Electronically Delivered

July 14, 2025

Licensee
Restart Inc
614 8th Street Southeast
Minneapolis, MN 55414

RE: Project Number(s) SL25373016

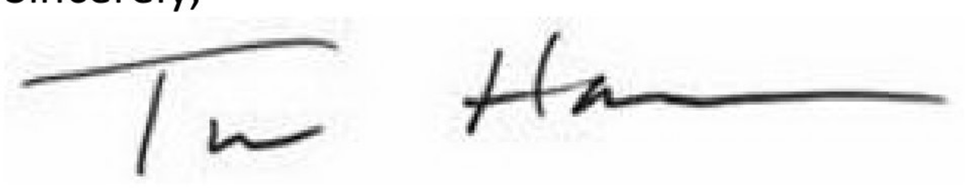
Dear Licensee:

On May 20, 2025, the Minnesota Department of Health completed a follow-up of your survey to determine correction of orders from the survey completed on December 6, 2024. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,



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

HHH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

April 14, 2025

Licensee
Restart Inc
614 8th Street Southeast
Minneapolis, MN 55414

RE: Project Number(s) SL25373016

Dear Licensee:

On February 27, 2025, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on December 6, 2024. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the December 6, 2024 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on December 6, 2024, found not corrected at the time of the February 27, 2025, follow-up survey and/or subject to penalty assessment are as follows:

0780-Fire Protection And Physical Environment-144g.45 Subd. 2 (a) (1)

The details of the violations noted at the time of this follow-up survey completed on February 27, 2025 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders outlined on the state form; however, plans of correction are not required to be submitted for approval.

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

We urge you to review these orders carefully. If you have questions, please contact Tim Hanna at 507-208-8982.

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

Sincerely,

Tim Hanna, Supervisor
State Engineering Services Section
Email: Tim.Hanna@state.mn.us
Telephone: 507-208-8982 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
	25373	A. BUILDING: _____ B. WING _____	R 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RESTART INC	614 8TH STREET SE MINNEAPOLIS, MN 55414

(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 FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS SL#25373016-1 On February 27, 2025 thru March 10, 2025, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on December 4, 2024. At the time of the survey, there were 5 residents; 5 receiving services under the Assisted Living License. As a result of the follow-up survey, the following orders were reissued.	{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.	
{0 460} SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request	{0 460}		

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{0 460}	Continued From page 1 assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by:	{0 460}		
			Not reviewed during this survey.	
{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	{0 480}		

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{0 480}	Continued From page 2 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 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.	{0 480}		

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{0 480}	Continued From page 3 This MN Requirement is not met as evidenced by:	{0 480}	Not reviewed during this survey.	
{0 650} SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by:	{0 650}	Not reviewed during this survey.	
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness	{0 680}		

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{0 680}	Continued From page 4 (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by:	{0 680}	Not reviewed during this survey.	
{0 780} SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of	{0 780}		

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{0 780}	Continued From page 5 bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on survey and interview, the licensee failed to ensure physical facility elements did not constitute a distinct hazard to life. The licensee failed to provide resident bedrooms with the minimum window opening meeting the minimum state standard for egress. This had the potential to directly affect all residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	{0 780}		

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{0 780}	Continued From page 6 On February 27, 2025, at 10:30 a.m., surveyor toured the facility with unlicensed personnel (ULP)-C to follow up on orders issued pursuant to a survey completed on December 6, 2024. Surveyor measured the windows in bedrooms 1, 6, and 7. OCCUPIED SLEEPING ROOMS: Bedroom 1: one window measured 27 inches wide, 22 inches in height and only 594 square inches in openable area. The window in bedroom 1 did not meet the minimum requirements for total openable area of 648 inches. On February 27, 2025, at 11:00 a.m., ULP-C stated they didn't know when work would be completed on the window in resident room 1. FINDINGS FROM INITIAL SURVEY ON December 4, 2024: OCCUPIED RESIDENT SLEEPING ROOMS Resident sleeping room one, measured 27 inches wide, 22 inches in height and only 594 square inches in openable area. Resident sleeping room six, measured 25 inches wide, 23 inches in height and only 575 square inches in openable area. Resident sleeping room seven, measured 27 inches wide, 23 inches in height and only 575 square inches in openable area. Existing emergency escape and rescue openings are required to meet a minimum clear opening	{0 780}		

