Electronically Delivered

April 4, 2025

Licensee
Wellness Homes Inc.
1824 15th Avenue
Minneapolis, MN 55404

RE: Project Number(s) SL33368016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on March 6, 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,

Renee L. Anderson

Renee Anderson, Supervisor
State Evaluation Team
Email: renee.anderson@state.mn.us
Telephone: 651-201-5871 Fax: 1-866-890-9290

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33368	A. BUILDING: _____ B. WING _____	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLNESS HOMES INC	1824 15TH AVENUE MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL #33368016-0 On March 3, 2025, through March 6, 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 3 residents, all of whom were receiving services under the provider's Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Licensing 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 pursuant to 144G.31 Subd. 1, 2 and 3.	
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	0 480		

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0 480	Continued From page 1 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 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part	0 480		

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0 480	Continued From page 2 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 March 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 to the FBEIR for any compliance dates.	0 480		

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0 660	Continued From page 3	0 660		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC). The licensee failed to ensure baseline screening for active TB (either by a two-step tuberculin skin test (TST) or a single Interferon-Gamma Release Assay (IGRA) blood test was completed and documented for two of three employees (unlicensed personnel (ULP)-B, ULP-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive	0 660		

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0 660	Continued From page 4 or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: ULP-B and ULP-C were hired November 15, 2023, and February 16, 2024, respectively, and provided direct cares for the licensee's residents. ULP-B and ULP-C's employee records each contained a first step TST, dated November 15, 2023, and January 30, 2024, respectively, but lacked a second step TST. On March 3, 2025, at 3:00 p.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A, stated ULP-B and ULP-C had not completed their second step TST. CNS/LALD-A further stated she thought they only needed one. The Minnesota Department of Health (MDH) guidelines, "Regulations for Tuberculosis Control in Minnesota Health Care Settings", dated July 2013, and based on CDC guidelines, indicated a TB infection control program should include the following: a team responsible for TB infection control; a facility TB risk assessment; written TB infection control procedures; and HCW education. The guidelines also indicate an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST-tuberculin skin test (first step) dated within 90 days before hire. The second TST may be performed after the HCW starts working with patients. Baseline TB screening should be documented in the employee's record.	0 660		

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0 660	Continued From page 5 The licensee's 8.16 Tuberculosis Screening policy, dated August 1, 2021, indicated new employees would have an IGRA blood test or a two-step Mantoux (TB skin test) upon hire, and results would be kept in the employee record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 775 SS=D	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the current State Fire Code in Minnesota Rules, chapter 7511. 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 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 March 6, 2025, from 1:30 p.m. to 4:30 p.m., the surveyor toured the facility with clinical nurse	0 775		

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0 775	Continued From page 6 supervisor/licensed assisted living director (CNS/LALD)-A. During the tour, the surveyor observed that hard-wired smoke alarms throughout the facility were over 10 years past the manufacture date. Single and multiple-station smoke alarms shall be replaced when: 1. They fail to respond to operability tests. 2. They exceed ten years from the date of manufacture. Smoke alarms shall be replaced with smoke alarms having the same type of power supply. There were two appropriate designated smoking areas, on each end of the facility. Surveyor observed used cigarette butts discarded in bedroom 3 on the 1824 side of the facility. Used cigarette butts are required to be discarded in the appropriate disposal container in accordance with the facility smoking policy. During a facility tour on March 6, 2025, at 3:30 p.m., CNS/LALD-A, verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Two (2) days	0 775		
0 780 SS=D	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 7 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 observation and interview, the licensee failed to provide facilities that were not a distinct hazard to life and failed to keep the facility in compliance with the Minnesota Fire Code. This had the potential to directly affect all of the residents and staff. 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 March 6, 2025, from 1:30 p.m. to 4:30 p.m.,	0 780		

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0 780	Continued From page 8 the surveyor toured the facility with clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A. During the tour, surveyor observed that hard-wired smoke alarms did not interconnect with other hard-wired smoke alarms in the facility. CNS/LALD-A had installed battery alarm throughout the facility, which did not interconnect either. Smoke alarms shall interconnect so that actuation of one alarm causes all alarms in the facility to operate. Throughout the facility battery smoke alarms were being used, facility has hard-wired alarms already. When a room or area is protected by hard-wired alarms, the power supply must be maintained. The hard-wired smoke alarm was missing from 1826 second floor hallway. Statute states, smoke alarms are to be maintained on each story of the facility. These deficient conditions were visually verified by CNS/LALD-A accompanying on the tour. TIME PERIOD FOR CORRECTION: Two (2) days	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	0 800		

