Electronically Delivered

November 12, 2025

Licensee
Heritage House
870 9th Avenue Northwest
New Brighton, MN 55112

RE: Project Number(s) SL36942016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on October 22, 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

CLN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36942	A. BUILDING: _____ B. WING _____	10/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HOUSE	870 9TH AVENUE NW NEW BRIGHTON, MN 55112

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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: SL36942016-0 On October 21, 2025, through October 22, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were three residents; three receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma	0 630		

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0 630	Continued From page 1 (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for two of two residents (R2, 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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2 R2 was admitted on August 15, 2025. R2's Service Plan (Waiver) - Addendum to Contract dated August 16, 2025, indicated R2	0 630		

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0 630	Continued From page 2 received assistance with medication administration. On October 22, 2025, at 11:59 a.m., the surveyor observed licensed assisted living director (LALD)-C prepare and administer medications to R2. R2's IAPP completed on August 16, 2025, lacked assessment of the person's risk of abusing other vulnerable adults. R3 R3 was admitted on May 19, 2021. R3's Service Plan (Waiver) - Addendum to Contract dated October 1, 2024, indicated R3 received assistance with medication administration. R3's IAPP completed on August 26, 2025, indicated R3 was at risk to be abused but lacked statements of the specific measures to be taken to minimize the risk of abuse to that person. Also, R3's IAPP lacked an assessment of the person's risk of abusing other vulnerable adults. On October 23, 2025, at 3:28 p.m., clinical nurse supervisor (CNS)-C stated they were not aware of the statute and would correct all IAPPs for the residents to include assessment for the risk to abuse other vulnerable adults and would include specific measures to be taken to minimize the risk of abuse. The licensee's 6.05 Individualized Abuse Prevention Plan policy dated August 1, 2021, indicated all residents would have an IAPP addressing the person's susceptibility to abuse,	0 630		

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0 630	Continued From page 3 the person's risk of abusing other vulnerable adults, and specific measures would be taken to minimize the risk of abuse to that person and other vulnerable adults. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
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.	0 680		

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0 680	Continued From page 4 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. 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 the potential to affect a large portion or all of the residents). The findings include: The licensee's undated EPP lacked evidence of the following required content: - procedures for tracking of staff and patients; - methods for sharing information; and - sharing information on occupancy/needs. On October 21, 2025, at 3:48 p.m., the surveyor asked licensed assisted living director (LALD)-C to describe the licensee's system to track staff and sheltered residents. LALD-C stated the licensee had all of the resident information in an electronic record and if their staff needed to take any resident to another location, then they could still access the resident information. Surveyor confirmed if the licensee had a policy and procedure for tracking of staff and residents in the licensee's EPP. LALD-C stated the licensee had tracking in our electronic record and then proceeded to show the surveyor how they could	0 680		

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0 680	Continued From page 5 write messages in the electronic record stating everyone can see the messages. LALD-C confirmed the licensee did not include a policy and procedure in the licensee's EPP for tracking of staff and residents. On October 22, 2025, at 3:05 p.m., LALD-C confirmed they were not able to locate the other missing contents required for the EPP and stated the licensee would work on the required content. The licensee's Emergency Preparedness policy dated November 30, 2023, indicated the facility would have an identified plan in place to ensure the safety and well-being of residents and staff during periods of an emergency or a disaster that disrupts facility services. The policy referenced CMS (Centers for Medicare and Medicaid Services) State Operations Manual Appendix Z. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 775 SS=E	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 requirements of Minnesota State Fire Code Rules, Chapter 7511. This had the potential to directly affect all building occupants.	0 775		

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0 775	Continued From page 6 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On October 21, 2025, at 1:15 p.m., the surveyor toured the facility with licensed assisted living director (LALD)-C. During the facility tour, the surveyor observed the following: OBSTRUCTED EGRESS In occupied resident sleeping room 4, the egress window was obstructed by the placement of an end table with an aquarium in front of the window. Facility staff attempted to relocate the end table during the tour and were only able to push the table away from the wall due to the weight of the aquarium. The improper placement of furniture and personal belongings in front of an egress window would delay exiting in the event of an emergency. CLOTHES DRYER MAINTENANCE There was an accumulation of lint in the clothes dryer exhaust vent, creating a fire hazard. This lint accumulation indicated the venting system had not been maintained. ELECTRICAL A weatherproof cover was not installed on one	0 775		

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0 775	Continued From page 7 exterior electrical wall outlet on the back of the building. Weatherproof covers for electrical outlets are required in outdoor locations to prevent water damage and electrical shocks. During the facility tour interview, LALD-C verified the above listed observations. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775		
0 790 SS=D	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain a portable fire extinguisher. This had the potential to directly affect all building occupants. 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	0 790		

