



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

October 1, 2025

Licensee

Humble Health Services LLC
13205 Humboldt Avenue South
Burnsville, MN 55337

RE: Project Number(s) SL40738015

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 August 12, 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,

A handwritten signature in black ink, appearing to read "Casey DeVries". The signature is fluid and cursive, with the first name "Casey" written in a larger, more prominent script than the last name "DeVries".

Casey DeVries, Supervisor
State Evaluation Team
Email: Casey.DeVries@state.mn.us
Telephone: 651-201-5917 Fax: 1-866-890-9290

KKM

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40738	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/12/2025
NAME OF PROVIDER OR SUPPLIER HUMBLE HEALTH SERVICES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 13205 HUMBOLDT AVENUE SOUTH BURNSVILLE, MN 55337			
(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: SL40738015-0 On August 11, 2025, through August 12, 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 were two residents; two 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.		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements	0 470			

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40738	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/12/2025
NAME OF PROVIDER OR SUPPLIER HUMBLE HEALTH SERVICES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 13205 HUMBOLDT AVENUE SOUTH BURNSVILLE, MN 55337		
(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
0 470	Continued From page 1 (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: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the required staffing plan was developed as required, potentially affecting the licensee's residents, staff, and any visitors of the licensee. This practice resulted in a level two violation (a	0 470			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40738	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/12/2025
NAME OF PROVIDER OR SUPPLIER HUMBLE HEALTH SERVICES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 13205 HUMBOLDT AVENUE SOUTH BURNSVILLE, MN 55337			
(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
0 470	Continued From page 2 violation that did not harm a licensee's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living license and was licensed for a capacity of five residents with a current census of two residents. On August 11, 2025, at 11:30 a.m., the surveyor requested the licensee's staffing plan. On August 11, 2025, at 11:35 a.m., licensed assisted living director (LALD)-A stated the staff schedule was posted; however, he was not aware of a staffing plan being created by the nurse. The licensee failed to develop and implement a staffing plan for determining its staffing level that: - included an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility. The licensee's Staffing and Scheduling policy dated April 1, 2024, indicated the clinical nurse supervisor will develop and implement a written staffing plan that provides an adequate number of qualified direct-care staff to meet the residents' needs 24-hours a day, seven-days a week. No further information was provided.	0 470			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40738	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/12/2025
NAME OF PROVIDER OR SUPPLIER HUMBLE HEALTH SERVICES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 13205 HUMBOLDT AVENUE SOUTH BURNSVILLE, MN 55337		
(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
0 470	Continued From page 3	0 470			
	TIME PERIOD FOR CORRECTION: Twenty-One (21) days				
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 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	0 480			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40738	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/12/2025
NAME OF PROVIDER OR SUPPLIER HUMBLE HEALTH SERVICES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 13205 HUMBOLDT AVENUE SOUTH BURNSVILLE, MN 55337			
(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
0 480	Continued From page 4 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 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:	0 480			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40738	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/12/2025
NAME OF PROVIDER OR SUPPLIER HUMBLE HEALTH SERVICES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 13205 HUMBOLDT AVENUE SOUTH BURNSVILLE, MN 55337		
(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
0 480	Continued From page 5 Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated August 11, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive	0 630			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40738	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/12/2025
NAME OF PROVIDER OR SUPPLIER HUMBLE HEALTH SERVICES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 13205 HUMBOLDT AVENUE SOUTH BURNSVILLE, MN 55337			
(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