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0 800	Continued From page 9 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) 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 March 6, 2025, from 1:30 p.m. to 4:30 p.m., the surveyor toured the facility with clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A. During the tour, surveyor observed on the 1824 side of the facility, the ceiling of the 2nd floor bathroom appeared to have been damaged. This has the potential to continue to grow and break thru, causing injury to staff, residents or visitors. Doorknob to bedroom 3 on the 1826 side of the facility was not secure against the door. This could cause injury to staff, resident, or visitor and/or delay egress during an emergency.	0 800		

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0 800	Continued From page 10 Landing on the 3rd floor of the 1826 side going to the rear deck was damaged. Flooring had been removed or worn away. This has the potential to be a tripping hazard for staff, residents and visitors. Basement bathroom on the 1826 side was missing the ventilation fan. The fan is needed to remove moisture from the area to prevent mold and water damaging the walls. These deficient conditions were visually verified by CNS/LALD-A accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be	0 810		

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0 810	Continued From page 11 readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop the fire safety and evacuation plan (FSEP) with required content, provide required training. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On March 6, 2025, from 1:30 p.m. to 4:30 p.m., the surveyor toured the facility with clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A. During the tour surveyor observed the posted evacuation plans lacked	0 810		

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0 810	Continued From page 12 identification of resident rooms. Exit plan diagrams must be accurate and correctly labeled to reduce confusion and potential obstructions for egress in a fire or similar emergency. On March 6, 2025, CNS/LALD-A provided documents on the fire safety and evacuation plan (FSEP), fire safety training and evacuation drills, for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP, titled "Fire Safety", dated August 1, 2024, failed to include the following: RESIDENT ACTIONS: 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. On March 6, 2025, at 2:30 p.m., CNS/LALD-A stated they understood the requirements for training residents and would implement a training program that was compliant with statute requirements. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 900 SS=D	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing;	0 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33368	A. BUILDING: _____ B. WING _____	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLNESS HOMES INC	1824 15TH AVENUE MINNEAPOLIS, MN 55404

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0 900	Continued From page 13 (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to execute a written contract containing a signature or other authentication by the licensee and by the resident or resident representative prior to providing assisted living services for one of two 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	0 900		

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0 900	Continued From page 14 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's service plan, dated December 14, 2023, indicated R2 received services including assistance with medication administration. On March 4, 2025, at 12:30 p.m., R2 was observed sitting on the couch with clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A. R2's record contained a contract, dated December 14, 2023, signed by CNS/LALD-A. The contract lacked a signature or other authentication by the resident or resident representative, or indication why the signature could not be obtained. On March 4, 2025, at 10:43 a.m., CNS/LALD-A stated R2's contract should have been signed by the resident, and she was not sure how it was missed. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 900		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan.	01640		

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01640	Continued From page 15 (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a current written service plan was revised and included a signature or other authentication by the facility and by the resident, or their representative, documenting agreement on the services to be provided for one of two 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).	01640		

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	33368	A. BUILDING: _____ B. WING _____	03/06/2025

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01640	Continued From page 16 The findings include: R2's service plan, dated December 14, 2023, indicated R2 received services including assistance with medication administration and management, housekeeping, laundry, appointments, transportation, shopping, safety checks, meals, behavior management, bathing and dressing reminders, grooming and vital sign checks. On March 4, 2025, at 12:30 p.m., R2 was observed sitting on the couch with clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A. R2's Task Detail Report dated February 1, 2025, to March 4, 2025, indicated R2 received the following additional services: assistance with exercises and financial activity. The additional services were not added to the service plan, and signed by the resident documenting agreement on the additional services to be provided. On March 5, 2025, at 2:17 p.m., CNS/LALD-A stated she did not realize the revisions were not on the service plan, and they should have been. CNS/LALD-A further stated she would update the service plan and have R2 sign it. The licensee's 6.08 Service Plan policy, dated August 1, 2021, indicated the service plan would include a description of the services to be provided, and any revisions would be signed by the resident indicating agreement with the services to be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	01640		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01640	Continued From page 17 (21) days	01640		
01710 SS=D	144G.71 Subd. 3 Individualized medication monitoring and reas The assisted living facility must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. 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 annual medication reassessment for one of two residents (R3). 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: R3's current signed service plan, dated May 23, 2024, indicated R3 received services including assistance with medication administration. R3's record contained an Individualized Medication Management Plan, dated January 1, 2024, but lacked documentation of a subsequent annual medication reassessment.	01710		