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0 790	Continued From page 8 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 October 21, 2025, at 1:15 p.m., the surveyor toured the facility with licensed assisted living director (LALD)-C. During the facility tour, the surveyor observed a portable fire extinguisher was stored on the floor near the front door. An empty bracket was installed on the wall. Facility staff unsuccessfully attempted to mount the fire extinguisher on the wall as the bracket was broken. During the facility tour interview, LALD-C verified the above listed observations. Fire extinguishers must be properly mounted to prevent them from being moved or damaged. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
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 9 emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with required content and complete required training and drills. This had the potential to directly affect all building occupants. 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	0 810		

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0 810	Continued From page 10 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 October 21, 2025, licensed assisted living director (LALD)-C 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 FSEP floor plan failed to accurately identify the location and number of resident sleeping rooms, portable fire extinguisher locations, and the front door emergency exit evident by the following: On October 21, 2025, at 1:15 p.m., the surveyor toured the facility with LALD-C. During the facility tour, the surveyor observed the following: - A number identifier was not posted at the occupied resident sleeping room door verbally identified as room 1 by LALD-C. - The resident sleeping room number labels on the FSEP floor plan did not match the numbers posted at resident sleeping room doors. All resident sleeping rooms must be accurately identified on the FSEP floor plan and correspond with the numbers installed at the sleeping room doors to provide efficient communication for exiting in the event of a fire or similar emergency. - One portable fire extinguisher was provided near the front door. The posted FSEP floor plan labeled fire extinguisher locations in the basement and upper floor level. Additionally, the	0 810		

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0 810	Continued From page 11 posted emergency information documents identified fire extinguisher locations in the basement near the laundry room and in the kitchen on the upper floor level. During the facility tour, LALD-C stated these fire extinguishers had been removed based on previous survey feedback received from the engineer and verified the floor plan and emergency information had not been updated to reflect these changes. - An exit sign was posted at the front door. The front door was not identified and labeled as an emergency exit on the posted FSEP floor plan. Emergency exit door labels are required on the FSEP floor plan in order to direct the building occupants to designated exits in the event of an emergency. Record review of the available documentation indicated the licensee failed to develop and maintain the FSEP with site specific procedures for the facility and building occupants evident by the following: - The FSEP had been created using templates from third party providers. The fire emergency procedures inaccurately referenced smoke compartment doors, fire sprinklers, fire doors on magnetic door holders, and a monitored fire alarm system in a building without fire resistant construction or life safety systems. The FSEP included standard employee procedures, but failed to provide site 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 employee actions were limited to the RACE (Remove, Alarm, Confine, Extinguish/Evacuate) and PASS	0 810		

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0 810	Continued From page 12 (Pull, Aim, Squeeze, and Sweep) acronyms. - The FSEP included standard resident evacuation procedures, but failed to provide evacuation procedures including individualized unique needs of residents evident by a lack of these procedures in the plan. Two residents had been identified in the emergency evacuation report as requiring employee assistance during an evacuation. This information was maintained electronically on the computer and was not included with the printed copy of the FSEP. During an interview on October 21, 2025, at 3:15 p.m., LALD-C verified the FSEP was lacking the above content. TRAINING Record review indicated the licensee failed to provide fire safety and evacuation training to residents at least once per year evident by the lack of documentation to support this training had been completed. During an interview on October 21, 2025, at 3:15 p.m., LALD-C stated residents were trained during employee fire drills and verified separate records for resident training were not available. Record review indicated the licensee failed to provide training to employees on the site specific FSEP at least twice per year. Employee records for emergency preparedness plan evacuation training were provided. Records were not provided to support FSEP training had been completed. During an interview on October 20, 2025, at 3:15 p.m., LALD-C stated employees were trained on	0 810		

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	36942	A. BUILDING: _____ B. WING _____	10/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HOUSE	870 9TH AVENUE NW NEW BRIGHTON, MN 55112

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0 810	Continued From page 13 the FSEP during fire drills and verified separate records for site specific FSEP training were not available. DRILLS Record review of the available documentation indicated the licensee failed to conduct evacuation drills twice per year, per shift, and at a frequency of every other month evident by a review of fire drill reports lacking the required frequency. - Fire drills were not recorded in February, March, or April 2025. - Morning, afternoon, and night shift employees participated in combined fire drills. - No fire drills were performed during the night shift in the past year. - The shift or time was not recorded on the January 2025 fire drill log. During an interview on October 21, 2025, at 3:15 p.m., LALD-C stated night shift drills had not been performed as the facility did not want to activate the smoke alarms while residents were sleeping. LALD-C stated fire drills had been perform by combing shifts, and verified the frequency was lacking. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 830 SS=D	144G.45 Subd. 3 Local laws apply Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements, except a facility with a licensed resident capacity of six or fewer is exempt from rental licensing	0 830		

