DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

June 9, 2025

Licensee
Cardenas Friendship Homes
3608 West 84th Street
Bloomington, MN 55431

RE: Project Number(s) SL20981016

Dear Licensee:

On April 30, 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 11, 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,

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

JMD

Electronically Delivered

March 11, 2025

Licensee
Cardenas Friendship Homes
3608 West 84th Street
Bloomington, MN 55431

RE: Project Number(s) SL20981016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on February 11, 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 - 0780 - 144g.45 Subd. 2 (a) (1) - Fire Protection And Physical Environment - $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

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,

Renee L. Anderson

Renee L. Anderson, Supervisor
State Evaluation Team
Email: Renee.L.Anderson@state.mn.us
Telephone: 651-201-5871 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
	20981	A. BUILDING: _____ B. WING _____	02/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDENAS FRIENDSHIP HOMES	3608 WEST 84TH STREET BLOOMINGTON, MN 55431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments 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: SL20981016-0 On February 10, 2025, through February 11, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were four residents; four receiving services under the Assisted Living Facility license. An immediate correction order was identified on February 11, 2025, issued for SL20981016-0, tag identification 0775. During the course of the survey, the licensee took action to mitigate the imminent risk for tag identification 0775. Noncompliance remained and the scope and level remain unchanged.	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 License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level pursuant to 144G.31 Subd. 1, 2 and 3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the	0 480		

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0 480	Continued From page 1 Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition;	0 480		

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0 480	Continued From page 2 (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. 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, 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: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated February 11, 2025, 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		

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0 580	Continued From page 3	0 580		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to engage in and maintain documentation of quality management activity. This had the potential to affect all four residents receiving assisted living services, and employees. 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 10, 2025, at 10:00 a.m., owner (O)-A stated the licensee's adminsitrative	0 580		

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0 580	Continued From page 4 employees discussed quality managment activities, but stated no current quality management activity was documented. The licensee's Quality Management Project policy, dated August 1, 2021, verified the licensee "will have at least one documented quality management project in place at all times, and retain records of such projects for at least two years." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 580		
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	0 680		

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0 680	Continued From page 5 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 have a written emergency preparedness (EP) plan with all the required content. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a 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 Assisted Living Emergency Preparedness Manual, dated August 1, 2021, lacked the following required content: -documentation of a facility risk assessment - EP policies/procedures review/updated annually; - role of the licensee under a waiver declared by the secretary in accordance with section 1135; - provision of subsistence needs for staff and residents to include (food, water, medical supplies, pharmacy supplies, sewer and waste disposal, emergency lighting, fire detection, extinguishing and alarm systems); -a written communication plan reviewed/updated	0 680		

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0 680	Continued From page 6 annually; -EP testing requirements including an annual full-scale exercise or individual facility-based functional exercise -must identify at risk population needs like maintaining independence, communication, transportation, supervision and medical care. On February 11, 2025, at 11:00 a.m., owner (O)-A verified the licensee will update and individualize the EP for each licensee housing with services site. The licensee's Disaster Planning and Emergency Preparedness policy, dated August 1, 2021, verified the licensee would 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 emergency. All of these elements are incorporated into the Appendix Z requirements." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 775 SS=I	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide resident sleeping rooms with	0 775	During the course of the survey, the licensee took action to mitigate the	

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0 775	Continued From page 7 egress windows in compliance with Minnesota State Fire Code under Minnesota Rules Chapter 7511. Egress windows in the facility failed to meet the minimum window opening requirement to comply with state standard for egress. This had the potential to affect some residents, staff, and visitors. 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: On February 10, 2025, from approximately 11:01 a.m. to 12:10 p.m., the surveyor toured the facility with licensed owner (O)-A. During the tour, the surveyor asked O-A to open the windows in the resident sleeping rooms for measurement and the surveyor measured the openable area of the windows. The noncompliant measurements were as follows: OCCUPIED SLEEPING ROOMS Resident sleeping room 2: One window measuring 16 inches clear width, 31 inches clear height, and 496 square inches total openable area. Resident sleeping room 3: One window measuring 26 inches clear width, 21 inches clear height, and 546 square inches total openable area. Resident sleeping room 4: One window	0 775	imminent risk. Noncompliance remained and the scope and level remain unchanged.	

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0 775	Continued From page 8 measuring 16 inches clear width, 31 inches clear height, and 496 square inches total openable area. Resident sleeping room 4 did also did not have a crank attached to window assembly at time of inspection, limiting the ability to readily open the window. Windows must be maintained readily openable. The windows in resident sleeping rooms 2, and 4 did not meet the minimum requirements for opening width. The windows in resident sleeping rooms 2, 3 and 4 did not meet the minimum requirements for total openable area. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. Surveyor explained to O-A that at least one window in each bedroom in a state-licensed facility must meet the minimum state fire code standard for an egress window to be a complying bedroom for resident occupancy. O-A stated that he had been unaware of the size requirements but confirmed understanding of the requirements stated by the surveyor during the survey and requirement to obtain any applicable permits for alterations. On February 10, 2025, the surveyor explained to O-A that an immediate correction order was issued for the above findings. O-A stated they understood the requirements for egress windows and would immediately start the process of getting the windows replaced. Furniture on the rear porch was stored such that	0 775		

