Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

October 17, 2023

Licensee
Wellness Homes Inc.
4137 Chicago Avenue
Minneapolis, MN 55407

RE: Project Number(s) SL32758015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 17, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the 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.

The 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. The 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 the MDH within 15 calendar days of the correction order receipt date.

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

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,

Jonathan Hill, Supervisor
State Evaluation Team
Email: jonathan.hill@state.mn.us
Telephone: 651-201-3993 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
	32758	A. BUILDING: _____ B. WING _____	08/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLNESS HOMES INC	4137 CHICAGO AVENUE MINNEAPOLIS, MN 55407

(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: SL32758015-0 On August 15, 2023, 2023, through August 17, 2023, 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 five (5) active residents; all of whom received services under the 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 Licensed 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 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according	0 480		

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0 480	Continued From page 1 to the Minnesota Food Code, Minnesota Rules, chapter 4626; and 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 included document titled, Food and Beverage Establishment Inspection Report dated August 15, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules;	0 650		

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0 650	Continued From page 2 (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure employee records included all required content for one of two employees (unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client'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 clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-B had a hire date of November 23, 2018, under the Comprehensive license and started providing assisted living services August 1, 2021. On August 16, 2022, between 8:00 a.m. and	0 650		

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0 650	Continued From page 3 10:00 a.m., ULP-B was observed administering medications to licensee's residents and assisting with morning cares. On August 16, 2022, at 11:10 a.m., licensed assisted living director (LALD)-A, who also acted as the clinical nurse supervisor (CNS), stated ULP-B's employee record lacked an annual performance review that identified areas of improvement needed and training needs. On August 16, 2022, at 1:00 p.m. LALD-A stated ULP-B's annual performance review was overlooked and should have been completed. The licensee's Employee Evaluation policy, revised August 1, 2021, indicated: the employee evaluation process at Wellness Homes Inc would be conducted in a manner which promotes the concepts of continuous improvement and frequent interaction between employees and their supervisors and all staff of Wellness Homes Inc would be given an employee evaluation at least annually. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff	0 680		

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0 680	Continued From page 4 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 (EPP) with all the required content. This had the potential to affect the all residents receiving services under the assisted living license, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	0 680		

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0 680	Continued From page 5 During the entrance conference on August 15, 2023, at 10:00 a.m., a request was made to view the licensee's emergency preparedness plan (EPP). The licensee's plan lacked the following required content: -current, all-hazards approach facility assessment -description of the population served by licensee -process for emergency preparedness (EP) cooperation with state and local EP officials/organizations -subsistence needs for staff and residents during an emergency -procedure for tracking staff and residents -handling medical documents-handling and use of volunteers -arrangement with other facilities (including sister facilities) -development of a communication plan, including primary and alternate means for communication -methods for sharing information -EP training and testing program -EP training program for staff (including documentation of training provided) -annual EP testing requirements. - process for cooperation and collaboration with local, tribal, regional, State and Federal EP to maintain integrated response. - process for arrangements with other facilities/providers to receive residents in the event of limitation/cessation of operations to maintain the continuity of services to residents. - policies and procedures on volunteers. The Emergency Preparedness/Disaster Planning and Emergency Preparedness policy 9.02, effective date, August 1, 2023, directed the licensee to have in place a general emergency preparedness plan, that was in alignment with	0 680		

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0 680	Continued From page 6 facility's requirement to also comply with CMS (Centers for Medicare & Medicaid Services) Appendix Z (EPP). On August 17, 2023, at 1:30 p.m., licensed assisted living director (LALD)-A stated the current emergency preparedness plan lacked all required content. LALD-A added, the information was received from an agency the licensee hired, "We have not yet developed or changed it to meet the needs of our residents." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 790 SS=F	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 fire extinguishers in accordance with MN Statute. This had the potential to affect	0 790		

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0 790	Continued From page 7 all current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On August 16, 2023, from approximately 9:45 a.m. to 11:30 a.m., survey staff toured the facility with the housing manager (HM)-B. It was observed that both fire extinguishers in the facility had a service tag showing that they had last been inspected in November of 2021. Licensee lacked records to show the required monthly visual inspections were performed on the portable fire extinguishers. During the tour, HM-B stated that the fire extinguisher was new in 2021 when it was purchased but had not updated the certification since. HM-B visually verified this deficient finding at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 790		
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	0 800		