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01710	Continued From page 18 On March 4, 2025, at 10:55 a.m., RN-B stated she had a schedule she followed and did annual medication reassessments every year. CNS/LALD-A further stated she must have missed R3's assessment. The licensee's 7.03 Medication Management Individualized Plan policy dated August 1, 2021, indicated the licensee would maintain a current individualized medication management record for each resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01710		

Minnesota Department of Health
Food, Pools, & Lodging Services
P.O. Box 64975
Saint Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *03/03/25*
Time: 12:00:00
Report: 1043251066

Food and Beverage Establishment Inspection Report

Location:
Wellness Homes Inc
1824 15th Avenue
Minneapolis, MN55404
Hennepin County, 27

Establishment Info:
ID #: 0039279
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6127015965
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.

4-400 Equipment Location and Installation

4-402.11A

MN Rule 4626.0725A Space fixed equipment to allow access for cleaning along the sides, behind and above the unit, or seal to adjoining equipment or walls.

(1) GAPS OBSERVED ALONG/BETWEEN TOP EDGES OF COUNTER TOP AND DRYWALL AND (2) AROUND OUTLET COVER ABOVE KITCHEN SINK. ADVISED STAFF TO SEAL GAPS WITH SILICONE/CAULK/ETC. COMPLY WITH ABOVE RULE.

Comply By: 03/03/25

4-600 Cleaning Equipment and Utensils

4-601.11C

MN Rule 4626.0840C Clean non-food contact surfaces of equipment and maintain free of accumulations of dust, dirt, food residue, and other debris.

BLACK BUILD UP OBSERVED ON DISHWASHER BASKET AND ON INTERIOR SIDE OF DOOR. ADVISED STAFF TO CLEAN AND MAINTAIN CLEAN. COMPLY WITH ABOVE RULE.

Comply By: 03/03/25

6-200 Physical Facility Design and Construction

6-202.15D

MN Rule 4626.1395D Protect the outside openings of the food establishment if the doors and windows are kept open for ventilation or other purposes by providing and maintaining tightly fitting screens (not less than 16 mesh to 1 inch), air curtains, or using other effective means.

BACK DOOR IN KITCHEN AREA WAS LEFT AJAR. ADVISED STAFF TO CLOSE THE DOOR IN BETWEEN USES OR TO PROVIDE MATERIALS AS DESCRIBED ABOVE TO PREVENT PESTS FROM ENTERING. COMPLY WITH ABOVE RULE.

Comply By: 03/03/25

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.11

MN Rule 4626.1515 Maintain the physical facilities in good repair.

(1) LARGE DENTS IN WALL OBSERVED ABOVE DISHWASHER AND KITCHEN SINK AREA AND (2) EXPOSED CONCRETE OBSERVED ON FLOOR AT BOTTOM RIGHT CORNER TO DISHWASHER. ADVISED STAFF TO REPAIR TO PROVIDE SMOOTH, EASILY CLEANABLE, NONABSORBENT, AND DURABLE SURFACES.

Comply By: 03/03/25

Hot Water: = at 160 Degrees Fahrenheit
Location: DISHWASHER
Violation Issued: No

Food and Equipment Temperatures

Process/Item: MILK
Temperature: 40 Degrees Fahrenheit - Location: REACH IN COOLER
Violation Issued: No

Process/Item: CHEESE
Temperature: 40 Degrees Fahrenheit - Location: REACH IN COOLER
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	0	0	4

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

This facility is a duplex and the two sides are joined - whole space is used as one. The facility has two kitchens, one on the 1824 side and one on the 1826 side. Staff uses the kitchen on the 1826 side.

Discussed highly susceptible populations, date marking, illness policy, sanitizer use, ware washing, temperature control, 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, tiled flooring, painted drywall, and granite countertops.

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.

Type: Full
Date: *03/03/25*
Time: 12:00:00
Report: 1043251066
Wellness Homes Inc

Food and Beverage Establishment Inspection Report

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: 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 1043251066 of 03/03/25.

Certified Food Protection Manager: Zahra H. Yousuf

Certification Number: FM124106 Expires: 05/24/27

Signed: _____

Zahra H. Yousuf
PIC

Signed: _____

Blia Lor
Public Health Sanitarian I
651-355-0641
blia.lor@state.mn.us