0 630	Continued From page 6 or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R1 was admitted on May 9, 2025, with diagnoses including stroke with left sided paralysis, chronic obstructive pulmonary disease (COPD-chronic lung disease), and chronic kidney disease. R1's Service Plan dated May 23, 2025, indicated services including medication administration, medication set-up, assistance with dressing, transfers, positioning, grooming, nail care, and toileting. R1's Service Plan lacked the treatment of compression stockings. On August 12, 2025, at 8:20 a.m., the surveyor observed licensed assisted living director (LALD)-A administer R1's medications, assist him with dressing, and donned R1's compression stockings. R1's IAPP dated August 9, 2025, indicated "false" to the question, "is resident susceptible to abuse from another individual including other vulnerable adults?" On August 12, 2025, at 9:40 a.m., clinical nurse supervisor (CNS)-B stated R1 was considered a vulnerable adult as he was receiving services from the licensee and further stated she had not considered that when answering the question considering a resident's ability to self-report abuse, neglect or exploitation. The licensee failed to accurately depict R1 as a vulnerable adult; furthermore, the licensee failed	0 630			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40738	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/12/2025
NAME OF PROVIDER OR SUPPLIER HUMBLE HEALTH SERVICES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 13205 HUMBOLDT AVENUE SOUTH BURNSVILLE, MN 55337			
(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
0 630	Continued From page 7 to include interventions to minimize the risk for abuse for R1. The licensee's Individual Abuse Prevention Plan policy dated April 1, 2024, indicated [licensee name] will develop and implement an individual abuse prevention plan for each vulnerable adult. All residents in an assisted living are categorically considered vulnerable adults. The plan will contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including: a. other vulnerable adults b. the person's risk of abusing other vulnerable adults, and c. statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630			
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees,	0 660			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40738	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/12/2025
NAME OF PROVIDER OR SUPPLIER HUMBLE HEALTH SERVICES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 13205 HUMBOLDT AVENUE SOUTH BURNSVILLE, MN 55337		
(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
0 660	Continued From page 8 contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included documentation of completion of a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test for one of two employees (licensed assisted living director (LALD)-A). 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 client'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: LALD-A's employee record indicated a hire date of May 3, 2024, to provide direct care services to the licensee's residents. On August 12, 2025, at 8:20 a.m., LALD-A	0 660			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40738	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/12/2025
NAME OF PROVIDER OR SUPPLIER HUMBLE HEALTH SERVICES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 13205 HUMBOLDT AVENUE SOUTH BURNSVILLE, MN 55337			
(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
0 660	Continued From page 9 assisted R1 with medication administration, assistance with dressing, and donning compression stockings. LALD-A's employee file included documentation of a completed health history and symptom screening dated September 10, 2024, and evidence he completed one of two TST skin tests dated September 8, 2024; however, LALD-A's record lacked evidence a second step TST was completed. On August 12, 2025, at 11:20 a.m., licensed assisted living director (LALD)-A stated he had completed one TST screening; however, was confused with the process and never returned to the clinic for the second step (second TST); and further stated he now realized it and was going to set up a blood test to adequately finish the process. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, and based on CDC guidelines, indicated an employee may begin working with residents after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW starts working with patients. Baseline TB screening should be documented in the employee's record. The licensee's Tuberculosis Screening policy dated April 1, 2024, indicated [facility name] will establish and maintain a comprehensive tuberculosis infection control program according	0 660			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40738	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/12/2025
NAME OF PROVIDER OR SUPPLIER HUMBLE HEALTH SERVICES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 13205 HUMBOLDT AVENUE SOUTH BURNSVILLE, MN 55337			
(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
0 660	Continued From page 10 to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report (MMWR). The program includes a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The policy further indicated: Staff whose essential job functions require work within the same air space of home care clients will be screened and tested for tuberculosis prior to the staff being exposed to clients. Baseline (upon hire) screening will be completed, but serial (annual) screening will only be required with increased occupational risk or exposure. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660			
01750 SS=F	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident.	01750			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40738	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/12/2025
NAME OF PROVIDER OR SUPPLIER HUMBLE HEALTH SERVICES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 13205 HUMBOLDT AVENUE SOUTH BURNSVILLE, MN 55337			
