Electronically Delivered

July 23, 2025

Licensee
Loving Touch Inc
5548 Girard Avenue North
Brooklyn Center, MN 55430

RE: Project Number(s) SL40771015

Dear Licensee:

This is your **official notice** that you have been **granted your assisted living facility license.** Your license effective and expiration dates remain the same as on your provisional license. Your updated status will be listed on the license certificate at renewal and **this letter serves as proof** in the meantime. If you have not received a letter from us with information regarding renewing your license within 60 days prior to your expiration date, please contact us at (651) 201-5273 or by email at Health.assistedliving@state.mn.us.

The Minnesota Department of Health completed an initial survey on May 21, 2025, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

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

STATE CORRECTION ORDERS

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

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

Per 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 residents/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS

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

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,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: Jess.Schoenecker@state.mn.us
Telephone: 651-201-3789 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
	40771	A. BUILDING: _____ B. WING _____	05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOVING TOUCH INC	5548 GIRARD AVE N BROOKLYN CENTER, MN 55430

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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: SL40771015-0 On May 19, 2025, through May 21, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were two (2) residents; 2 residents receiving services under the provisional Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 110 SS=C	144G.10 Subdivision 1a Assisted living director license required	0 110		

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0 110	Continued From page 1 Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the licensed assisted living director (LALD) was listed as the director of record for the licensee. This had the potential to affect all the licensee's residents, staff, and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: The licensee's Staff List indicated LALD-D was hired on May 22, 2024. On May 19, 2025, at 10:30 a.m., during the entrance conference, the surveyor asked if LALD-D was listed as the director of record (DOR) for this facility. The surveyor pulled up the Minnesota Board of Executives for Long-Term Services and Supports (BELTSS) website and searched LALD-D's name and was unable to locate the facility's health facility ID number (HFID) 40771 nor locate the current DOR for this facility. LALD-D explained she had been trying to get in contact with someone at BELTSS to add	0 110		

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0 110	Continued From page 2 herself but was unsuccessful. During facility tour on May 19, 2025, at 11:36 a.m., the surveyor observed LALD-G's DOR certificate, which was to expire October 31, 2025, posted near the dining room table. On May 20, 2025, at 3:15 p.m., unlicensed personnel (ULP)-C and LALD-D stated someone from BELTSS informed them LALD-D needed to apply for the shared DOR, so they added LALD-G as the DOR for this facility. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be:	0 470		

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0 470	Continued From page 3 (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to update their staffing plan at least twice annually, to meet the needs of all residents, potentially affecting all the licensee's current 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: On May 19, 2025, at 10:30 a.m., during entrance conference, licensed assisted living director (LALD)-D stated there was one unlicensed personnel (ULP) for each shift but there was a second ULP whom helped run errands. The licensee's undated Staffing Plan indicated the following: -7:00 a.m. to 3:00 p.m. (day shift)-one ULP; -3:00 p.m. to 10:00 p.m. (evening shift)-two	0 470		

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0 470	Continued From page 4 ULPs; and -10:00 p.m. to 7:00 a.m. (overnight shift)-one ULP. The staff schedule for May 1 through 31, 2025, indicated the following schedule: -Monday through Saturday (every week)-one ULP for day, evening, and overnight shifts; and -Sundays (every week)-one ULP from 7:00 a.m. to 7:00 p.m. (day/evening) and one ULP from 7:00 p.m. to 7:00 a.m. (overnight). On May 19, 2025, at 2:30 p.m., clinical nurse supervisor (CNS)-A was unsure if the staffing plan was for this facility or their sister facility owned by the same owner. CNS-A was also unsure when the staffing plan was created and thought it needed to be reviewed/revised at least annually. The licensee's Staffing policy dated July 24, 2021, indicated, "The staffing plan is based on an evaluation of the appropriateness of the staffing levels in the facility and is reviewed at least twice a year." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
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 Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed	0 480		

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0 480	Continued From page 5 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; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb	0 480		

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0 480	Continued From page 6 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 May 20, 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		
0 650 SS=E	144G.42 Subd. 8 (a) Staff records	0 650		

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0 650	Continued From page 7 (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records included all required content for two of two employees (unlicensed personnel (ULP)-E, ULP-F). 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 pattern scope (when more than a limited number of residents are affected, more	0 650		