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{0 780}	Continued From page 7 area of 648 square inches and have a minimum dimension of 20 inches in height and a minimum dimension of 20 inches in width. Windowsill height shall not be more than 48 inches from the floor to the clear opening. No Further information was provided.	{0 780}		
{0 800} SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{0 800}	Not reviewed during this survey.	
{0 810} SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar	{0 810}		

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{0 810}	Continued From page 8 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:	{0 810}	Not reviewed during this survey.	
{01290} SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12.	{01290}		

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{01290}	Continued From page 9 (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by:	{01290}		
{01620} SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.	{01620}	Not reviewed during this survey.	

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{01620}	Continued From page 10 This MN Requirement is not met as evidenced by:	{01620}	Not reviewed during this survey.	
{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:	{01760}	Not reviewed during this survey.	
{01890} SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by:	{01890}	Not reviewed during this survey.	

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Electronically Delivered

February 5, 2025

Licensee
Restart, Inc.
614 8th Street Southeast
Minneapolis, MN 55414

RE: Project Number(s) SL25373016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on December 6, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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 . . ."

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS

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

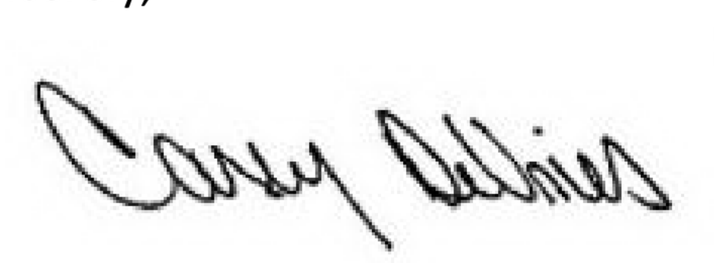
To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,



Casey DeVries, Supervisor
State Evaluation Team
Email: Casey.DeVries@state.mn.us
Telephone: 651-201-5917 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
	25373	A. BUILDING: _____ B. WING _____	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RESTART INC	614 8TH STREET SE MINNEAPOLIS, MN 55414

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL25373016-0 On December 2, 2024, through December 6, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were six resident(s); six receiving services under the Assisted Living Facility license. An immediate correction order was identified on December 4, 2024, issued for SL25373016-0, tag identification 0780. During the survey, the licensee provided corrective documentation on action taken to mitigate the imminent risk to residents identified in the immediate order. Noncompliance remained and the scope and level remained unchanged.	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.	
0 460 SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request	0 460		

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0 460	Continued From page 1 assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide a means for residents to request assistance for health and safety needs 24 hours a day, seven days a week. This had the potential to affect all residents. 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:	0 460		

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0 460	Continued From page 2 On December 2, 2024, at 10:00 a.m., during the entrance conference, licensed assisted living director (LALD)-A stated the facility had no system in place for residents to request assistance. On December 2, 2024, from 11:04 a.m., to 11:21 a.m., during a facility tour, the surveyor observed a three-level home and did not observe call lights, call pendants, bells, or any other means for residents to request assistance located in the rooms of the residents or in the common areas. On December 3, 2024, at 10:00 a.m., clinical nurse supervisor (CNS)-B stated everyone had a cell phone to call for assistance if needed, and all residents had safety checks included in their service plans and were checked every two hours. On December 4, 2024, at 1:02 p.m., LALD-A stated that all residents received waivered services. LALD-A stated that if the residents required a call light system, the waiver would have included a designation for a personal protection and summoning system. LALD-A stated their residents were not assessed as needing a call light system, so they would not be able to provide this service as it would be outside of the residents assessed needs. On December 4, 2024, at 12:15 p.m., CNS-B stated all residents had cell phones and could use their cell phones independently and without assistance. On December 4, 2024, at 1:16 p.m., CNS-B stated staff make all phone calls for R6. On December 4, 2024, at 1:17 p.m., LALD-A stated R6 was unable to independently use a cell	0 460		

