Electronically Delivered

August 14, 2025

Licensee
Blessed Hands Health Care LLC
8465 79th Street South
Cottage Grove, MN 55016

RE: Project Number(s) SL37831016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 23, 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.

MDH 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. 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;
Level 3: a fine of $1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 4: a fine of $3,000 per incident, in addition to any enforcement mechanism authorized in

§ 144G.20;
Level 5: a fine of $5,000 per violation, in addtion 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 - 0340 - 144g.30 Subd. 5 - Correction Orders - $500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $500.00**. 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
	37831	A. BUILDING: _____ B. WING _____	07/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLESSED HANDS HEALTH CARE LLC	8465 79TH STREET S COTTAGE GROVE, MN 55016

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL37831016-0 On July 21, 2025, through July 23, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there was one resident; one receiving services under the 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.	
0 340 SS=F	144G.30 Subd. 5 Correction orders (a) A correction order may be issued whenever	0 340		

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0 340	Continued From page 1 the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, an agent of the facility, or staff of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction. (b) The commissioner shall mail or email copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must: (1) document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to record actions taken to comply with all correction orders from a survey completed March 28, 2023. The lack of action to ensure compliance with regulations 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) and was issued at a widespread scope (when problems are pervasive	0 340		

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0 340	Continued From page 2 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 result of the licensee's previous survey, concluded on March 28, 2023, was sent to the licensee via email on April 11, 2023. The communication indicated the licensee was granted an assisted living license. The longest time period for correction (the time frame in which the licensee must document and correct orders) was 21 days from the date the licensee received their results, or May 2, 2023. On Tuesday July 22, 2025, at 4:50 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A provided, via email, the licensee's plans of correction (POC) from the survey concluded March 28, 2023. The plan indicated a completion date of April 6, 2023. On Wednesday July 23, 2025, at 10:50 p.m., after the survey concluded, LALD/CNS-A provided, via email, another corrective action plan dated April 6, 2023. Both plans of correction lacked documented corrective actions for the following order: -0680, 144G.42 Subd. 10. Disaster planning and emergency preparedness plan. The licensee remained out of compliance with the above-listed statutes, and correction orders were reissued as a result of the current survey, ending July 23, 2025. On July 23, 2025, at 8:31 a.m., LALD/CNS-A stated he had updated the facility fire plan	0 340		

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0 340	Continued From page 3 emergency plan but did not realize there were remaining Appendix Z emergency documentation and training to be completed. LALD/CNS-A verbalized he planned to use resources discussed to assist the licensee with integrating the Appendix Z emergency preparedness guidelines for the facility. The Minnesota Department of Health (MDH) Correction Order Documentation Guidelines, dated January 3, 2023, indicated, correction order documentation should include the following: -identify how each order was corrected related to each individual client(s)/employee(s) identified in the order; -identify how each order was corrected for all the provider's clients/employees identified in the order; and -identify what changes to the provider's systems and practices were made to ensure compliance with the specific statute. Include information about how the provider will maintain compliance in the future. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 340		
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 capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part	0 480		

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0 480	Continued From page 4 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 breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and	0 480		

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0 480	Continued From page 5 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, July 21, 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		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment	0 550		

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0 550	Continued From page 6 All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post the required information related to the grievance procedure, including the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. This had the potential to affect all 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 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	0 550		

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0 550	Continued From page 7 On July 21, 2025, at 9:55 a.m., upon entrance to the facility, the surveyor observed the licensee lacked a complaint or grievance posting including the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. On July 21, 2025, at 10:40 a.m., manager/unlicensed personnel (M/ULP)-B stated he was not aware of the grievance posting requirements. On July 22, 2025, at 7:33 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated he thought the complaint procedure was posted and not sure why it was no longer posted. LALD/CNS-A verbalized he planned to get the grievance procedure and contact information posted in the facility. The licensee's 2.10 Complaint/Grievance Posting policy, dated January 18, 2023, indicated, "1. [Licensee] will post, in a conspicuous place, information about our complaint/ grievance procedure, and the name, telephone number, and email contact information for the individual(s) who are responsible for handling resident complaint/grievances." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements:	0 680		