(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
01750	Continued From page 11 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to specify in writing, specific instructions for as needed (PRN) medications and documented those instructions for one of one resident (R1) for medication administration delegated to unlicensed personnel. 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: R1 R1 was admitted on May 9, 2025, with diagnoses including stroke with left sided paralysis, chronic obstructive pulmonary disease (COPD-chronic lung disease), and chronic kidney disease. R1's Service Plan dated May 23, 2025, indicated services provided included medication administration and medication set-up. On August 12, 2025, at 8:20 a.m., the surveyor observed licensed assisted living director (LALD)-A administer R1's medications, assist him with dressing, and apply R1's compression stockings.	01750			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40738	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/12/2025
NAME OF PROVIDER OR SUPPLIER HUMBLE HEALTH SERVICES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 13205 HUMBOLDT AVENUE SOUTH BURNSVILLE, MN 55337		
(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
01750	Continued From page 12 R1's signed medication orders dated May 7, 2025, and August 1, 2025, included two medications for high blood pressure, one blood thinner, one for HIV (human immunodeficiency virus), two for constipation, one for edema, one for neuropathy (nerve pain), one for high cholesterol, one for obesity, one inhaler for COPD, and one supplement. Additionally, R1's signed medication orders included one medication for mild pain, one for muscle spasms, two for constipation, and two for shortness of breath/COPD. R1's medication administration record (MAR) dated August 2025, included the following PRN medications: -docusate 100 milligrams (mg), give one soft gel as needed, up to three times per day by mouth for constipation -psyllium 25%, give one packet as needed by mouth for constipation -Ipratropium-albuterol 0.5-2.5 mg/3 milliliter (ml), give one vial as needed by inhalation for shortness of breath -Ventolin 90 microgram (mcg)/act, give two puffs as needed by inhalation for COPD The licensee did not provide instruction for the unlicensed personnel (ULP) to understand which PRN medication for constipation (docusate or psyllium) should be used and which PRN medication for shortness of breath (ipratropium-Albuterol nebulizer or Ventolin inhaler) should be used first, second, etc. On August 12, 2025, at 9:20 a.m., clinical nurse supervisor (CNS)-B stated she was not aware the nurse needed to provide written instructions when multiple PRN medications were prescribed	01750			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40738	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/12/2025
NAME OF PROVIDER OR SUPPLIER HUMBLE HEALTH SERVICES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 13205 HUMBOLDT AVENUE SOUTH BURNSVILLE, MN 55337			
(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
01750	Continued From page 13 for the same symptom. The licensee's Medication and Treatment-Administration and Delegation policy dated April 1, 2024, indicated when administration of medications or treatment/therapy is delegated or assigned to unlicensed personnel, [licensee name] will ensure that the registered nurse has: -Specified, in writing, specific instructions for each resident and documented those instructions in the resident's records No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750			
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	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40738	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/12/2025
NAME OF PROVIDER OR SUPPLIER HUMBLE HEALTH SERVICES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 13205 HUMBOLDT AVENUE SOUTH BURNSVILLE, MN 55337			
(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
01760	Continued From page 14 review, the licensee failed to ensure prescriber's orders were accurately transcribed for one of one resident (R1) receiving medication services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted on May 9, 2025, with diagnoses including stroke with left sided paralysis, chronic obstructive pulmonary disease (COPD-chronic lung disease), and chronic kidney disease. R1's Service Plan dated May 23, 2025, indicated services including medication administration and medication set-up. On August 12, 2025, at 8:20 a.m., the surveyor observed licensed assisted living director (LALD)-A administer R1's medications, assist him with dressing, and apply R1's compression stockings. R1's signed medication orders dated May 7, 2025, May 29, 2025, and August 1, 2025, indicated: - cyclobenzaprine oral tablet, give one tablet by mouth every eight hours needed for muscle pain - over the counter laxative (psyllium), one packet daily as needed for constipation - ipratropium-albuterol Inhalation solution 0.5-2.5	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40738	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/12/2025
NAME OF PROVIDER OR SUPPLIER HUMBLE HEALTH SERVICES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 13205 HUMBOLDT AVENUE SOUTH BURNSVILLE, MN 55337			
(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