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0 460	Continued From page 3 phone and would not be able to independently use a call light system. R3 R3 was admitted to the licensee on October 17, 2022, to receive assisted living services. R3's service plan (Waiver) - Addendum to contract dated June 15, 2023, indicated that R3 received safety checks five times a day. R3's assessment dated September 20, 2024, indicated R3 was unable to activate an emergency call system and would need assistance. Additionally, the assessment indicated that R3 could use a cell phone but sometimes needed assistance. R6 R6 was admitted to the licensee on June 13, 2007, and began receiving assisted living services on Augst 1, 2021. R6's service plan (Waiver) - Addendum to contract dated June 15, 2023, indicated R6 received safety checks five times a day. R6's assessment dated September 20, 2024, indicated R6 would be unable to activate an emergency call system and would require assistance from staff. Additionally, R6 was assessed as not being able to independently use a cell phone. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 460		

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0 480	Continued From page 4	0 480		
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 existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink;	0 480		

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0 480	Continued From page 5 (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: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated December 2, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24	0 480		

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0 480	Continued From page 6 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 650 SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records contained the required content for three of three employees (clinical nurse supervisor (CNS)-B, unlicensed personnel (ULP)-C, ULP-F).	0 650		

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0 650	Continued From page 7 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: CNS-B CNS-B was hired April 3, 2024, to provide assisted living services. On December 2, 2024, and December 3, 2024, the surveyor observed CNS-B accessing medical records of residents residing within the facility. ULP-C ULP-C was hired February 26, 2023, to provide assisted living services. On December 2, 2024, between 10:00 a.m., and 3:20 p.m., the surveyor observed ULP-C provide assisted living services to residents residing within the facility. ULP-F ULP-F was hired June 26, 2023, to provide assisted living services. On December 3, 2024, between 7:37 a.m., to 8:12 a.m., the surveyor observed ULP-F provide medications to residents residing within the facility. CNS-B, ULP-C, and ULP-F's employee records	0 650		

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0 650	Continued From page 8 lacked documentation of evidence of completion of the following required orientation topics: - overview of assisted living statutes; - review of provider's policies and procedures; - review of types of assisted living services the employee will provide and provider's scope of license. On December 3, 2024, from 11:38 a.m., to 12:00 p.m., in separate interviews, CNS-B, ULP-C, and ULP-F stated they recalled receiving orientation on the missing required contents. The licensee's Personnel Records policy dated August 1, 2021, indicated personnel records would be kept up todate, well organized and confidential and would comply with the assisted living law and other relevant laws. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor;	0 680		

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0 680	Continued From page 9 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 maintain a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z and failed to post the emergency plan prominently. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On December 2, 2024, at 12:54 p.m., the surveyor retrieved a printed EPP that was pinned to the wall of the facility office area directly adjacent to the kitchen.	0 680		

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0 680	Continued From page 10 On December 2, 2024, at 1:17 p.m., the surveyor asked if the item pinned to the wall was the licensee's complete EPP. Licensed assisted living director (LALD)-A stated there was a big red binder that was a more complete version of the one found pinned to the wall. House manager (HM) went into the basement of the facility to retrieve the complete copy of licensee's EPP. On December 2, 2024, 1:26 p.m., HM-D returned from the basement and informed the surveyor they were unable to locate the big red binder that housed the completed version of the licensee's EPP. The licensee's posted EPP lacked evidence of the following required content: - annual review of the EPP, last review date was August 1, 2021; - quarterly review of missing resident policy; - annual review of the written risk assessment utilizing an all-hazards approach; - annual review and/or updates of policies; - policies and procedures for subsistence needs for staff and residents; - listed as Appendix Q and Appendix R but was not available for review at time of survey; - policies and procedures for tracking staff and patients; - listed as Appendix C but was not available for review at time of survey; - policies and procedures for sheltering in place; - referenced in table of contents but was not available for review at time of survey; - policies and procedures for medical documents; - referenced in plan outline but was not available for review at time of survey. - policies and procedures for volunteers; - referenced in plan outline but was not	0 680		

