



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

August 8, 2025

Licensee

Healing Heart Nursing Care LLC

6937 West Palmer Lake Drive

Brooklyn Center, MN 55429

RE: Project Number(s) SL39103016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 5, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

STATE CORRECTION ORDERS

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

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,



Jess Schoenecker, Supervisor

State Evaluation Team

Email: Jess.Schoenecker@state.mn.us

Telephone: 651-201-3789 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39103	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/05/2025
NAME OF PROVIDER OR SUPPLIER HEALING HEART NURSING CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 6937 WEST PALMER LAKE DRIVE BROOKLYN CENTER, MN 55429		
(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 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: SL#39103016 On June 2, 2025, through June 5, 2025, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 4 active residents; 4 receiving services under the provisional Assisted Living 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 License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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0 480	Continued From page 1 (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; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are	0 480			

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0 480	Continued From page 2 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) 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: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated June 3, 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	0 480			

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0 480	Continued From page 3 to the FBEIR for any compliance dates.	0 480			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have a written emergency preparedness plan with all the required content and failed to post an emergency preparedness plan prominently. This had the potential to impact all residents, staff, and visitors	0 680			

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0 680	Continued From page 4 to the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On June 2, 2025, at approximately 11:00 a.m. during a tour of the facility, the surveyor did not observe any signage or information regarding the licensee's emergency preparedness plan posted in a prominent location. On June 2, 2024, at approximately 11:30 a.m., the surveyor requested the licensee's emergency preparedness plan. Assisted living director/clinical nurse supervisor (ALD/CNS)-A stated an emergency preparedness plan for the licensee had been created but a resident tore it up a few days ago and the licensee did not have a copy for the surveyor to review. The licensee's undated 9.01 Emergency Preparedness Plan - Appendix Z Compliance policy dated May 5, 2025, indicated the licensee would create and post an emergency preparedness plan with all required content related to Appendix Z. No additional information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			

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0 810	Continued From page 5	0 810			
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at 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			

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0 810	Continued From page 6 Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content, to provide the required training, and to conduct evacuation 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 June 3, 2025, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP, Fire Safety, dated August 1, 2021, failed to include the following: The FSEP failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The provided FSEP was from a third-party provider and had not been updated to the specific facility. The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency.	0 810			

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0 810	Continued From page 7 The FSEP failed to provide specific procedures for resident movement, evacuation, or relocation during a fire or similar emergency, including the individualized, unique needs of residents. The plan identified residents who need assistance, but did not include any resident-specific procedures for staff to follow during evacuation, nor did it provide instructions for staff to follow in case of relocation. On June 3, 2025, at 1:30 p.m., LALD/CNS-A stated they didn't understand that the third-party policy they were using was not correct. LALD/CNS-A stated they would work on bringing them into compliance. The policy reviewed was an unedited policy from a third-party provider that was not specific to the facility. TRAINING: The licensee failed to provide evacuation training to residents at least once per year. LALD/CNS-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. The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. LALD/CNS-A lacked documentation showing any training was completed or training was scheduled for a future date for employees on the fire safety and evacuation plan. DRILLS: The licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. Record review of licensee's evacuation drill log,	0 810			

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0 810	Continued From page 8 Fire Drill Report, multiple dates, indicated evacuation drills were conducted on April 2, 2025, February 2, 2025, and December 2, 2024. The dates on the first and second pages of the reports did not match. LALD/CNS-A stated the dates for April and February should be 2025 and they accidentally put 2024. On June 3, 2025, at 1:30 p.m., LALD/CNS-A stated they did staff training twice per year at the same time as the other emergency preparedness training and completed evacuation drills every other month. LALD/CNS-A stated they did not have any of the documentation for training or drills because the three-ring binder that held all the policy, training and drill documentation was destroyed by one of the residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810			
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were stored securely for one of one resident (R2) with medication management services. This practice resulted in a level two violation (a	01880			