01760	Continued From page 15 milligrams (mg)/3 milliliters(ml), one vial inhaled orally every six hours as needed for shortness of breath - Ventolin HFA, give 2 puffs by mouth every four hours as needed for shortness of breath R1's medication administration record (MAR) dated August 2025, included the following PRN medications: -cyclobenzaprine 10 mg, give one tablet as needed by mouth for muscle spasms -psyllium 25%, give one packet as needed by mouth for constipation -ipratropium-albuterol 0.5-2.5 mg/3 ml, give one vial as needed by inhalation for shortness of breath -Ventolin 90 microgram (mcg)/act, give two puffs as needed by inhalation for COPD R1's MAR did not match the signed prescriber's orders for cyclobenzaprine, psyllium, ipratropium-albuterol, and Ventolin. On August 12, 2025, at 9:20 a.m., clinical nurse supervisor (CNS)-B stated she didn't realize the frequency was missed with some of the PRN medications when she transcribed them to the MAR and would need to be included as per the physician's order. The licensee's Medication and Treatment Record Documentation and Refusal policy dated April 1, 2024, indicated [licensee name] will create and maintain a correct and accurate medication and/or treatment/therapy record for each resident receiving medication assistance or administration and or treatments and therapies No further information was provided.	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40738	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/12/2025
NAME OF PROVIDER OR SUPPLIER HUMBLE HEALTH SERVICES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 13205 HUMBOLDT AVENUE SOUTH BURNSVILLE, MN 55337			
(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
01760	Continued From page 16	01760			
	TIME PERIOD FOR CORRECTION: Seven (7) days.				
01770 SS=F	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure documentation of medication setup included the required content for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: During the entrance conference on August 11, 2025, at 11:30 a.m., licensed assisted living director (LALD)-A stated the licensee provided medication management services to their residents, including medication setup. R1's Service Plan dated May 23, 2025, indicated services including medication administration and	01770			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40738	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/12/2025
NAME OF PROVIDER OR SUPPLIER HUMBLE HEALTH SERVICES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 13205 HUMBOLDT AVENUE SOUTH BURNSVILLE, MN 55337			
(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
01770	Continued From page 17 medication set-up. On August 12, 2025, at 8:40 a.m., the surveyor observed LALD-A prepare R1's morning medications from a med-minder found in the licensee's locked medication cart. LALD-A stated the nurse set R1's medications up on a weekly basis, the unlicensed personnel (ULP) were to count the number of tablets/pills in the designated day and match to the number of pills found on the medication administration record (MAR). R1's MAR dated August 2025, indicated he received two medications for high blood pressure, one for blood thinning, one for HIV (human immunodeficiency virus), two for constipation, one for edema, one for neuropathy (nerve pain), one for high cholesterol, one for obesity, one inhaler for COPD (chronic obstruction pulmonary disease-a chronic lung disease), and one supplement. Additionally, R1's MAR included as needed (PRN) medications including one for mild pain, one for muscle spasms, two for constipation, and two for shortness of breath/COPD. R1's progress notes dated June 26, 2025, July 3, 2025, July 10, 2025, July 17, 2025, July 31, 2025, and August 7, 2025, indicated the nurse set up medications for the week. R1's record lacked documentation by the licensed nurse at the time of setup to include the name of medication, quantity of dose, times to be administered, and route of administration as required. On August 12, 2025, at 10:00 a.m., clinical nurse	01770			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40738	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/12/2025
NAME OF PROVIDER OR SUPPLIER HUMBLE HEALTH SERVICES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 13205 HUMBOLDT AVENUE SOUTH BURNSVILLE, MN 55337			
(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
01770	Continued From page 18 supervisor (CNS)-B stated she documented a clinical note regarding the medications she set up in R1's med minder; however, was not aware of the additional required content for documentation of medication set up services. The licensee's Medication Management Dosage Box Setup policy dated April 1, 2024, indicated when the licensed nurse has completed setting up the medications into the dosage box, the set-up is documented on the MAR. No further information was provided. TIME PERIOD TO CORRECT: Seven (7) Days	01770			
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy	01940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40738	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/12/2025
NAME OF PROVIDER OR SUPPLIER HUMBLE HEALTH SERVICES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 13205 HUMBOLDT AVENUE SOUTH BURNSVILLE, MN 55337			
(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