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0 680	Continued From page 11 available for review at time of survey; - arrangements with other facilities; - listed as Appendix V but was not available for review at time of survey; - roles under wavier declared by secretary; - policies and procedures for providing care and/or treatments at alternative care sites under 1135 waiver; - methods for sharing information; - referenced in plan outline but was not available for review at time of survey; - sharing information on occupancy needs. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 780 SS=I	144G.45 Subd. 2 (a) (1) Fire protection and physical environment for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except	0 780		

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0 780	Continued From page 12 that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide facilities that were not a distinct hazard to life. This had the potential to directly affect a limited number of residents and staff. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On a facility tour on December 4, 2024, from 1:45 p.m. to 3:30 p.m., with licensed assisted living director (LALD)-A, it was observed that compliant emergency escape and rescue openings were not provided in resident sleeping rooms 1, 6 and 7. OCCUPIED RESIDENT SLEEPING ROOMS Resident sleeping room 1, emergency escape and rescue clear window opening measurements were 27 inches wide, 22 inches in height and only 594 square inches in openable area. The window was measured with LALD-A, and the surveyor	0 780		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 780	Continued From page 13 present. The window did not meet the minimum requirements for total clear opening square inch area. Resident sleeping room 6, emergency escape and rescue clear window opening measurements were 25 inches wide, 23 inches in height and only 575 square inches in openable area. The window was measured with LALD-A, and the surveyor present. The window did not meet the minimum requirements for total clear opening square inch area. Resident sleeping room 7, emergency escape and rescue clear window opening measurements were 27 inches wide, 23 inches in height and only 575 square inches in openable area. The window was measured with LALD-A, and the surveyor present. The window did not meet the minimum requirements for total clear opening square inch area. It was explained to LALD-A, that at least one compliant emergency escape and rescue opening is required within each resident sleeping room. Existing emergency escape and rescue openings are required to meet a minimum clear opening area of 648 square inches and have a minimum dimension of 20 inches in height and a minimum dimension of 20 inches in width. Windowsill height shall not be more than 48 inches from the floor to the clear opening. These deficient conditions were visually verified by LALD-A, accompanying on the tour. Survey staff explained that an immediate correction order was issued for the above findings. TIME PERIOD FOR CORRECTION: Immediate.	0 780		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25373	A. BUILDING: _____ B. WING _____	12/06/2024

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RESTART INC	614 8TH STREET SE MINNEAPOLIS, MN 55414

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0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On a facility tour with licensed assisted living director (LALD)-A, on December 4, 2024, from 1:30 p.m. to 4:00 p.m., the surveyor made the following observations.	0 800		

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0 800	Continued From page 15 Plaster/paint in the main entry way, dining room on main level, is cracked and need of repair. Caulk was missing around the toilet and bathtub in the main floor bathroom. During the tour LALD-A, visually verfied the above deficient condtions and stated that the newly hired facility maintenance team member would make the repairs as soon as possible. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the	0 810		

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0 810	Continued From page 16 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 required content, make the plan readily available, provide required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On December 4, 2024, at, 3:30 p.m. Licensed assisted living director (LALD)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. The FSEP did not identify specific fire protection actions for residents. There was no section in the	0 810		

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0 810	Continued From page 17 policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation nor did it include instructions for staff to follow in case of relocation. On December 4, 2024, at 3:30 p.m., LALD-A stated they understood the areas of their policy that were incomplete and would work on bringing them into compliance. The policy reviewed was a provider made policy that was not specific to the facility. TRAINING The licensee failed to provide evacuation training to residents at least once per year. LALD-A lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan. On December 4, 2024, at 3:30 p.m., LALD-A stated they understood the requirements for training residents and staff and would implement a training program that was compliant with statute requirements. DRILLS	0 810		