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0 800	Continued From page 8 good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On August 16, 2023, from approximately 9:45 a.m. to 11:30 a.m., survey staff toured the facility with the housing manager (HM)-B. The following was observed: It was observed that occupied bedroom #1 on the main level had a large hole in the ceiling near the closet. The ceiling was stained in that area and cracked throughout the rest of the room. It was clear that the damage was coming from the upstairs bathroom.	0 800		

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0 800	Continued From page 9 It was observed that the upstairs bathroom had multiple locations where the tile was broken and the grout was missing. The remaining grout in the shower, around the toilet, and in the sink area was heavily stained and looked to be growing mold or mildew. The bathroom smelled heavily of stagnant water. It was observed that the sconce light adjacent to the sink area was not secured to the wall and had wires that were easily exposed to anyone using the bathroom. It was observed that the water shut-off valve for the toilet was broken and missing the knob that allowed the shut-off to function. It was observed in the upstairs bathroom that the sealant joints were degraded or completely missing around the base of the toilet, along the top of the bathtub, along all the joints where the floor meets the walls, and where the side of the bathtub meets the wall. Missing sealant in bathrooms leads to water penetration behind the finish materials, which can lead to mold and rot in the sub-materials and structure of the home. It was observed that the stair landing, immediately outside the upstairs bathroom was soft and spongy when stepped on. Survey staff and HM-B could feel the dipping in the material from the door to the bathroom, all the way to the edge of the top stair, and into the narrow hallway adjacent to the landing. It appeared that some time in the recent history of the home, the bathroom had leaked or flooded under the flooring material and had damaged the subfloor material.	0 800		

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0 800	Continued From page 10 It was observed that occupied upstairs bedroom #1 had a broken window pane and the only window was partially obstructed by a window air conditioning unit. It was observed that occupied upstairs bedroom #2 did not have a functioning overhead light. Survey staff were not able to tell if the lightbulb was burned out or if the wall switch did not work. It was also observed that the only egress-sized window was obstructed by a window air conditioning unit. It was observed that the bathroom on the main level had significant damage to the latch area of the door. HM-B stated that a resident had recently tried to kick in the door when another resident was using the bathroom. The door had been partially fixed using wood filler and screws, but there were still rough areas where the material could be a hazard to residents. It was also observed that the base cabinet had significant water damage. The laminate was peeling off of the doors and the sides of the base cabinet were waterlogged. When survey staff pressed on the side of the cabinet, black water squeezed out and ran down the side. It was observed that the window pane in the main level bathroom had a large crack running across the bottom left quarter of the window. It was observed that there was no light in the stairway down to the basement. Survey staff and HM-B struggled to descend the staircase safely due to a lack of light. It was observed that the steps into occupied basement bedroom #5 were irregularly shaped	0 800		

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0 800	Continued From page 11 and irregularly sized. The top step was 4 inches in height and the second stair was 10.5 inches in height. Stairs should be designed and built to meet all relevant building codes. Irregular stairs are a high risk for falls and tripping. It was observed in occupied basement bedroom #5 that there was a large hole in the ball adjacent to the fin tube radiant heater. The hot water pipe was exposed as well as other building materials. This hole was adjacent to an exterior wall and could also be a point of penetration for pests and vermin. It was observed that the basement had multiple locations on the walls where some sort of damage or growth was happening. The basement smelled strongly of stagnant water and had evidence of water damage on some of the walls. Most of the lights in the basement were missing lightbulbs. It was observed that miscellaneous items were being stored throughout the basement and had become home to pests. Fly-catching paper was adhered to the ceiling with the carcasses of twenty dead flies present at the time of the survey. Survey staff observed multiple crawling bugs moving around the piles of household items and boxes as well as build-up of cobwebs, spiderwebs, and spiders around the ceiling corners and windows. It was observed in the basement furnace room that combustible items were being stored up against and near gas-fired appliances. Survey staff recommended to HM-B that nothing combustible be stored immediately adjacent to the furnace and water heater.	0 800		