01940	Continued From page 19 services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to include on the service plan a written statement of the treatment or therapy services provided for one of one resident (R1) receiving treatments. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on August 11, 2025, at 11:30 a.m., licensed assisted living director (LALD)-A stated the licensee provided treatment and therapy services to residents as prescribed. R1 was admitted on May 9, 2025, with diagnoses including stroke with left sided paralysis, chronic	01940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40738	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/12/2025
NAME OF PROVIDER OR SUPPLIER HUMBLE HEALTH SERVICES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 13205 HUMBOLDT AVENUE SOUTH BURNSVILLE, MN 55337			
(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
01940	Continued From page 20 obstructive pulmonary disease (COPD-chronic lung disease), and chronic kidney disease. R1's Service Plan dated May 23, 2025, indicated services included medication administration, medication set-up, assistance with dressing, transfers, positioning, grooming, nail care, and toileting. R1's Service Plan lacked the treatment of compression stockings. On August 12, 2025, at 8:20 a.m., the surveyor observed LALD-A administer R1's medications, assist him with dressing, and apply R1's compression stockings. R1's record included a signed prescriber's order dated May 7, 2025, for thigh high compression stockings, on every morning and off at bedtime. R1's Comprehensive Assessment dated August 9, 2025, in the section labeled "Treatments" indicated "Place compression socks in the morning and take them off at night" and an "X" in the column identifying "Full Assist". R1's record lacked documentation of compression stocking management. The licensee failed to include R1's treatment of compression stockings in his Service Plan and failed to develop and maintain an individualized treatment and therapy management for R1 to include: 1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks	01940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40738	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/12/2025
NAME OF PROVIDER OR SUPPLIER HUMBLE HEALTH SERVICES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 13205 HUMBOLDT AVENUE SOUTH BURNSVILLE, MN 55337		
(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
01940	Continued From page 21 that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. On August 12, 2025, at 9:35 a.m., clinical nurse supervisor (CNS)-B stated she didn't realize R1's compression stockings were not on the service plan and needed to complete a more formal treatment plan to include the required content. The licensee's Treatment and Therapy Management Plan policy dated April 1, 2024, indicated for each resident at [licensee name] receiving management of ordered or prescribed treatments or therapy services, the facility will prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The licensee will develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: a. A statement of the type of services that will be provided b. Documentation of specific resident instructions relating to the treatments or therapy administration c. Identification of treatment or therapy tasks	01940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40738	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/12/2025
NAME OF PROVIDER OR SUPPLIER HUMBLE HEALTH SERVICES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 13205 HUMBOLDT AVENUE SOUTH BURNSVILLE, MN 55337			
(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
01940	Continued From page 22 that will be delegated to unlicensed personnel d. Procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services e. Any resident-specific requirements relating to documentation of treatment and therapy received f. Verification that all treatment and therapy was administered as prescribed g. Monitoring of treatment or therapy to prevent possible complications or adverse reactions. No further information provided TIME PERIOD FOR CORRECTION: Seven (7) days	01940			
01950 SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and	01950			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40738	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/12/2025
NAME OF PROVIDER OR SUPPLIER HUMBLE HEALTH SERVICES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 13205 HUMBOLDT AVENUE SOUTH BURNSVILLE, MN 55337			
(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
01950	Continued From page 23 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) specified, in writing, specific instructions and documented those instructions in the resident record for one of one resident (R1) with treatments. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on August 11, 2025, at 11:30 a.m., licensed assisted living director (LALD)-A stated the licensee provided treatment and therapy services to residents as prescribed. R1 was admitted on May 9, 2025, with diagnoses including stroke with left sided paralysis, chronic obstructive pulmonary disease (COPD-chronic lung disease), and chronic kidney disease. R1's Service Plan dated May 23, 2025, included medication administration, medication set-up, assistance with dressing, transfers, positioning, grooming, nail care, and toileting. R1's service plan lacked the treatment of compression stockings.	01950			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40738	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/12/2025
NAME OF PROVIDER OR SUPPLIER HUMBLE HEALTH SERVICES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 13205 HUMBOLDT AVENUE SOUTH BURNSVILLE, MN 55337		
(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