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0 830	Continued From page 14 regulations imposed by any town, municipality, or county. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to submit a Minnesota Department of Health (MDH) engineering services plan review application for a facility construction project. This had the potential to directly affect one resident and all 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, 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: On October 21, 2025, at 1:15 p.m., the surveyor toured the facility with licensed assisted living director (LALD)-C. During the facility tour, the surveyor observed the door for occupied resident room 1 had been removed. A sliding barn door had been installed inside the room using hardware installed on the wall in an attempt to meet accessibility standards. During the facility tour interview, LALD-C stated this new door had been installed 3 days ago. LALD-C verified a plan review application had not been submitted to MDH engineering services.	0 830		

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0 830	Continued From page 15 TIME PERIOD FOR CORRECTION: Seven (7) days	0 830		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter	01060		

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01060	Continued From page 16 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation to the resident, legal representative, and designated representative for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and 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: R2 was admitted on August 15, 2025. R2's Service Plan (Waiver) - Addendum to Contract dated August 16, 2025, indicated R2 received assistance with medication administration. R2's progress notes dated September 27, 2025, at 10:55 p.m., indicated R2 was sent to	01060		

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01060	Continued From page 17 emergency room (ER) by ambulance for weakness, slurred speech, abdominal and back pain, and confusion. R2's After Visit Summary (AVS) dated September 27, 2025, indicated R2 was seen in ER for headache, abdominal pain, and altered mental status. R2's record lacked documentation R2, R2's legal representative, and R2's designated representative had received a written notice with all the required content for an emergency relocation. On October 22, 2025, at 8:53 a.m., clinical nurse supervisor (CNS)-D stated they had called the family to inform them of R2 going to ER. CNS-D stated they were not aware of a written notice given and they would ask licensed assisted living director (LALD)-C. On October 22, 2025, at 8:59 a.m., LALD-C stated R2 went to ER and had only been there a few hours but did not stay there. LALD-C stated they would only give an emergency relocation notice if the resident were to stay overnight as that was how they were trained. The licensee's Emergency Relocation policy dated August 1, 2021, indicated the facility would, as soon as practicable, provide written notice in the event of an emergency relocation to the resident, the resident's legal representative, the resident's designated representative, and the residents case manager if the resident received home and community-based services with all of the required content as indicated in Statue.	01060		

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01060	Continued From page 18 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by:	01650		

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01650	Continued From page 19 Based on interview and record review, the licensee failed to ensure the service plan included the required content for two of two residents (R2, 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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2 R2 was admitted on August 15, 2025. R2's Service Plan (Waiver) - Addendum to Contract dated August 16, 2025, indicated R2 received assistance with medication administration; and under Waivered Services, the resident would be responsible to cover the cost of services if for any reason their county contract were to be discontinued. The service plan lacked a description of the fees for services. R3 R3 was admitted on May 19, 2021. R3's Service Plan (Waiver) - Addendum to Contract dated October 1, 2024, indicated R3 received assistance with medication administration; and under Waivered Services, the resident would be responsible to cover the cost of services if for any reason their county contract were to be discontinued. The service plan lacked	01650		

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01650	Continued From page 20 a description of the fees for services. On October 22, 2025, at 4:01 p.m., licensed assisted living director (LALD)-C stated it was an oversight as the licensee's old service plan included the fees. LALD-C stated they printed the services separately that included the fees by the county but did not have the residents sign to acknowledge the fees. LALD-C stated the licensee accepted other payments other than from the county. The licensee's Service Plan policy dated August 1, 2025, indicated the service plan would include the fees for services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

HERITAGE HOUSE
870 9TH AVENUE NW
New Brighton, MN 55112
Ramsey County
Parcel:

Phone:

License Info

License: HFID 36942

Risk:
License:
Expires on:
CFPM: AMAL MOHAMED
CFPM #: 108413; Exp: 9/27/2027

Inspection Info

Report Number: F8058251132
Inspection Type: Full - Single
Date: 10/21/2025 Time: 2:53:09 PM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

No orders were issued for this inspection report.

Food & Beverage General Comment

HRD INSPECTOR RHAWNIE QUINEHAN

RESIDENTIAL HOME IN WITH NON COMMERCIAL APPLIANCES AND FINISHES

177 DISH MACHINE
41 LETTUCE COOLER
41 CHEESE COOLER

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 F8058251132 from 10/21/2025

AMAL MOHAMED
PIC

Aaron Gertz,
Public Health Sanitarian 3
651-201-4516
aaron.gertz@state.mn.us