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0 800	Continued From page 12 It was observed that the wooden deck area had two posts missing from the guard rail. Nails were protruding down from the top rail where the posts were missing and could be a potential hazard to residents. It was observed that the handrail for the stairs to the wooden deck was severely degraded and heavily weathered. The wood was cracked and extremely rough in multiple locations along the whole handrail. The wood had split at the bottom of the stairs and was protruding into the clear width of the stairs. Wood blocking that separated the handrail from the top rail of the banister had deteriorated in two locations leaving the long screws exposed where they could be a potential hazard to residents. It was observed that the gutters around the entire home were clogged, rusted through, or disconnected from the downspouts. It was observed that miscellaneous plastic items, garbage, and damaged yard accessories were strewn about the side yards and back yards of the house. The grass was overgrown, obscuring the walking area of the yard and making it difficult to know where to step. Residents have access to the yard and it should be kept at a length that allows the resident to step safely and not become a tripping hazard. HM-B visually verified these deficient findings at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32758	A. BUILDING: _____ B. WING _____	08/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLNESS HOMES INC	4137 CHICAGO AVENUE MINNEAPOLIS, MN 55407

(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
0 810	Continued From page 13	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) employee 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) Employees 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 employees 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 a record review and interview, the	0 810		

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0 810	Continued From page 14 licensee failed to develop a fire safety and evacuation plan with the required elements, and failed to provide required employee and resident training on fire safety and evacuation. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A record review and interview were conducted on August 16, 2023, at approximately 12:00 p.m. with the licensed assisted living director (LALD)-A and the housing manager (HM)-B on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review of the available documentation indicated that the licensee did not have employee actions to be taken in the event of a fire or similar emergency. The facility plan indicated to use RACE acronym but was very vague and did not provide complete actions for employees to take in the event of a fire or similar emergency. During interview, LALD-A and HM-B verified that the fire safety and evacuation plan for the facility lacked these provisions. Record review of the available documentation indicated that the licensee did not have fire	0 810		

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0 810	Continued From page 15 protection procedures necessary for residents included in the fire safety and evacuation plan. During interview, LALD-A and HM-B verified that the fire safety and evacuation plan for the facility lacked these provisions. Record review of the available documentation indicated that the fire safety and evacuation plan did not include 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. The facility plan did include some provisions for the relocation of residents but did not specify how to move or evacuate residents or identify the unique and unusual needs of the residents. During interview, LALD-A and HM-B verified that the fire safety and evacuation plan for the facility lacked these provisions. Record review of available documentation indicated that the licensee did not provide employee training on the fire safety and evacuation plan twice per year after the training at initial hire. During interview, LALD-A stated the licensee did not have documentation on employee training on the fire safety and evacuation plan, but only had documentation of training the staff on the emergency preparedness manual, which is not the same as the fire safety and evacuation procedures. Record review of the available documentation indicated that the licensee did not provide annual training to residents who can assist in their own evacuation on the proper actions to take in the event of a fire including movement, evacuation, or relocation as required by statute. During interview, LALD-A and HM-B stated that the	0 810		

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0 810	Continued From page 16 facility did not have documentation on offering resident training on the fire safety and evacuation plan. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property of a resident. This had the potential to affect the residents residing in the facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect 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 the residents). The findings include:	0 970		

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	32758	A. BUILDING: _____ B. WING _____	08/17/2023

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0 970	Continued From page 17 On August 15, 2023, at 10:00 a.m., during the entrance conference, a copy of the facility's assisted living contract was requested. The Wellness Homes, Inc Housing with Services Contract and Lease Agreement, term dated June 20, 2023, through June 20, 2024, included clauses that indicated the provider was not liable to resident in the following incidents: - Indemnification- Tenant would indemnify and hold harmless Landlord, its employees and agents from and against all claims, actions, damages, and liability and expense in connection with loss of life, personal injury or damage to property. arising from or out of the use by Tenant of the rented premises or any other part of Landlord's property or caused wholly or in part by an act or omission of Tenant or Tenant's guests or agents. -Liability- Landlord was not liable to Tenant or Tenant's guests for any injury, death or property damage occurring in the Room or on Landlord's premises unless such injury, death or property damage occurs as the result of an equipment malfunction or hazardous conditions within the building not caused by Tenant or Tenant's guests. Landlord was also not liable for any injury, death or damage occurring as the result of Tenant's receipt of health-related, supportive or other services from third party providers. Landlord may be liable to Tenant for its own negligent acts or those of its employees or agents. Unless caused by one of the aforementioned excepted reasons, Tenant agreed to hold Landlord harmless from any and all claims for injuries. property damage or any other loss resulting from an accident or other occurrence in the Room or on Landlord's premises.	0 970		