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0 810	Continued From page 18 The licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. No other documentation was provided. On December 4, 2024, at 3:30 p.m., LALD-A stated drills were being performed every month. All drills were being conducted for day with only one during the afternoon shift, and none for the night shift. No additional documented drills for the facility, education was given on statue requirement. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01290 SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	01290		

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01290	Continued From page 19 review, the licensee failed to ensure a background study was affiliated with the licensee's health facility identification number (HFID) prior to staff providing services for one of eight employees (unlicensed personnel (ULP)-E). 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: ULP-E began working for the licensee on December 19, 2023, to provide assisted living services. ULP-E's employee record contained a background study affiliated to the licensee's sister facility with HFID#25371. The affiliated facility maintained active licensure and was accessible to the licensee's sensitive information person (SIP) in NETStudy 2.0 (web-based system used to submit background study requests to the Department of Human Services). ULP-E's record lacked evidence to indicate the licensee had submitted a background study that was affiliated to the licensee's HFID number prior to the start of the survey. The licensee's weekly schedule indicated ULP-E was scheduled to work from 2:00 p.m., to 10:00 p.m., November 12, November 13, November 14, November 15, November 16, November 17, November 19, November 20, November 21,	01290		

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01290	Continued From page 20 November 22, November 26, November 27, November 28, November 29, November 30, and November 31, 2024. On December 2, 2024, at 1:47 p.m., licensed assisted living director (LALD)-A stated ULP-E had a background study which was completed at an affiliated facility with a separate HFID number and was not affiliated to this licensee. LALD-A stated ULP-E's background study was likely run through the licensee's affiliated facility, and just never affiliated to the licensee. The licensees Background Checks policy dated August 1, 2021, indicated employees as well as contractors, and regularly scheduled volunteers of the facility with direct resident contact will undergo a background study through DHS. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be	01620		

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01620	Continued From page 21 completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed an ongoing resident reassessment that did not exceed 90 days as required for one of three residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 was admitted on April 27, 2006, and began receiving assisted living services August 1, 2021. R2's signed service plan (waiver) - Addendum to Contract, dated June 15, 2023, indicated R2 received assistance with bathing reminders, deep room cleaning, grooming, housekeeping, laundry,	01620		

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01620	Continued From page 22 linen change, behavior management, meal reminder, medication administration, medication setup, orientation, vital signs, garbage removal, and safety checks. R2's record indicated their most recent assessment occurred on April 11, 2024. As of the survey start date, December 2, 2024, 235 days had passed since the last assessment, On December 2, 2024, at 2:57 p.m., CNS-B confirmed R2's assessments exceeded 90 days and confirmed there were no other assessments completed for R2. CNS-B stated they had begun an assessment for R2 around July but had left for maternity leave during that time and was unable to complete assessments until later. CNS-B stated because the assessment had been opened and never finished, they were not notified that the next assessment date had come due. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
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	01760		

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01760	Continued From page 23 follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medication administration was administered as prescribed and in compliance with the resident's medication management plan for one of six residents (R4) who received medication management. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R4 was admitted on August 22, 2018, and began receiving assisted living services on August 1, 2021. R4's signed service plan dated June 15, 2023, indicated R4 received services including activity assistance, deep room clean, laundry, linen change, behavior management, meal reminder, medication administration, medication setup, orientation, vitals, and safety check. R4's 90-day assessment dated September 20, 2024, indicated R4 needed assistance with all medication management, and all medications	01760		