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0 775	Continued From page 9 it impeding egress by obstructing doors leading out of the facility from kitchen area and resident room porch. Cigarettes were observed present on the rear porch area as well as on the carpeted front entry area to the facility. There were burn marks on the front entryway area near the improperly disposed of cigarettes. Cigarettes should be disposed of in approved receptacle. O-A confirmed the presence of the cigarette butts and discussed their possible interest in removing carpeting material from the front entry area. TIME PERIOD FOR CORRECTION: Immediate	0 775		
0 780 SS=I	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; (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;	0 780		

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0 780	Continued From page 10 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain required interconnection of smoke alarms. This had the potential to directly affect all residents, staff, and visitors. 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: On February 10, 2025, from approximately 11:01 a.m. to 12:10 p.m., the surveyor toured the facility with owner (O)-A. During the tour, the surveyor observed the following: During the survey the surveyor requested that O-A activate and test the smoke alarms throughout the facility. O-A initiated smoke alarm testing by pushing the test buttons on smoke alarms. O-A tested smoke alarms in resident room 3, resident room 4, and bedroom hallway. When the alarms were tested, no interconnection was observed and only the specific alarm tested sounded upon testing. Smoke alarms should be interconnected such that the activation of any alarm will trigger alarms throughout the facility to	0 780		

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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
0 780	Continued From page 11 sound. O-A confirmed that the smoke alarms were not properly interconnected at time of inspection. Provided smoke alarm near the rear exit was found to have been manufactured on May 29, 2008, according to manufacture information listed on the device. This alarm also did not contain batteries and was found to not be maintained in proper condition. Smoke alarms should be replaced when they exceed manufacturer expiration or replacement date. Smoke alarms should be regularly maintained, with batteries replaced as needed and smoke alarm devices replaced per manufacturer instructions. O-A indicated that the smoke alarm had not been consistently maintained. Hardwired smoke alarm should be replaced with another alarm maintaining the hardwired connection. Hardware for a hardwired smoke alarm was present in the basement without attached hardwired smoke alarm. Hardwired smoke alarms must be supplied and maintained. TIME PERIOD FOR CORRECTION: Two (2) 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	0 790		

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	20981	A. BUILDING: _____ B. WING _____	02/11/2025

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0 790	Continued From page 12 Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain supplied fire extinguishers. 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 the potential to affect a large portion or all of the residents). The findings include: On February 10, 2025, from approximately 11:01 a.m. to 12:10 p.m., the surveyor toured the facility with owner (O)-A. During the tour, the surveyor observed the following: The extinguishers on the main level and the basement were not properly maintained and serviced. The provided extinguisher on the main floor had a manufacture year of 2022 and did not have current annual service tags nor was a record available of monthly inspections by staff. The extinguisher provided in the basement was not properly mounted and had an attached annual service tag indicated it had last been serviced in 2020. Fire extinguishers must be maintained and either replaced or inspected and certified by licensed entity at least annually, and facility staff should preform and record monthly inspections of	0 790		

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0 790	Continued From page 13 the extinguishers to ensure upkeep. O-A acknowledged that required inspections had not been conducted. On February 10, 2025, the surveyor explained to O-A requirements and the findings related to fire extinguisher maintenance. O-A stated they understood the requirements for extinguishers and would have the extinguishers replaced or serviced. 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) 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	0 810		

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0 810	Continued From page 14 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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On February 10, 2025, at approximately 12:10 p.m., owner (O)-A provided documentation on the fire safety and evacuation plan (FSEP), fire safety, and evacuation training. The licensee's FSEP failed to include the following: The FSEP did not include documentation	0 810		

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0 810	Continued From page 15 including the locations and resident room numbers. The FSEP included Floor and Escape Plan which included drawn diagram of facility, but did not label room numbers appropriately. The FSEP did not include fire procedure documentation for residents. O-A stated that no written procedures for residents has been created for the facility, and that no procedures for resident evacuation are present in the FSEP. The FSEP did not include identification of unique resident needs for movement or evacuation. The FSEP must include information identifying unique or unusual resident needs for an evacuation. The FSEP did not include documentation of staff training on FSEP. O-A was unable to produce records of staff training on the FSEP. The licensee's Orientation Checklist dated October 15, 2024, indicated training would be provided upon hire and once a year thereafter. O-A indicated that they would provide documentation of staff training via email. Surveyor did not receive further information on staff training from O-A. The FSEP did not include documentation of sufficient staff fire drills. Fire Drill Tracking Tool for the year 2024 included records of a total of four drills that were conducted in 2024 at the facility. The recorded drills did not include specific times but occurred on 1/10/24 and 7/11/24 for the afternoon shift and 3/4/24 and 4/24/24 for the morning shift. The surveyor explained to O-A that evacuation drills are required at least twice per year per shift and at least once every other month. The recorded drills were insufficient to meet requirements. O-A represented that they	0 810		