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0 650	Continued From page 8 than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During observation on May 20, 2025, at 10:50 a.m., the surveyor observed R2's right foot and ankle to be swollen and asked staff why the compression sock was not applied. House manager/unlicensed personnel (HM/ULP)-B stated she would apply them which she did incorrectly, but R2 refused to have her fix them. Clinical nurse supervisor (CNS)-A was made aware of the surveyor's observation. The surveyor also observed R2's bilevel positive airway pressure (BiPAP-helps keep airway open) machine within his room which R2 stated he used at night. R2's Service Plan (Waiver)-Addendum to Contract dated January 30, 2025, indicated R2 received BiPAP and compression sock services. ULP-E and ULP-F were hired on March 17, 2025, and March 29, 2025, respectively, to provide direct care services to residents. ULP-E and ULP-F's employee records included compression sock training, however, lacked documentation of evaluated competency by the registered nurse (RN) for compression socks. Both records lacked documentation of training and evaluated competency by the RN on the BiPAP machine. During phone interview on May 20, 2025, at 4:16 p.m., ULP-E stated she was trained by clinical nurse supervisor (CNS)-A on both the compression socks and BiPAP and was observed	0 650		

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0 650	Continued From page 9 by the nurse performing compression sock application. During interview on May 21, 2025, at 10:00 a.m., CNS-A stated she trained both ULP-E and ULP-F on compression socks and BiPAP but did not document it. The licensee's Staff Orientation and Education policy, dated November 1, 2023, indicated [Licensee] would maintain proof of orientation and education in the personnel files. The licensee's Staff Competency policy dated July 24, 2021, indicated the following documentation would be maintained related to competency evaluations: a. Facility name, location and license number b. Name of topic and methodology (verbal, observation, written or practicum) c. Date and total time d. Name/title of instructor and evaluator (if different from instructor) with signature(s) and a statement attesting that the employee successfully passed the training and competency evaluation e. Name/title of staff person completing the competency evaluation and a statement attesting that the person successfully completed the training as described. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness	0 680		

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0 680	Continued From page 10 (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 observation, interview, and record review, the licensee failed to maintain a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. The licensee also failed to post emergency exit diagrams on each floor. 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	0 680		

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0 680	Continued From page 11 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 May 19, 2025, at 10:20 a.m., before entrance conference, the surveyor observed a rambler style home with one level and a basement. There were three bedrooms on the main level which two were occupied and one unoccupied bedroom on the lower level. The surveyor was brought downstairs in the living room area to set up. On May 19, 2025, at 12:37 p.m., the surveyor searched for the emergency exit diagram in the basement and was unable to locate one. On May 20, 2025, at 9:56 a.m., the emergency exit diagram on the upper level was posted up high above the dining room table showed both ground and lower-level floor plan along with a site plan and its details all on one 8.5" x 11" sized paper. Unlicensed personnel (ULP)-C stated the exit diagram should be posted in the bedroom downstairs so both ULP-C and surveyor went downstairs and did not observe any postings. The licensee's emergency disaster preparedness plan last revised May 6, 2025, lacked evidence of the following required content: - the development of policies/procedures to address: -subsistence needs for staff and residents specific to the needs of the facility (resident specific medical equipment such as oxygen and bilevel positive airway pressure (BiPAP helps keep airway open); and	0 680		

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	40771	A. BUILDING: _____ B. WING _____	05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOVING TOUCH INC	5548 GIRARD AVE N BROOKLYN CENTER, MN 55430

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 680	Continued From page 12 -alternate sources of energy to maintain temperatures to protect resident health/safety and sewage and waste disposal. On May 21, 2025, at 1:15 p.m., ULP-C stated the EPP could be more tailored to their facility and include details on how residents would be transported during an evacuation and how to meet the needs of the residents during a power outage when they require oxygen and BiPAP machine. The licensee's Emergency Preparedness policy dated July 24, 2021, indicated the licensee would have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services. The emergency disaster plan would be prominently posted on each floor of the facility that included emergency exit diagrams. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program.	0 800		