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01760	Continued From page 24 were to be securely stored and accessible only to authorized personnel. On December 3, 2024, at 8:05 a.m., the surveyor observed ULP-F adminsiter Claritin-D (loratadine/pseudophedrine 10/240mg) to R4. The surveyor observed the medication was listed on the licensee's electronic medical record (EMAR). On December 3, 2024, at 1:20 p.m., the surveyor observed a bottle of nasal spray on a table in the room of R4. R4 stated that he still routinely used the nasal spray, but that it was not effective. The surveyor requested to look at the bottle of nasal spray. The bottle of nasal spray was prescribed Ipratropium 0.03% with an expiration date November 21, 2024. R4's record contained an after-visit summary (AVS) dated April 16, 2024, which instructed R4 to stop taking their nasal steroid spray, and to start using Claritin-D. On December 2, 2024, at 11:30 a.m., clinical nurse supervisor (CNS)-B stated they were responsible for monitoring for expired and discontinued medications, and the medication should have been removed from R4's room. The licensee's Documentation of medication, treatment and therapy management services policy, dated August 1, 2022, indicated the nurse will document actions to implement a new prescription when it is received, and actions to request and obtain needed refills for residents, including communications with the prescriber, pharmacy, resident and/or resident's representative or family.	01760		

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01760	Continued From page 25 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure expired medications were disposed of for one of six residents (R6). 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 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: On December 2, 2024, at 11:36 a.m., the surveyor conducted a review of the licensee's locked medication closet. The surveyor found the following medications stored together in bag belonging to R6 within the resident's medication bin:	01890		

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01890	Continued From page 26 - Carrington Zinc Cream, with an expiration date of November 1, 2022; and - cadexomer iodine gel 0.9%, with a damaged and indecipherable medication label. On December 2, 2024, at 11:48 a.m., clinical nurse supervisor (CNS)-B stated they were responsible for monitoring the medication closet for expired and damaged medications. CNS-B stated the two medications should have been disposed of in the licensee's destroy bin. CNS-B stated the bin was located on the top of the shelf which contained all medications stored for residents. CNS-B stated the bag of creams possibly fell off the top shelf and was possibly put back into R6's medication bin. The licensee's Storage of Medications policy dated August 1, 2021, indicated that medications will be handled and stored per acceptable standards. Additionally, this policy indicated that medications must be kept in its original container bearing the original prescription label with legible information stating the prescription number, name of drug, strength and quantity of drug, expiration date of time-dated drug, directions for use, resident's name, prescriber's name, date of issue and the name and address of the licensed pharmacy that issued the medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

Minnesota Department of Health

3333 Division St #212
St. Cloud
320 223-7300

Type: Full
Date: *12/02/24*
Time: 11:00:00
Report: 1051241182

Food and Beverage Establishment Inspection Report

Location:
Restart Inc
614 8th Street Se
Minneapolis, MN55414
Hennepin County, 27

Establishment Info:
ID #: 0038524
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6127013645
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

The following orders were issued during this inspection.

6-300 Physical Facility Numbers and Capacities

6-301.14A

MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands

POST A HANDWASHING SIGN IN THE BASEMENT RESTROOM.
Comply By: 12/02/24

Food and Equipment Temperatures

Process/Item: Upright Cooler
Temperature: 40 Degrees Fahrenheit - Location: AMBIENT-BASEMENT
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 41 Degrees Fahrenheit - Location: AMBIENT-MAIN KITCHEN
Violation Issued: No

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

MET WITH NURSE EVALUATOR, ZACHARY MORTH.

DISCUSSED THE FOLLOWING WITH THE SITE MANAGER, SYLVIA:

EMPLOYEE ILLNESS LOG
VOMIT CLEAN-UP PROCEDURES
HANDWASHING & GLOVE USE

THE KITCHEN HAS VINYL WOODEN FLOORS, LAMINATE COUNTERTOPS WITH HOLLOW BASES, LAMINATE CABINETS, A NSF 184 DISHWASHER, AND A SMOOTH TEXTURE CEILING.

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 1051241182 of 12/02/24.

Certified Food Protection Manager: Maria D. Medina

Certification Number: FM25320 Expires: 04/05/26

Inspection report reviewed with person in charge and emailed.

Signed: _____

Sylvia
Site Manager

Signed: _____

Kai Yang
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