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0 810	Continued From page 16 understood requirements for drills as explained by surveyor and would increase drills to comply moving forward. During interview on February 10, 2025, at 12:20 p.m., the surveyor explained the requirements for frequency of drills, resident training, employee training, and documentation. O-A stated they understood the requirements. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01060 SS=D	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	01060		

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01060	Continued From page 17 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not 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, and designated representative and failed to provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC) when the resident did not return from the emergency relocation after four (4) days for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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).	01060		

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01060	Continued From page 18 The findings include: R2 was admitted to the licensee on February 20, 2024, and received services to include medication administration. R2's record included the following progress notes by clinical nurse supervisor (CNS)-B: -February 5, 2025, at 11:15 a.m.: "Resident sent to the hospital this morning, Residents left cheek was swollen and urine was dark. Asked EMS [emergency medical services] to report to ER that resident be checked for a UTI [urinary tract infection] as well as what's going on with the swelling in face." -February 10, 2025, at 9:15 a.m.: "Spoke with nurse from FV southdale [Fairview Southdale] on Friday. Resident is needing one assist with a transfer belt and walker. Due to resident not a baseline TCU [transitional care unit] was suggested for resident. Waiting to hear back from hospital about TCU placement." -February 11, 2025, at 12:30 p.m.: "Resident is at [transitional care unit]. Placed call to SW [social worker] to get update. Waiting to hear back." On February 11, 2025, at 11:00 a.m., owner (O)-A stated that he was not sure if the emergency relocation was completed for R2, but will send today, if able to locate the documentation. The licensee's Emergency Relocation policy, dated July 25, 2022, verified the licensee will provide a written notice that contains, at a minimum: "the reason for the relocation; the name and contact information for the location to which the resident has been relocated and any new service provider; contact information for the Office of Ombudsman for Long-Term Care and	01060		

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01060	Continued From page 19 Office of Ombudsman for Mental Health and Developmental Disabilities; 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 a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01500 SS=D	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 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;	01500		

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01500	Continued From page 20 (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 challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received at least eight (8) hours of annual training for each 12 months of employment for two of two employees	01500		

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01500	Continued From page 21 (clinical nurse supervisor (CNS)-B, unlicensed personnel (ULP)-C). 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: CNS-B was hired July 3, 2023, and provided direct and supervisory cares for residents of the facility. ULP-C was hired November 1, 2022, and provided direct cares and services for residents of the facility. CNS-B and ULP-C's employee records lacked evidence of eight hours of annual training to include a review of the licensee's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures. On February 11, 2025, at 11:00 a.m., owner (O)-A stated the licensee did complete annual training for employees and would ensure the policies and procedures were included in the training. The licensee's Orientation & Training policy, dated August 1, 2021, verified the annual training would include a "review of the facility's policies and procedures relating to the provision of assisted living services and how to implement	01500		

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01500	Continued From page 22 those policies and procedures." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		

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

Type: Full
Date: *02/11/25*
Time: 11:15:00
Report: 1005251031

Food and Beverage Establishment Inspection Report

Location:
Cardenas Friendship House
3608 West 84th Street
Bloomington, MN55431
Hennepin County, 27

Establishment Info:
ID #: 0037566
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6126701380
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.

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.

THE TEMPERATURE TEST STRIPS ON SITE INDICATED A TEMPERATURE OF 180 DEGREES F. THE DISHWASHER NEEDS TO PROVIDE A MINIMUM UTENSIL SURFACE TEMPERATURE OF 160 DEGREES. PROVIDE TEST STRIPS FOR 160 DEGREES F, OR A MAXIMUM REGISTERING THERMOMETER.

Comply By: 02/18/25

4-200 Equipment Design and Construction

4-202.16

MN Rule 4626.0540 Provide non-food contact surfaces that are free of unnecessary ledges, projections and crevices and are designed and constructed to allow easy cleaning.

THE VENEER IS PEELING OFF OF MANY OF THE CABINET DOORS AND DRAWERS. REPAIR OR REPLACE TO PROVIDE SURFACES THAT ARE SMOOTH AND EASILY CLEANABLE.

Comply By: 08/11/25

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: 40 Degrees Fahrenheit - Location: KITCHEN REFRIGERATOR
Violation Issued: No

Process/Item: Cold Hold/DELI MEAT
Temperature: 41 Degrees Fahrenheit - Location: KITCHEN REFIRGERATOR
Violation Issued: No

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

INSPECTION COMPLETED WITH HOME HEALTH AIDE AND EMAILED TO HRD NURSING EVALUATOR JOLENE BERTELSEN.

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

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.

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

FLOORING IS LAMINATE, COUNTERS ARE LAMINATE, AND THE 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.

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 1005251031 of 02/11/25.

Certified Food Protection Manager: JESSE J. WOLF

Certification Number: FM105865 Expires: 04/10/27

Inspection report reviewed with person in charge and emailed.

Signed: _____
CRYSTAL SHARP
HOME HEALTH AIDE

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