01950	Continued From page 24 On August 12, 2025, at 8:20 a.m., the surveyor observed LALD-A administer R1's medications, assist him with dressing, and apply R1's compression stockings. R1's record included a signed prescriber's order dated May 7, 2025, for thigh high compression stockings, on every morning and off at bedtime. R1's Comprehensive Assessment dated August 9, 2025, in the section labeled "Treatments" indicated "Place compression socks in the morning and take them off at night" and an "X" in the column identifying "Full Assist". R1's record lacked documentation of compression stocking management. R1's record lacked written instruction for unlicensed personnel (ULP) to follow for concerns or monitoring for redness, skin breakdown, warmth or discomfort noted with the use of compression stockings. On August 12, 2025, at 9:40 a.m., clinical nurse supervisor (CNS)-B stated she had not developed a treatment plan for R1's compression stockings and did not provide written instructions for what ULP should be monitoring for. The licensee's Treatment and Therapy Management Plan policy dated April 1, 2024, indicated [licensee's name] will develop and maintain a current individualized treatment and therapy management record for each resident and would contain documentation of specific resident instructions relating to the treatments or therapy administration.	01950			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40738	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/12/2025
NAME OF PROVIDER OR SUPPLIER HUMBLE HEALTH SERVICES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 13205 HUMBOLDT AVENUE SOUTH BURNSVILLE, MN 55337		
(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
01950	Continued From page 25 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950			
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure treatment services were documented for one of one resident (R1) receiving treatments. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include:	01960			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40738	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/12/2025
NAME OF PROVIDER OR SUPPLIER HUMBLE HEALTH SERVICES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 13205 HUMBOLDT AVENUE SOUTH BURNSVILLE, MN 55337			
(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
01960	Continued From page 26 During the entrance conference on August 11, 2025, at 11:30 a.m., licensed assisted living director (LALD)-A stated the licensee provided treatment and therapy services to residents as prescribed. R1 was admitted on May 9, 2025, with diagnoses including stroke with left sided paralysis, chronic obstructive pulmonary disease (COPD-chronic lung disease), and chronic kidney disease. R1's Service Plan dated May 23, 2025, included medication administration, medication set-up, assistance with dressing, transfers, positioning, grooming, nail care, and toileting. R1's service plan lacked the treatment of compression stockings. On August 12, 2025, at 8:20 a.m., the surveyor observed LALD-A administer R1's medications, assist him with dressing, and apply R1's compression stockings. R1's record included a signed prescriber's order dated May 7, 2025, for thigh high compression stockings, on every morning and off at bedtime. R1's Comprehensive Assessment dated August 9, 2025, in the section labeled "Treatments" indicated "Place compression socks in the morning and take them off at night" and an "X" in the column identifying "Full Assist". R1's record lacked documentation of R1's compression stocking management by the licensee. On August 12, 2025, at 9:40 a.m., clinical nurse	01960			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40738	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/12/2025
NAME OF PROVIDER OR SUPPLIER HUMBLE HEALTH SERVICES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 13205 HUMBOLDT AVENUE SOUTH BURNSVILLE, MN 55337			
(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
01960	Continued From page 27 supervisor (CNS)-B stated she had not created a treatment plan for R1's compression stockings and the unlicensed personnel (ULP) were not documenting the treatment. The licensee's Medication and Treatment Record Documentation and Refusal policy dated April 1, 2024, indicated [licensee name] will create and maintain a correct and accurate medication and/or treatment/therapy record for each resident receiving medication assistance or administration and or treatments and therapies. The following must be documented in the resident's medication and/or treatment/therapy records after providing medication/treatment assistance or administration: a. The date, b. The time, c. The quantity of dosage, d. The method of administration of all prescribed legend and over-the-counter medications and or treatments/therapy e. Signature and title of the authorized person who provided the assistance and/or administration of medications/treatment/therapy No further information was provided. TIME PERIOD TO CORRECT- Seven (7) days.	01960			
02310 SS=F	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards.	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40738	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/12/2025
NAME OF PROVIDER OR SUPPLIER HUMBLE HEALTH SERVICES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 13205 HUMBOLDT AVENUE SOUTH BURNSVILLE, MN 55337			
(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