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0 680	Continued From page 8 (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have all the written requirements in the emergency preparedness plan (EPP) as defined in Appendix Z (a section of the Centers for Medicare and Medicaid Services (CMS) state operations manual which includes the emergency preparedness guidelines). In addition, the licensee failed to ensure the missing resident policy was reviewed quarterly as required under section 4659.0110. This had the potential to affect all residents, staff and visitors of the facility. This practice resulted in a level two violation (a	0 680		

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0 680	Continued From page 9 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: The licensee's undated emergency disaster preparedness plan lacked evidence of annual review and the following required content: -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; -hazard vulnerability risk assessment; -EP program resident population; -arrangement with other facilities; -procedures for tracking staff and residents; -process for emergency preparedness (EP) cooperation with state and local EP officials/organizations; -participate in an annual full-scale exercise that is community based OR conduct an annual, individual, facility-based functional exercise OR if the facility experiences an actual emergency requiring activation of plan, facility is exempt from engaging in its next required full-scale exercise; and -missing resident policy reviewed quarterly. On July 23, 2025, at 8:31 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated, via phone, he was familiar with Appendix Z, but the licensee had not fully	0 680		

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0 680	Continued From page 10 developed and implemented the facility's emergency preparedness plan/program to include the above requirements. Also, LALD/CNS-A verbalized the licensee had not participated in an annual full-scale exercise or facility-based functional exercise. The licensee's 9.01 Emergency Preparedness Plan -Appendix Z Compliance policy, dated, February 9, 2023, indicated, "Procedure: [Licensee]emergency preparedness plan will include all required elements of appendix Z. The plan will be in writing and reviewed annually. The plan is based on our assisted living-based and community-based risk assessments, utilizing an all-hazards approach. Key elements of the plan include four primary components: 1. Risk assessment and planning 2. Policies and procedures 3. A communication plan 4. Staff training and exercises/drills." The licensee's 2.28 Missing Resident policy, dated. January 18, 2023, indicated, "12. [Licensee] will review this policy and any individual resident plans that pertain to elopement at least quarterly, and all changes will be documented." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
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	0 810		

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0 810	Continued From page 11 plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. 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.	0 810		

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	37831	A. BUILDING: _____ B. WING _____	07/23/2025

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0 810	Continued From page 12 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: During facility tour on July 22, 2025, from 10:30 a.m. to 1:30 p.m., the surveyor toured the facility with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A. Surveyor observed the fire safety and evacuation plan was not located in a central location for all staff, residents and visitor accessibility. July 22, 2025, from 10:30 a.m. to 1:30 p.m., with LALD/CNS-A; provided documents on the FSEP, fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP, titled "Fire Policy", revised date 5-15-25, failed to include the following: STAFF ACTIONS: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The provided FSEP was from a third-party provider and had not been updated to the specific facility. RESIDENT ACTIONS: The FSEP did not identify specific fire protection	0 810		

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0 810	Continued From page 13 actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. UNIQUE AND UNUSUAL RESIDENT NEEDS: The facility uses an electronic care plan website for standard resident evacuation procedures. The FSEP does not include instructions on how to use or what do in the loss of power/internet event for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. On July 22, 2025, at 12:30 p.m., LALD/CNS-A stated they understood the areas of their policy that were incomplete and would work on bringing them into compliance. TRAINING: The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. LALD/CNS-A e-mailed documentation with an agenda for staff training, no signatures or proof that staff received the training. No other training documentation was provided. On July 1, 2025, at 12:30 p.m., LALD/CNS-A stated they understood the requirements for training staff and would implement a training program that was compliant with statute requirements. DRILLS The licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. LALD/CNS-A e-mailed a calendar of when fire drills had taken place with no supporting	0 810		

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0 810	Continued From page 14 documentation. On July 22, 2025, at 12:30 p.m., LALD/CNS-A stated there were no additional documented drills for the facility. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
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 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 assisted living contracts did not include language waiving the licensee's liability for health, safety, or personal property of a resident for one of one resident (R2). This practice resulted in a level one violation (a violation that will cause only 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:	0 970		