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0 800	Continued From page 13 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to 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 May 20, 2025, at approximately 10:00 a.m., the surveyor toured the facility with unlicensed personnel (ULP)-C. The following was observed. GENERAL MAINTENANCE: 1. The wall covering in the basement mechanical room had staining and black growth on the surface. The surveyor explained the staining and growth could affect the air quality for the residents. ULP-C stated the water heater leaked, flooded the room damaging the wall covering, and the water heater needed to be replaced. ULP-C stated they would replace the damaged and stained wall covering. 2. In the lower-level closet, underneath the stairs, an uncapped plumbing pipe was observed. The	0 800		

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0 800	Continued From page 14 surveyor explained the potential of sewer gas entering the facility due to the uncapped plumbing pipe. ULP-C stated they would get the maintenance staff to cap the pipe. On May 20, 2025, ULP-C acknowledged the above-listed deficiencies while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at	0 810		

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0 810	Continued From page 15 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. 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 May 20, 2025, licensed assisted living director (LALD)-D provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP failed to include the following: The FSEP included standard employee	0 810		

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0 810	Continued From page 16 procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate) but the plan was designed for a building with life safety systems such as a fire alarm system with pull stations. The policy had not been updated to provide complete actions for employees to take in the event of a fire or similar emergency at the licensed facility which did not have pull stations for the fire alarm system. On May 20, 2025, LALD-D stated they would work to bring the deficient portion of the facility FSEP into compliance. TRAINING: The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. LALD-D stated that staff training was done in Educare and not on the facilities written FSEP. No other training documentation was provided. On May 20, 2025, LALD-D stated they understood the requirements for training staff and would implement a training program that was compliant with statute requirements. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 900 SS=C	144G.50 Subdivision 1 Contract required	0 900		

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0 900	Continued From page 17 (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide to the Office of Ombudsman for Long-Term Care (OOLTC) a complete unsigned copy of the assisted living contract. This had the potential to affect all current residents.	0 900		

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0 900	Continued From page 18 This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: The licensee's provisional license was issued on May 23, 2024, and set to expire on May 22, 2025. During the entrance conference on May 19, 2025, at 10:30 a.m., licensed assisted living director (LALD)-D stated the licensee was familiar with current minimum assisted living requirements. R1 and R2's record included signed copies of an assisted living contract dated January 30, 2025. On May 21, at 9:35 a.m., unlicensed personnel (ULP)-C stated she sent a notification to OOLTC regarding R1 and R2 transferring from their sister facility to the current one, but did not send an unsigned contract to them. On May 27, 2025, at 9:27 a.m., the regional ombudsman through OOLTC replied to the surveyor's email (electronic email), indicating they never received the licensee's unsigned copy of the assisted living contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 900		

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0 910	Continued From page 19	0 910		
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required health facility identification (HFID) number for two of two residents (R1, R2). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: The licensee's current resident roster dated January 30, 2025, indicated R1 and R2 were admitted for services on January 31, 2025. R1's Service Plan (Waiver)-Addendum to	0 910		

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0 910	Continued From page 20 Contract dated February 28, 2025, indicated R1 received services for medication management, bathing assistance, dressing/grooming, behavior management, and meals. R2's Service Plan (Waiver)-Addendum to Contract dated January 30, 2025, indicated R2 received assistance with medication and treatment management, dressing/grooming, toileting, transfers, and behavior management. R1 and R2's [Licensee] Assisted Living Contract both signed on January 30, 2025, lacked the licensee's HFID 40771. During contract review on May 20, 2025, at 1:09 p.m., unlicensed personnel (ULP)-C was unable to locate the HFID on their contract and verbalized understanding that it was required to be on the contract. The licensee's Notifications policy dated July 24, 2021, indicated prior to providing housing or assisted living services, the assisted living contract will be presented and signed by the resident, the resident's designated representative and/or the resident's legal representative. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 910		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or	0 970		

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0 970	Continued From page 21 should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety, or personal property of a resident. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On May 19, 2025, at 12:04 p.m., via email (electronic email), the licensee provided their blank assisted living contract they utilized for all residents. R1 and R2's [Licensee] Assisted Living Contract both signed on January 30, 2025, included the following sections that indicated a waiver of liability on page 153: "Miscellaneous Provisions: Insurance Liability and Release. The resident shall maintain at all times his or her own health, personal property, liability, automobile (if applicable), and other insurance coverages and shall provide evidence of same by	0 970		