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01880	Continued From page 9 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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: R2 was admitted on May 28, 2023. R2's Service Plan (Waiver) - Addendum to Contract dated May 02, 2025, indicated R2 received medication administration services. R2's Assessment by Date dated April 5, 2025, read under Medications section, "all medications will be locked at all times". On June 2, 2025, at 10:00 a.m., during the entrance conference, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated all medications were securely stored and always locked. On June 2, 2024, at 11:00 a.m., during a tour of the facility, surveyor observed an unlocked refrigerator in the kitchen area of the facility. Inside of the refrigerator were food for the facility's residents and four unopened Lantus 100 units/milliliter (ml) insulin pens (a multiple dose pen shaped injector device for insulin administration) for R2. A thermometer was present in the refrigerator to verify proper medication storage temperature and temperature tracking was performed daily by the licensee. On June 2, 2024, at 11:15 a.m., LALD/CNS-A	01880			

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01880	Continued From page 10 stated R2's insulin pens should have been locked up and the licensee has a small fridge that was going to be set up soon as the facility's locked medication fridge with temperature tracking. The licensee's 7.11 Medication Storage policy dated June 27, 2022, indicated medications would be securely locked and stored consistent with manufacture's recommendations (refrigerated, room temperature, or frozen). No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880			



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

Healing Heart Nursing Care LLC
6937 West Palmer Lake Drive
Brooklyn Center, MN 55429
Hennepin County
Parcel:

Phone:

License Info

License: HFID 39103

Risk:
License:
Expires on:
CFPM: Candace Wright
CFPM #: FM119623; Exp: 11/4/2026

Inspection Info

Report Number: F1043251043
Inspection Type: Full - Single
Date: 6/3/2025 Time: 3:07:44 PM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 1
Total Priority 2 Orders: 1
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: REPEAT FROM 9/26/23. BOX OF RAW SHELL EGGS STORED ON SHELF ABOVE MEDICINE AND READY-TO-EAT FOODS (HOT DOGS) IN FRIDGE. ADVISED STAFF TO STORE RAW FOODS AT BOTTOM OF FRIDGE OR IN A SPILL PROOF CONTAINER THAT IS PULLED OUT WHEN EGGS ARE NEEDED. COMPLY WITH ABOVE RULE.

Comply By: 6/3/2025 Originally Issued On: 6/3/2025

New Order: 3-300C Protection from Contamination: equipment/utensils, consumers

3-304.14B *Priority Level: Priority 3 CFP#: 41*

MN Rule 4626.0285B Wiping cloths used for wiping counters and other equipment surfaces must be held in an approved sanitizing solution and laundered daily.

COMMENT: WET CLOTH STORED ON DIVIDER OF 2 COMPARTMENT SINK. ADVISED STAFF TO STORE WET CLOTHS IN A SANI BUCKET IN BETWEEN USES. COMPLY WITH ABOVE RULE.

Comply By: 6/3/2025 Originally Issued On: 6/3/2025

New Order: 3-500C Microbial Control: date marking

3-501.17A *Priority Level: Priority 2 CFP#: 23*

MN Rule 4626.0400A Mark the refrigerated, ready-to-eat, TCS food prepared and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded.

COMMENT: NO DATE MARKING ON OPENED BAG OF SAUSAGE AND HOT DOGS FROM A PREVIOUS DAY. ADVISED STAFF TO DATE MARK TCS FOODS AND DISCARD LEFTOVERS AFTER 7 DAYS. FACT SHEET PROVIDED WITH REPORT. COMPLY WITH ABOVE RULE.

Comply By: 6/3/2025 Originally Issued On: 6/3/2025

Food & Beverage General Comment

Inspection was completed with Carl Samrock as the lead Health Regulation Division Nurse Evaluator completing the site survey.

Discussed highly susceptible populations, date marking, illness policy, sanitizer use, ware washing, temperature control, same day service, cleaning, pest control, vomit/fecal procedures, test kits, food storage, and food handling procedures.

Foods cooked in house must be fully cooked (exception for pasteurized eggs) and must only be available for same day

service for highly susceptible populations, discard any leftovers by the end of the day.

This facility has a residential kitchen with residential equipment, wooden cabinetry, and smooth walls, floors, and countertops.

TEMPERATURES (F)

FRIDGE: SAUSAGE 40, HOT DOG 40, MILK 40

DISH MACHINE: UTENSIL SURFACE 160

Contact Health Regulation Division for plan review approval when facility/kitchen undergoes remodeling.

***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.

If any customer complains of illness, establishment is required to notify the Minnesota Department of Health and provide the foodborne illness hotline phone number to the customer: 1-877-366-3455

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

I acknowledge receipt of the Metro District Office inspection report number F1043251043 from 6/3/2025

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