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0 970	Continued From page 15 R2 was admitted on March 1, 2023, with diagnoses including paranoid bipolar type schizoaffective disorder (a mental health disease). R2's Service Plan dated March 1, 2023, indicated R2 received services including assistance with housekeeping, laundry, meals, bathing, behavior management, and medication administration. R2's Assisted Living Contract dated March 1, 2023, included the following language indicating waivers of liability: "Miscellaneous Provisions 1. 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 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 or the resident's agents, guests or invitees, 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 or the resident's agents, guests, or invitees, unless caused by the negligence of [Licensee] or its employees or agents." On July 22, 2025, at 10:49 a.m., licensed assisted living director/clinical nurse supervisor	0 970		

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0 970	Continued From page 16 (LALD/CNS)-A stated he was not aware of the waiver of liability language requirement. LALD/CNS-A verbalized he planned to correct the waiver of liability verbiage in the contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01370 SS=F	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional;	01370		

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01370	Continued From page 17 (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency was completed with all required content for two of two employees (manager/unlicensed personnel (M/ULP)-B, 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 residents 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 the potential to affect a large portion or all of the residents). The findings include: On July 22, 2025, at 7:15 a.m., during the entrance conference, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated initial training, and competency was completed by the licensee's nurse. Also, LALD/CNS-A verbalized the licensee's orientation	01370		

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01370	Continued From page 18 and training was completed both in person and utilizing an online training program. M/ULP-B M/ULP-B was hired on February 1, 2023, to provide direct care services to residents of the assisted living facility. On July 21, 2025, at 11:52 a.m., the surveyor observed M/ULP-B assist R2 with medication administration. M/ULP-B's employee record lacked documentation of training and competency evaluations including: -training on the prevention of falls; and -understanding appropriate boundaries between staff and residents and the resident's family. ULP-C ULP-C was hired on April 1, 2023, to provide direct care services to residents of the assisted living facility. ULP-C's employee record lacked documentation of training and competency evaluations including: -training on the prevention of falls; -communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; -understanding appropriate boundaries between staff and residents and the resident's family; and -awareness of commonly used health technology equipment and assistive devices. On July 22, 2025, at 9:20 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated some of the training content was missed being assigned or completed	01370		

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01370	Continued From page 19 for M/ULP-B and ULP-C. LALD/CNS-A verbalized he planned to follow up with the employees on the incomplete required content. The licensee's 4.18 General Employee Orientation policy, dated April 20, 2025, indicated, "Upon hire and prior to performing any functions of their position at Blessed Hands Health Care, each new employee and volunteer will receive orientation that meets Minnesota Department of Health (MDH) requirements and internal policy and procedure expectations." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the 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	01500		

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01500	Continued From page 20 blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	01500		

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01500	Continued From page 21 review, the licensee failed to ensure employees received at least eight (8) hours of annual training including required content, for each 12 months of employment for two of two employees (manager/unlicensed personnel (M/ULP)-B. 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 residents 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 the potential to affect a large portion or all of the residents). The findings include: M/ULP-B and ULP-C were hired on February 1, 2023, and April 1, 2023, respectively, and provided direct cares for residents. On July 21, 2025, at 11:52 a.m., the surveyor observed M/ULP-B assist R2 with medication administration. M/ULP-B and ULP-C's employee records both included an online education training transcript of annual training last completed in 2023. M/ULP-B and ULP-C's employee records lacked documentation of the number of hours of annual training completed within the last 12 months, and lacked documentation the following required topics were completed: -training on reporting of maltreatment of vulnerable adults under section 626.557; -review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise	01500		

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01500	Continued From page 22 and protection of those rights; -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; -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; -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 -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. On July 22, 2025, at 9:20 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated some of the training content was missed being completed in 2024 or 2025 for both M/ULP-B and ULP-C. The licensee's Annual Training policy dated March 15, 2025, indicated, "All employees are required to complete mandatory annual training on essential topics relevant to their roles. This ongoing education promotes compliance with state regulations, supports a culture of safety, and enhances resident well-being. Training Requirements: 1. Core Annual Training Topics (All Staff) -Resident rights and confidentiality (HIPM)	01500		

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	37831	A. BUILDING: _____ B. WING _____	07/23/2025