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0 970	Continued From page 22 copies of binders or policies provided to [licensee] upon request. The resident acknowledges that [licensee] is not an insurer of the resident's person or property. The resident agrees that [licensee] will not be liable to the resident for any personal injury or property damage (including, without limitation, damage to, or loss or theft of, automobiles or personal property of resident) suffered by the resident ... unless and to the extent that the injury or damage is caused by the negligence of [licensee] or its employees or agents. The resident hereby releases [licensee] from liability for any personal injury or property damage suffered by the resident... unless caused by the negligence of [licensee] or its employees or agents." During contract review on May 20, 2025, at 1:09 p.m., unlicensed personnel (ULP)-C appeared surprised to see the waiver of liability in the contract because she said she had removed it since their last survey (sister facility) but must have printed the wrong contract to use for their current residents. The licensee's Notifications policy dated July 24, 2021, indicated prior to providing housing or assisted living services, the assisted living contract will be presented and signed by the resident, the resident's designated representative and/or the resident's legal representative. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01290 SS=F	144G.60 Subdivision 1 Background studies required	01290		

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01290	Continued From page 23 (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a background study (BGS) was submitted and a clearance received in affiliation with the assisted living licensee's current health facility identification (HFID) for 6 of 10 employees (unlicensed personnel (ULP)-C, ULP-E, ULP-F, ULP-H, ULP-J, housekeeper (H)-I). This had the potential to affect all residents living within the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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).	01290		

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01290	Continued From page 24 The findings include: From May 19 through May 21, 2025, throughout the survey, the surveyor observed ULP-C at the facility assisting with the survey and assisting licensee's residents. On May 19, 2025, at 12:58 p.m., the surveyor was provided the licensee's NetStudy Roster 2.0 for HFID 37500 (sister facility). The surveyor asked house manager/unlicensed personnel (HM/ULP)-B for the licensee's NetStudy Roster 2.0 for HFID 40771. HM/ULP-B stated they were having a hard time adding staff to the roster and had been in contact with NetStudy, but were not getting anywhere. The surveyor's supervisor provided the surveyor with the NetStudy Roster 2.0 for HFID 40771 dated May 19, 2025, at 1:04 p.m., which listed three people (HM/ULP-B, licensed assisted living director (LALD)-D, and LALD-G). During phone interview on May 20, 2025, at 4:16 p.m., ULP-E stated she was hired middle of March and worked full-time during morning and evening (AM/PM) shifts for this facility. ULP-C was not listed on the licensee's Employee List dated March 29, 2025. The licensee's May 2025 staff schedule dated May 1-31, 2025, indicated ULP-C worked morning shift (7:00 a.m. to 2:00 p.m.) Monday through Thursday each week. ULP-E, ULP-F, ULP-H, and ULP-J began providing assisted living services to licensee's residents on March 17, 2025, March 29, 2025, May 4, 2025, and March 17, 2025, respectively.	01290		

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01290	Continued From page 25 H-I was hired on September 1, 2021, and began performing housekeeping and cleaning duties for this facility on January 31, 2025. ULP-C, ULP-E, ULP-F, ULP-H, ULP-J, and H-I had background studies affiliated with the licensee's sister facility under HFID 37500. They lacked evidence of a current, cleared background study affiliated with the licensee's current assisted living HFID 40771. The licensee's Recruitment and Hiring policy dated July 24, 2021, indicated the licensee would ensure all staff were appropriately screened prior to employment. The policy indicated a criminal background check would be submitted to Minnesota Department of Human Services (DHS) following the step-by-step procedure established by DHS. The policy lacked instruction on affiliating staff to multiple HFID's. No further information was provided. TIME PERIOD OF CORRECTION: Two (2) days	01290		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication	01730		

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	40771	A. BUILDING: _____ B. WING _____	05/21/2025

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LOVING TOUCH INC	5548 GIRARD AVE N BROOKLYN CENTER, MN 55430

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01730	Continued From page 26 management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and maintain a current individualized medication management record to include all required content for one of one resident (R1). This practice resulted in a level two violation (a	01730		