02310	Continued From page 28 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure care and services were provided according to acceptable health care and medical or nursing standards for one of one resident (R1) with side rails. 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 August 11, 2025, at 11:30 a.m. during entrance conference, licensed assisted living director (LALD)-A stated the licensee had one resident (R1) with a hospital bed which included side rails; and further stated R1 was not currently using the hospital bed due to the discomfort of the mattress. LALD-A stated he was only aware of the requirement for the vendor to set the bed up per manufacturer's instructions. R1 was admitted on May 9, 2025, with diagnoses including stroke with left sided paralysis, chronic obstructive pulmonary disease (COPD-chronic lung disease), and chronic kidney disease. R1's Service Plan dated May 23, 2025, included medication administration, medication set-up, assistance with dressing, transfers, positioning, grooming, nail care, and toileting.	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40738	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/12/2025
NAME OF PROVIDER OR SUPPLIER HUMBLE HEALTH SERVICES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 13205 HUMBOLDT AVENUE SOUTH BURNSVILLE, MN 55337			
(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
02310	Continued From page 29 On August 12, 2025, at 8:20 a.m., the surveyor observed LALD-A administer R1's medications, assist him with dressing, and apply R1's compression stockings. The surveyor observed a hospital bed with bilateral side rails in the upper locked position. The side rails were securely fastened to the hospital bed. R1 stated he was sleeping in his lift recliner since the mattress with the hospital bed was very uncomfortable. He further stated his county case manager was working to find a different mattress and he would not use the bed until the new/acceptable mattress was received. R1's record and comprehensive assessments dated May 9, 2025, May 23, 2025, and August 9, 2025, lacked evidence the registered nurse completed an assessment of R1's ability to safely use the side rail system, lacked evidence the licensee provided education including the risks and benefits of side rails, and lacked evidence measurements of zones 1-4 had been completed as required. On August 12, 2025, at 10:00 a.m., clinical nurse supervisor (CNS)-B stated she was not aware of the requirements surrounding the bedrails. CNS-B and LALD-A completed measurements of the hospital bed side rails from zones 1-4 and documented all zones noting the measurements followed FDA recommendations. CNS-B stated she would work to complete the assessment and risks verses benefits discussion before R1 used the bed again. The licensee's Side Rails policy dated April 1, 2024, indicated When [licensee name] is aware a home care resident is utilizing side rails (a	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40738	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/12/2025
NAME OF PROVIDER OR SUPPLIER HUMBLE HEALTH SERVICES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 13205 HUMBOLDT AVENUE SOUTH BURNSVILLE, MN 55337			
(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
02310	Continued From page 30 medical device) on a bed, [licensee name] will assess the use, educate the resident, and when appropriate, the responsible person, regarding the risks and benefits of side rails, and verify that the side rail in use is of a safe design and utilized consistent with the manufacturer's directions. This policy shall be followed regardless of who owns or is supplying the side rail. When side rails are in use, an RN must conduct an assessment to identify the intended purpose of the side rail and the risks regarding the use of the side rail. If the side rail is acting as a restraint, appropriate action should be taken. Staff from [licensee name] will determine if the side rail is safe. "Safe" shall be defined as meeting all the requirements listed below: a. The side rail is used consistent with manufacturer's directions. Be aware of side rails that slide between the mattress and box spring designed for toddler use. b. The side rails are installed securely and maintained in good operating condition. Be aware of "wobbly" side rails. c. The side rail design is consistent with the FDA's 2006 recommended dimensional measurements to reduce entrapment. This means side rail zones 1,2, and 3 must not exceed 4.75". The Food and Drug Administration's (FDA), A Guide to Bed Safety, dated 2000, and revised April 2010, indicated following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40738	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/12/2025
NAME OF PROVIDER OR SUPPLIER HUMBLE HEALTH SERVICES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 13205 HUMBOLDT AVENUE SOUTH BURNSVILLE, MN 55337			
(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
02310	Continued From page 31 be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." The March 10, 2006, FDA Side Rail Entrapment Zones and Dimensional Recommendations indicated to reduce the risk of entrapment, zone 1 (within the rail) should not exceed 4 and 3/4 inches, zone 2 (under the rail, between rail supports or next to a single rail support) should not exceed 4 and 3/4 inches, zone 3 (between the rail and the mattress), should not exceed 4 and 3/4 inches, and zone 4 (under the rail, at the ends of the rail) should not exceed 2 and 3/8 inches or be greater than a 60 degree angle. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) Days	02310			