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01500	Continued From page 23 -Abuse prevention, reporting, and vulnerable adult law -Infection control and standard precautions -Fire safety and emergency response -Elopement prevention and procedures -Incident reporting -Cultural competency and respectful workplace -Workplace violence prevention -Emergency preparedness procedures -Professional conduct and ethics 2. Direct Care Staff Additional Topics (DSPs, CNAs, Nurses) -Safe resident handling, transfers, and fall prevention -Recognizing and reporting changes in resident condition -Medication assistance (if applicable) -Dementia care and communication -De-escalation techniques and behavior support plans -CPR/First Aid recertification (as required). In addition, included, "Training must be completed annually, with a renewal cycle of 12 months from the date of hire or last training." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
01530 SS=F	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia	01530		

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01530	Continued From page 24 topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure employees	01530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37831	A. BUILDING: _____ B. WING _____	07/23/2025

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01530	Continued From page 25 completed dementia care training (at least eight hours within 160 working hours of the employment start date), two hours of initial training on mental illness and de-escalation, and two hours of annual dementia training for two of two employees (manager/unlicensed personnel (M/ULP)-B, 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 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: M/ULP-B M/ULP-B had a hire date of February 1, 2023, and provided direct care to residents. On July 21, 2025, at 11:52 a.m., the surveyor observed M/ULP-B assist R2 with medication administration. M/ULP-B's employee record included 1.5 hours of initial dementia training completed on September 27, 2023. M/ULP-B's employee record lacked documentation M/ULP-B completed the following: -initial eight hours of training related to dementia care, within 160 working hours of M/ULP-B's employment start date; -two hours of initial training on mental illness and de-escalation topics; and -two hours of annual dementia training.	01530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37831	A. BUILDING: _____ B. WING _____	07/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLESSED HANDS HEALTH CARE LLC	8465 79TH STREET S COTTAGE GROVE, MN 55016

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01530	Continued From page 26 ULP-C ULP-C had a hire date of April 1, 2023, and provided direct care to residents. ULP-C's employee record lacked documentation ULP-C completed the following: -initial eight hours of training related to dementia care, within 160 working hours of ULP-C's employment start date, -two hours of initial training on mental illness and de-escalation topics; and -two hours of annual dementia training. On July 23, 2025, at 8:31 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated, via phone, the online training provided was the only training the licensee had for M/ULP-B and ULP-C. LALD/CNS-A verbalized he noticed ULP-C's transcript the courses were assigned but never completed. In addition, LALD/CNS-A stated he agreed both M/ULP-B and ULP-C were missing the required initial dementia and mental health training, and annual dementia training. The licensee's Annual Training policy dated, March 15, 2025, indicated, "All employees are required to complete mandatory annual training on essential topics relevant to their roles. This ongoing education promotes compliance with state regulations, supports a culture of safety, and enhances resident well-being. Training Requirements: 1. Core Annual Training Topics (All Staff) -Resident rights and confidentiality (HIPM) -Abuse prevention, reporting, and vulnerable adult law -Infection control and standard precautions -Fire safety and emergency response	01530		

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	37831	A. BUILDING: _____ B. WING _____	07/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLESSED HANDS HEALTH CARE LLC	8465 79TH STREET S COTTAGE GROVE, MN 55016

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01530	Continued From page 27 -Elopement prevention and procedures -Incident reporting -Cultural competency and respectful workplace -Workplace violence prevention -Emergency preparedness procedures -Professional conduct and ethics 2. Direct Care Staff Additional Topics (DSPs, CNAs, Nurses) -Safe resident handling, transfers, and fall prevention -Recognizing and reporting changes in resident condition -Medication assistance (if applicable) -Dementia care and communication -De-escalation techniques and behavior support plans -CPR/First Aid recertification (as required)." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01530		
01820 SS=F	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a written or electronically recorded prescription was obtained for medications administered, and prescriptions were renewed at least every 12 months for one of	01820		

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01820	Continued From page 28 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 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: R2 had diagnoses including schizoaffective disorder (a mental health disorder). R2's Service Plan, dated March 1, 2023, indicated R2 received services including assistance with medication management. On July 21, 2025, at 11:52 a.m., the surveyor observed M/ULP-B assist R2 with medication administration. R2's "Medication Administration Record" for July 1, 2025, to July 21, 2025, indicated R2 was administered the following medications daily: -pantoprazole (to treat excessive stomach acid production) 40 milligrams (mg), one tablet, once daily; -vitamin B-12 (a supplement) 50 micrograms (mcg), one tablet, once daily; -escitalopram (for depression) 30 mg, one tablet, once daily; -Refresh liquigel (for dry eyes) 1 percent (%) ophthalmic solution; one drop in both eyes, four times daily; -celecoxib (for pain) 200 mg, one capsule, twice daily with a meal;	01820		