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01730	Continued From page 27 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's diagnoses included atrial fibrillation (irregular heart rhythm), chronic kidney disease, and high blood pressure. R1's Service Plan (Waiver)-Addendum to Contract dated February 28, 2025, indicated R1 received assistance with medication administration four times per day. R1's admission assessment completed by clinical nurse supervisor (CNS)-A on January 30, 2025, indicated R1 required assistance with medication administration and management. R1's provider orders dated April 10, 2025, indicated R1 was hypotensive (low blood pressure) at the clinic visit and the provider discontinued Amlodipine (blood pressure medication). Follow up blood pressure check in two weeks. The order started Hydralazine 50 milligram (mg) tablet, give one tablet by mouth three times per day. Do not give this medication if blood pressure (BP) is lower than 110/60 and heart rate is lower than 60. R1's Med Admin Summary-May 2025, indicated the following: -"Hydralazine 50 mg tablet, take one tablet by mouth three times a day. Do not give this	01730		

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01730	Continued From page 28 medication if BP is lower than 110/60 or heart rate is lower than 60." Medication was given in the morning, midday, and bedtime. R1's vital sign record dated May 1-20, 2025, indicated staff checked R1's blood pressure and pulse once daily at various times in the morning, as early as 7:44 a.m. and as late as 1:31 p.m. R1's medication plan lacked the following: -clear resident specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions; and -maintaining an updated medication management record when there were changes. During interview on May 21, 2025, at 10:00 a.m., CNS-A stated staff did check R1's blood pressure three times per day because it was running low but R1's medical provider had asked to have it checked once daily. CNS-A said she asked staff to still check it prior to administering hydralazine. CNS-A confirmed the second and third blood pressure checks were not documented, but stated she would update the instructions. During interview on May 21, 2025, at approximately 10:45 a.m., the surveyor asked R1 how many times per day his blood pressure was checked, he stated two times per day. The licensee's Assessment of Medications policy dated July 24, 2021, indicated the medication management plan would be evaluated/updated as needed with changes in medication. No further information was provided.	01730		

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01730	Continued From page 29 TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to correctly transcribe a medication dosage change based on international normalized ratio (INR-how well blood is able to clot) results and accurately document medication administration for one of one resident (R1) receiving medication management. 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	01760		

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01760	Continued From page 30 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included atrial fibrillation (irregular heart rhythm), chronic kidney disease, and high blood pressure. R1's Service Plan (Waiver)-Addendum to Contract dated February 28, 2025, indicated R1 received assistance with medication administration four times per day. R1's admission assessment completed by clinical nurse supervisor (CNS)-A on January 30, 2025, indicated R1 required assistance with medication administration and management. TRANSCRIPTION ERROR During observation on May 20, 2025, at 9:15 a.m., house manager/unlicensed personnel (HM/ULP)-B went to the locked medication closet and pulled out R1's medications. R1's morning medications were packaged together by the pharmacy in a bubble pack. The bubble pack included the following medications: -Bumex 1 milligram (mg), one tablet (for swelling); -hydrazaline 50 mg, one tablet (to lower blood pressure); -metformin 1000 mg, one tablet (lowers blood glucose); -potassium chloride 20 milliequivalent (mEq), one tablet (supplement); and -tamsulosin 0.4 mg, two capsules (promotes urine flow). R1's electronic medication administration record (eMAR) showed warfarin 5 mg, give 7.5 mg (one and one-half tablets) on Monday, Wednesday,	01760		

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01760	Continued From page 31 Friday, and 5 mg (one tablet) all other days (helps prevent blood clots). HM/ULP-B then took a pharmacy bottle labeled warfarin 5 mg and took out one tablet and added it to the rest of the medications. HM/ULP-B stated the warfarin tablets were scored so they could be cut in half when needed. On May 20, 2025, at 2:40 p.m., during R1's record review, the surveyor noted the warfarin dose on the saved eMAR (printed May 19, 2025) indicating the following: "Give 7.5 mg every Fri, and 5 mg all other days. INR check on 02/18/2025." The surveyor then went to observe R1's eMAR on the licensee's computer and noted the instructions were changed before the morning medication observation. R1's provider orders received April 25, 2025, indicated the resident's INR was 1.7 (targeted INR range of 2.0-3.0) and the warfarin dosing plan was: 7.5 mg every Monday, Wednesday, Friday, and 5 mg all other days. R1's provider orders received on May 2, 2025, at 5:30 p.m. via facsimile, indicated the resident's INR was 2.2 and the warfarin dosing plan was the same as the April 25, 2025, dosing plan. INR recheck on May 30, 2025. On May 20, 2025, at 3:00 p.m., the surveyor observed the warfarin bottle with unlicensed personnel (ULP)-C and licensed assisted living director (LALD)-D to ensure the medication had been administered per provider's most recent order which it appeared it was administered correctly (if staff were following the old instructions on the eMAR, there would have been extra tablets leftover).	01760		

