demonstrated to the clinician competence in the procedure; - The procedure is documented in the resident's clinical record; and - The home health aides competence is documented in his/her personnel file. No further information was provided.	01950		

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01950	Continued From page 25 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01950		

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

Type: Full
Date: *07/29/24*
Time: 12:00:00
Report: 1005241165

Food and Beverage Establishment Inspection Report

Location:
Hopeville Homes
4925 78th Lane North
Brooklyn Park, MN55443
Hennepin County, 27

Establishment Info:
ID #: 0038557
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7638438850
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.

3-500B Microbial Control: hot and cold holding

3-501.16A2 ***** Priority 1 *****

MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

TCS FOODS IN THE DRAWERS OF THE KITCHEN REFRIGERATOR WERE ABOVE 41 DEGREES F. FRIDGE WAS ADJUSTED TO A COLDER SETTING. ALSO RECOMMEND REARRANGING FRIDGE TO KEEP NON-TCS FOODS (SUCH AS BREAD AND PRODUCE) IN DRAWERS.

Comply By: 07/29/24

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.

NO FOOD THERMOMETER COULD BE LOCATED DURING INSPECTION. CEO LATER EMAILED A PICTURE TO INSPECTOR SHOWING THAT A THERMOMETER IS NOW ON SITE.

Comply By: 07/29/24

4-300 Equipment Numbers and Capacities

4-302.13B ***** Priority 2 *****

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

THERE WAS NO DEVICE ON SITE TO MEASURE THE UTENSIL SURFACE TEMPERATURE IN THE DISHWASHER. PROVIDE TEMPERATURE STRIPS OR A MAXIMUM REGISTERING THERMOMETER TO VERIFY THAT THE UTENSIL SURFACE TEMPERATURE IS 160 DEGREES F OR ABOVE.

Comply By: 08/05/24

Surface and Equipment Sanitizers

Utensil Surface Temp.: = at 160+ Degrees Fahrenheit
Location: DISHWASHER
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Hold/MILK
Temperature: 41 Degrees Fahrenheit - Location: KITCHEN REFRIGERATOR - TOP SHELF
Violation Issued: No

Process/Item: Cold Hold/SAUSAGE
Temperature: 44 Degrees Fahrenheit - Location: KITCHEN REFRIGERATOR - DRAWER
Violation Issued: Yes

Process/Item: Cold Hold/CHEESE
Temperature: 43 Degrees Fahrenheit - Location: KITCHEN REFRIGERATOR - DRAWER
Violation Issued: Yes

Process/Item: Cold Hold/AMBIENT
Temperature: <37 Degrees Fahrenheit - Location: GARAGE REFRIGERATOR
Violation Issued: No

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

INSPECTION COMPLETED WITH CEO AND REVIEWED WITH HRD NURSE EVALUATOR, SARABETH REMKER.

INSPECTOR LEFT THERMOLABELS ON SITE AND AFTER INSPECTION OPERATOR SENT INSPECTOR A PICTURE OF THE TEMPERATURE STRIP THEY RAN THROUGH THEIR DISHWASHER, WHICH SHOWED IT PROVIDED A UTENSIL SURFACE TEMPERATURE OF 160+ DEGREES F.

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

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

FLOORING IS LAMINATE, CABINETS ARE WOOD WITH HOLLOW BASE, AND CEILING HAS A POPCORN FINISH. 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.

Type: Full
Date: *07/29/24*
Time: 12:00:00
Report: 1005241165
Hopeville Homes

Food and Beverage Establishment Inspection Report

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 1005241165 of 07/29/24.

Certified Food Protection Manager: DEAREST BADIO

Certification Number: FM122198 Expires: 01/21/27

Inspection report reviewed with person in charge and emailed.

Signed: _____
CARLOS SMITH
CEO

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