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	37831	A. BUILDING: _____ B. WING _____	07/23/2025

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01820	Continued From page 29 -baclofen (for muscle spasms) 10 mg, half tablet (5 mg), twice daily; -atorvastatin (treats high cholesterol) 20 mg, one tablet, at bedtime; -paliperidone (to treat schizophrenia) extended release 3 mg, one tablet, at bedtime; -tamsulosin (treats enlarged prostate) 0.4 mg, one capsule, at bedtime; -carbidopa/levodopa (to treat Parkinson's disease) 25-100 mg, one tablet three times daily; -ketoconazole (treats fungal infections) 2 % shampoo, use on scalp, eyebrows and beard, twice weekly; -gabapentin (for pain) 600 mg, one tablet, three times daily; and -lorazepam (for anxiety) 1 mg, one tablet, three times daily. R2's medical record included a medication list dated July 1, 2025, but lacked current written or electronically recorded prescriptions as defined in section 151.01, subdivision 16 a., for all prescribed medications that the assisted living facility was managing for the resident. On July 22, 2025, at 9:54 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A provided a copy of R2's medication list received from the licensee's pharmacy. LALD/CNS-A stated he did not realize the R2's medication list was not authenticated with the required providers manual or electronic signature. LALD/CNS-A verbalized he planned to follow up with the provider. On July 24, 2025, at 10:57 a.m., LALD/CNS-A provided, via email, a copy of R2's provider orders, manually signed July 23, 2025, after the initiation of the survey.	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01820	Continued From page 30 Minnesota Statutes section 151.01 Definitions Subd. 16 a., Prescription indicated, "A prescription written or printed on paper that is given to the patient or an agent of the patient or that is transmitted by fax must contain the practitioner's manual signature. An electronic prescription must contain the practitioner's electronic signature." The licensee's 7.17 Medication & Treatment Orders - Receiving policy, dated February 9, 2023, indicated, "An RN, LPN, therapist, or person at [Licensee] who is qualified to receive orders will obtain all medications and treatment orders either in writing, verbally, or electronically by an authorized prescriber." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the required posting at the main entry way of the facility, included statutory language to disclose electronic monitoring	03090		

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03090	Continued From page 31 activity, potentially affecting all current residents in the assisted living facility, staff, and any visitors to the facility. This practice resulted in a level one violation (a violation that will cause only 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 July 21, 2025, at 9:55 a.m., upon entrance to the facility, the surveyor observed the licensee lacked an electronic monitoring notice with the required statutory language. On July 21, 2025, at 10:40 a.m., manager/unlicensed personnel (M/ULP)-B stated he was not aware of the electronic monitoring posting requirement. On July 22, 2025, at 7:33 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated he was not aware of the electronic monitoring posting requirement. -7:35 a.m., the surveyor provided, via email, the statutory language for the electronic monitoring posting notification to the licensee. The licensee's Electronic Monitoring policy, dated July 23, 2025, indicated "[Licensee] permits and supports the use of resident-initiated electronic monitoring (RIEM) in accordance with Minnesota state law. Residents or their legal representatives have the right to install and use electronic monitoring devices in their living spaces, provided it complies with privacy, consent, and notification	03090		

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03090	Continued From page 32 requirements outlined in MN Statute § 144.6502." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090		

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

Blessed Hands Health Care in C
8465 79TH STREET S
Cottage Grove, MN 55016
Washington County
Parcel:

Phone:

License Info

License: HFID 37831

Risk:
License:
Expires on:
CFPM: Dominic Irabor
CFPM #: FM115379; Exp: 3/2/2026

Inspection Info

Report Number: F1004251078
Inspection Type: Full - Single
Date: 7/21/2025 Time: 12:10:00 PM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 2
Total Priority 2 Orders: 5
Total Priority 3 Orders: 1
Delivery: Emailed