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01760	Continued From page 32 DOCUMENTATION ERROR R1's eMAR dated May 1 through 19, 2025, indicated staff initialed/documented on the following medication: -warfarin 5 mg, give 7.5 mg every Friday, and 5 mg all other days (the new order would have been implemented on May 3, 2025, due to receiving the order after medication administration for that day). During interview on May 20, 2025, at 4:16 p.m., ULP-E stated she was trained to check the date, name, medication, resident, route, and compare that information against the eMAR. She said she administered R1's warfarin in the morning and followed the eMAR. When the surveyor stated the eMAR was not updated to reflect the provider's current warfarin orders, ULP-E stated she used the provider's faxed order and acknowledged the eMAR was not current when she administered medications. She also stated she was instructed by CNS-A to follow the faxed order and document the medication administration on R1's eMAR (which resulted incorrect documentation). R1's medical record lacked current transcribed warfarin orders since April 25, 2025, when the dose changed. R1's medical record also lacked accurate documentation of warfarin administration. During interview on May 21, 2025, at 10:00 a.m., CNS-A explained when the facility received the faxed order, the staff would not notify her right away but would notify CNS-A before the next dose was administered. CNS-A stated she instructed the staff to follow the faxed order and did not update R1's eMAR. She stated her new process would be to have the clinic contact her directly or have staff notify her right away once	01760		

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01760	Continued From page 33 received so she would update the eMAR. The licensee's Assessment of Medications policy dated July 24, 2021, indicated the resident's medication management plan would be evaluated/updated as needed with changes in medications. The licensee's Medication Documentation policy dated July 24, 2021, indicated each medication administered by licensee would be documented in the resident's clinical record. Documentation would be complete, accurate and legible. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01890 SS=E	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to monitor for expired medications for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	01890		

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01890	Continued From page 34 cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During entrance conference on May 19, 2025, at 10:30 a.m., clinical nurse supervisor (CNS)-A stated all of licensee's residents received medication administration and management. On May 20, 2025, at 9:50 a.m., after medication administration observation, the surveyor observed the medication closet with house manager/unlicensed personnel (HM/ULP)-B. The surveyor noted expired medication for R1 and R2. HM/ULP-B and CNS-A both confirmed expired medications with the surveyor. R1 R1's Med Admin Summary-May 2025, indicated the following: -nitroglycerin 0.4 milligram (mg) sublingual (under the tongue), dissolve one tablet under tongue every 5 minutes for 3 doses as needed for chest pain-if no relief call 911 after 1st dose. R1's provider orders signed April 10, 2025, ordered nitroglycerin as written above. R1 had the following expired medication: -nitroglycerin 0.4 mg dissolvable tablet (used for chest pain), one full bottle with unbroken seal, expired March 2025. R2 R2's Med Admin Summary-May 2025, indicated	01890		

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01890	Continued From page 35 the following: -cyclobenzaprine 10 mg tablet, take one tablet by mouth three times a day as needed for muscle spasm. R2's provider orders signed April 3, 2025, ordered cyclobenzaprine as written above. R2 had the following expired medication: -cyclobenzaprine 10 mg tablet-one full bottle for muscle spasms, expired January 2025. CNS-A explained R1 had never used nitroglycerin but noted there were no medication available should R1 have chest pain. On May 20, 2025, at 10:00 a.m., CNS-A stated she was responsible for checking medication administration compliance, medication supply and checking for expired medications on a weekly basis and did not know how the expired medications were missed. The licensee's Disposition and Disposal of Medications policy dated July 24, 2021, indicated expired medications must be disposed of. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

Loving Touch Inc
5548 Girard Ave N
Brooklyn Park, MN 55430
Hennepin County
Parcel:

Phone:

License Info

License: HFID 40771

Risk:
License:
Expires on:
CFPM:
CFPM #: ; Exp:

Inspection Info

Report Number: F1047251014
Inspection Type: Full - Single
Date: 5/20/2025 Time: 11:00 am
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 1
Total Priority 2 Orders: 1
Total Priority 3 Orders: 0
Delivery: Emailed

New Order: 3-500A Microbial Control: cooling
3-501.15A *Priority Level: Priority 2 CFP#: 33*
MN Rule 4626.0390A Cool food by: 1) placing the food in shallow pans; 2) separating the food into smaller portions 3) using rapid cooling equipment; 4) stirring the food in a container placed in an ice water bath; 5) using containers that facilitate heat transfer; 6) adding ice as an ingredient; or other effective methods.
COMMENT: FOOD COOKED EARLIER IN THE MORNING WAS IN PROCESS OF COOLING. LID WAS ON CONTAINER, TRAPPING HEAT. USE ABOVE METHOD TO HELP FOOD COOL WITHIN ALLOWABLE TIMEFRAME. INFORMATION ON COOLING PROVIDED WITH REPORT.
Comply By: 5/20/2025 Originally Issued On: 5/20/2025

! **New Order: 3-500B Microbial Control: hot and cold holding**
3-501.16A2 *Priority Level: Priority 1 CFP#: 22*
MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.
COMMENT: TEMPERATURES IN REFRIGERATOR RANGED FROM 42F TO 51F. TEMPERATURE OF FRIDGE WAS DECREASED. FACILITY SHOULD CONTINUE TO MONITOR FOOD TEMPERATURES IN REFRIGERATOR. FACILITY CONFIRMED TEMPERATURE IS NOW BELOW 41F.
Comply By: Complied On Site Originally Issued On: 5/20/2025

Food & Beverage General Comment

Inspection conducted with F. Ali and reviewed with MDH Nurse Evaluator A. Bohnen.

The establishment has a residential kitchen & serves food that is prepared that day. The kitchen has wood cabinets, tiled walls, wood/laminate floor, granite countertop, and painted/textured ceilings.

The state certified food protection manager certificate is shared between two facilities.

A two basin sink is located in the kitchen. One sink basin is designated for handwashing. A residential dish machine is located in the kitchen.

Discussed hand washing, ware washing, staff illness policy, temperature control, final cook temperatures, cleaning, serving highly susceptible populations, and food handling procedures.

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Metro District Office inspection report number F1047251014 from 5/20/2025

Fadumo Ali
Kitchen Manager

Holly Sievers,
Public Health Sanitarian 2
651-201-5946
holly.sievers@state.mn.us

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

Temperature Observations/Recordings

Establishment Info

Loving Touch Inc
Brooklyn Park
County/Group: Hennepin County

Inspection Info

Report Number: F1047251014
Inspection Type: Full
Date: 5/20/2025
Time: 11:00 am

Food Temperature: Product/Item/Unit: Cheese**; Temperature Process:** Cold-Holding
Location: Refrigerator at 50 Degrees F.
Comment:
Violation Issued?: Yes

Food Temperature: Product/Item/Unit: Beef Stew**; Temperature Process:** Cooling
Location: Refrigerator at 95 Degrees F.
Comment:
Violation Issued?: Yes

Food Temperature: Product/Item/Unit: Pizza**; Temperature Process:** Cold-Holding
Location: Refrigerator at 42 Degrees F.
Comment:
Violation Issued?: Yes

Food Temperature: Product/Item/Unit: Butter**; Temperature Process:** Cold-Holding
Location: Refrigerator at 44 Degrees F.
Comment:
Violation Issued?: Yes

Food Temperature: Product/Item/Unit: Pizza**; Temperature Process:** Cold-Holding
Location: Refrigerator at 39 Degrees F.
Comment: Corrected temperature for refrigerator
Violation Issued?: No

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

Sanitizer Observations/Recordings

Establishment Info

Loving Touch Inc
Brooklyn Park
County/Group: Hennepin County

Inspection Info

Report Number: F1047251014
Inspection Type: Full
Date: 5/20/2025
Time: 11:00 am

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Kitchen **Equal To** 160 Degrees F.
Comment:
Violation Issued?: No