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

Page: 1

Establishment Info

HUMBLE HEALTH SERVICES LLC
13205 HUMBOLDT AVENUE SOUTH
Burnsville, MN 55337
Dakota County
Parcel:

Phone:

License Info

License: HFID 40738

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

Inspection Info

Report Number: F1018251033
Inspection Type: Full - Single
Date: 8/11/2025 Time: 2:45:45 PM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 1
Total Priority 2 Orders: 0
Total Priority 3 Orders: 1
Delivery:

! New Order: 3-300B Protection from Contamination: cross-contamination, eggs

3-302.11A(1) *Priority Level: Priority 1 CFP#: 15*

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

COMMENT: Raw eggs observed to be stored over ready to eat foods in the refrigerator. Discussed with manager to keep raw eggs at the bottom of the refrigerator to prevent cross contamination.

Comply By: 8/11/2025 Originally Issued On: 8/11/2025

New Order: 3-400A Destroying Organisms: cooking time/temperature, freezing

3-401.11D(1) & (2) *Priority Level: Priority 3 CFP#: 18*

MN Rule 4626.0340D(1)(2) Discontinue offering raw or undercooked fish, shellstock, eggs, steak tartar or comminuted beef to a highly susceptible population which includes children.

COMMENT: Manager stated that residents may order eggs undercooked (Sunny side up, over easy, etc) if they like.

Discussed with owner that all eggs must be fully cooked before being served to residents as they are considered an at risk population. Comply with rule.

Comply By: 8/11/2025 Originally Issued On: 8/11/2025

Food & Beverage General Comment

Establishment is a residential home with residential equipment and facilities.

Establishment is doing all same day service of foods.

Establishment has a dishwasher with a sanitize function available. Dishwasher test strips indicated proper temperature was achieved during the cycle.

Kitchen has a two-compartment sink with one basin specifically for hand washing and one for food prep.

Establishment has a needle point thermometer for checking food temperatures.

Discussed pest control.

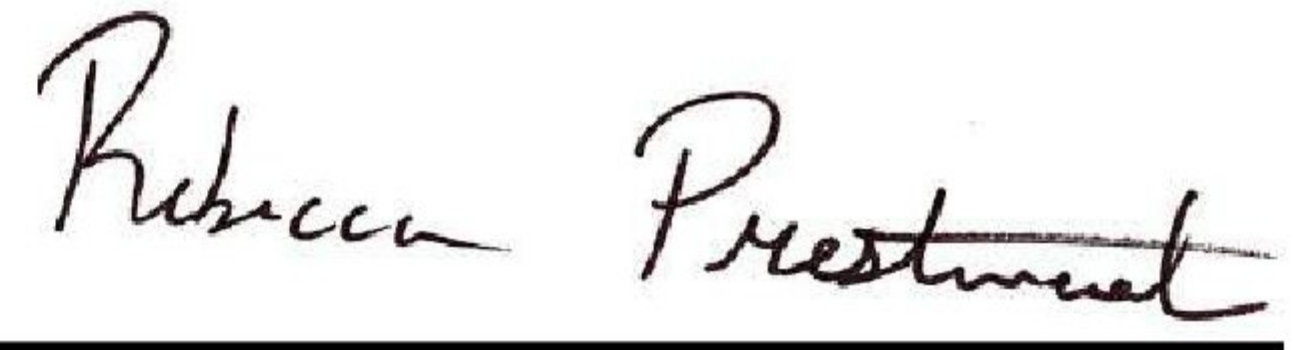
Discussed employee illness and viewed illness log.

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 F1018251033 from 8/11/2025

Abdirahman M Abdullahi
Manager



Rebecca Prestwood, REHS
Public Health Sanitarian 3
651-201-3777
rebecca.prestwood@state.mn.us