New Order: 2-100 Supervision
2-102.11ABCQ *Priority Level: Priority 2 CFP#: 1*
MN Rule 4626.0030ABCQ The person in charge must be able to demonstrate their knowledge to the inspector of the following factors associated with employee health and the transmission of foodborne disease: symptoms of illness frequently associated with foodborne diseases; food worker illness reporting requirements; and medical conditions requiring exclusion of an employee from work or the restriction of their work duties.
COMMENT: **PERSON IN CHARGE COULD NOT ADEQUATELY DEMONSTRATE KNOWLEDGE OF A REQUIRED EMPLOYEE ILLNESS POLICY, REPORTING AND RECORDING OF SYMPTOMS OF ILLNESS, EXCLUSION POLICY FOR ILL EMPLOYEES, OR SYMPTOMS OF ILLNESS ASSOCIATED WITH FOODBORNE DISEASES. *INFORMATION SUPPLIED WITH REPORT.**

ALL EMPLOYEES MUST BE FULLY TRAINED ON AN EMPLOYEE ILLNESS POLICY AND EXCLUSION REQUIREMENTS.
Comply By: 7/21/2025 Originally Issued On: 7/21/2025

New Order: 2-100 Supervision
2-102.12DMN *Priority Level: Priority 3 CFP#: 2*
MN Rule 4626.0033D Post the certified food protection manager certificate.
COMMENT: **CERTIFIED FOOD PROTECTION MANAGER CERTIFICATE WAS NOT POSTED ON SITE. POST AND MAINTAIN.**
Comply By: 7/21/2025 Originally Issued On: 7/21/2025

! **New Order: 2-200 Employee Health**
2-201.11C *Priority Level: Priority 1 CFP#: 3*
MN Rule 4626.0040C The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority at the specific request of the regulatory authority.
COMMENT: **PERSON IN CHARGE STATED ESTABLISHMENT DOES NOT RECORD REPORTS OF EMPLOYEE ILLNESS (EMPLOYEE ILLNESS LOG). ESTABLISHMENT IS REQUIRED TO RECORD ALL REPORTS OF EMPLOYEE ILLNESS WITH SYMPTOMS OF ILLNESS THAT COULD BE TRANSMISSIBLE THROUGH FOOD OR ASSOCIATED WITH FOODBORNE ILLNESS. *EMPLOYEE ILLNESS LOG SUPPLIED WITH REPORT.**
Comply By: 7/21/2025 Originally Issued On: 7/21/2025

New Order: 2-500 Cleanup of Vomiting and Diarrheal Events
2-501.11 *Priority Level: Priority 2 CFP#: 5*
MN Rule 4626.0123 Provide employees with procedures to follow for cleanup of vomit or fecal matter in the establishment. The procedures must minimize the spread of contamination to food and surfaces within the facility, and minimize the exposure of employees and consumers to contamination.
COMMENT: **NO EMPLOYEE TRAINING ON HOW TO EFFECTIVELY CLEAN UP A VOMIT OR FECAL INCIDENT. ENSURE ALL STAFF ARE TRAINED TO REDUCE THE EXPOSURE AND CONTAMINATION FOLLOWING A VOMIT OR FECAL INCIDENT *INFORMATION SUPPLIED WITH THE REPORT.**
Comply By: 7/21/2025 Originally Issued On: 7/21/2025

New Order: 4-300 Equipment Numbers and Capacities
4-302.13B *Priority Level: Priority 2 CFP#: 48*
MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.
COMMENT: **NO IRREVERSIBLE TEMPERATURE INDICATOR FOR THE DISH MACHINE. PROVIDE AND USE FREQUENTLY TO ENSURE A SURFACE UTENSIL TEMPERATURE OF AT LEAST 160*F IS REACHED FOR SANITIZING.**
Comply By: 7/21/2025 Originally Issued On: 7/21/2025

New Order: 4-500 Equipment Maintenance and Operation
4-502.11B *Priority Level: Priority 2 CFP#: 36*
MN Rule 4626.0820B Calibrate food temperature measuring devices in accordance with manufacturer's specifications as often as necessary to ensure accuracy.
COMMENT: **PERSON IN CHARGE STATED THAT THERMOMETERS ARE NOT BEING CALIBRATED/VERIFIED FOR ACCURACY. ENSURE ALL FOOD THERMOMETERS ARE CALIBRATED/VERIFIED FREQUENTLY TO ENSURE ACCURACY. *INFORMATION SUPPLIED WITH REPORT.**
Comply By: 7/21/2025 Originally Issued On: 7/21/2025

! **New Order: 4-700 Sanitizing Equipment and Utensils**
4-703.11B *Priority Level: Priority 1 CFP#: 16*
MN Rule 4626.0905B Sanitize food contact surfaces of equipment and utensils after cleaning by using mechanical hot water operations that achieve a utensil surface temperature of 160 degrees F (71 degrees C) and are set up and maintained in accordance with the specifications of NSF International and the manufacturer's data plate.
COMMENT: **IRREVERSIBLE TEMPERATURE INDICATOR LEFT ON SITE FOR DISH MACHINE VERIFICATION FAILED (STICKER WAS UNABLE TO BE LOCATED), SO MACHINE COULD NOT BE VERIFIED. ESTABLISHMENT IS PURCHASING IRREVERSIBLE TEMPERATURE INDICATORS AND WILL FOLLOW-UP WITH INSPECTOR ONCE THEY HAVE BEEN RECEIVED AND THE MACHINE HAS BEEN TESTED.**
Comply By: 7/28/2025 Originally Issued On: 7/21/2025

New Order: 5-200C Plumbing: Maintenance, fixture location
5-205.11AB *Priority Level: Priority 2 CFP#: 10*
MN Rule 4626.1110AB The handwashing sink must be accessible at all times for employee use, and must be used only for handwashing.
COMMENT: **SIGN AT HANDWASHING SINK INDICATES LEFT BASIN IS FOR HANDWASHING, BUT THERE WERE ITEMS STORED IN THE BASIN INCLUDING A DRYING RACK. DISCONTINUE USING THE HANDWASHING SIDE OF THE SINK FOR PURPOSES OTHER THAN HANDWASHING. *ITEMS WERE REMOVED DURING INSPECTION.**
Comply By: 7/21/2025 Originally Issued On: 7/21/2025

Food & Beverage General Comment

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

DISCUSSED:
-EMPLOYEE ILLNESS POLICY AND LOG

-HANDWASHING
-SANITIZER USE
-CLEANING/SANITIZING FOOD CONTACT SURFACES AND UTENSILS
-HIGH TEMPERATURE SANITIZING DISH MACHINE TEMPERATURE VERIFICATION
-DATE MARKING PROCEDURES
-THERMOMETER USE AND CALIBRATION
-SERVING A HIGHLY SUSCEPTIBLE POPULATION (NO RAW/UNDERCOOKED ANIMAL FOODS, NO UNPASTEURIZED JUICE, MILK, ETC)
-VOMIT/FECAL INCIDENT CLEAN UP PROCEDURES
-FOOD SOURCE
-FOOD SERVICE PROCEDURES (SAME-DAY SERVICE)
-PEST CONTROL
-PHYSICAL FACILITIES AND MAINTENANCE

*REPORT WAS DISCUSSED WITH THE PERSON IN CHARGE ON SITE, STEPHEN, AND WITH THE NURSE EVALUATOR, DEDE.

*FLOORS ARE LAMINATE, WALLS AND CEILING ARE SMOOTH PAINTED DRYWALL. COUNTERTOPS ARE LAMINATE AND CABINETS ARE LAMINATE WITH HALLOW BASE. 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.

*KITCHEN HAS A 2-BASIN SINK. ONE BASIN IS DESIGNATED AS THE HANDWASHING SINK. THIS BASIN MAY ONLY BE USED FOR HANDWASHING PURPOSES.

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

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 F1004251078 from 7/21/2025

Molly Dougherty

Stephen Irabor
Person In Charge

Molly Dougherty,
Public Health Sanitarian 3
651-201-3978
molly.dougherty@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

Blessed Hands Health Care in C
Cottage Grove
County/Group: Washington County

Inspection Info

Report Number: F1004251078
Inspection Type: Full
Date: 7/21/2025
Time: 12:10:00 PM

Equipment Temperature: Product/Item/Unit: Ambient Temperature**; Temperature Process:** Cold-Holding
Location: Refrigerator at <38 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Milk**; Temperature Process:** Cold-Holding
Location: Refrigerator at 37 Degrees F.
Comment:
Violation Issued?: No