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0 970	Continued From page 18 Insurance- Landlord would maintain appropriate levels and types of insurance covering the building and its contents. Because Landlord did not maintain insurance covering the contents of tenants' rooms, Tenant was strongly encouraged to carry appropriate levels of liability insurance covering both the contents of the Room, as well as any injury to Tenant or Tenant's guests occurring within the Room ("renter's insurance"). Tenant acknowledged and understood that the lack of such insurance coverage may result in personal loss to and/or liability of Tenant. Tenant agreed to provide Landlord with a certificate of insurance upon request. In the event Tenant's property is damaged or destroyed by fire, efforts to extinguish a fire, or other causes that may be covered by standard fire and extended coverage insurance, or by other insurance coverage, (resident)hereby waived: (a) all claims against Landlord and its representatives for any such loss or damage; and (b) all rights of subrogation of any insurance company carrying any insurance covering such damage or destruction -Personal Property- The landlord was not responsible for any loss or damage to the president's personal property due to theft, or damage due to fire, water, tornado or other acts of nature and events beyond the landlord's control. The resident was strongly encouraged to obtain renter's insurance. On August 17, 2022, at 1:30 p.m. the licensed assisted living director (LALD)-A stated the assisted living contract required residents to waive the facility's liability for health, safety, or personal property. LALD-A stated The Wellness Homes, Inc Housing with Services Contract and Lease Agreement was signed by all residents	0 970		

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0 970	Continued From page 19 residing in the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		
01290 SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study (BGS)was affiliated to the licensee's health facility identification number (HFID) prior to staff providing services for two of two employees, licensed assisted living director (LALD-A) and unlicensed personnel (ULP-B). 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	01290		

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01290	Continued From page 20 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: LALD-A, who also acted as the clinical nurse supervisor, had a hire date of October 16, 2016, under the comprehensive license and started providing services to residents of the facility. On August 15, 2023, at 10:00 a.m., during the entrance conference, LALD-A stated they were the CNS and was responsible for resident assessments and over-looked care and well-being. LALD-A's employee record included a NetStudy clearance dated August 28. 2020, for HFID 32390. LALD-A's record lacked evidence of a completed BGS clearance affiliated with the licensee's HFID 32758. ULP-B had a hire date of November 23, 2018, under the comprehensive license and started providing care and services to residents of the facility. On August 16, 2022, between 8:00 a.m. and 10:00 a.m., ULP-B was observed administering medications to licensee's residents and assisting with morning cares. ULP B's employee record included a NetStudy clearance dated November 1, 2021, for HFID 32390. ULP-B's record lacked evidence of a completed background study clearance affiliated	01290		

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01290	Continued From page 21 with the licensee's HFID 32758. On August 16, 2023, at 1:35 p.m., ULP-B, who was also the sensitive information person (SIP) stated they were not aware the licensee was required to affiliate an employee's BGS to the licensee's HFID prior to providing care and services. ULP- B stated all staff were affiliated with HFID 32390 and would correct the situation as soon as possible. On August 17, 2023, at 1:30 p.m., LALD-A stated all employees working in the facility had the incorrect HFID affiliated to their BGS. LALD-A stated the licensee was aware of the requirement for all employees to have a BGS but not the concept of "affiliation." LALD-A stated the licensee was working on correcting this and all future BGS would be affiliated with the correct HFID number. The licensee's Background Studies policy dated August 1, 2021, indicated the licensee would conduct a Minnesota Department of Human Services Background Study on all employees and volunteers and contractors. No employee may provide direct services and have independent direct contact with any resident until acceptable results of the background study have been received. The licensee would not employ individuals whose results of the background study indicate disqualification for the position. No further information was provided.TIME PERIOD FOR CORRECTION: Two (2) days	01290		

Minnesota Department of Health
Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *08/15/23*
Time: 11:45:00
Report: 10392377

Food and Beverage Establishment Inspection Report

Location:
Wellness Homes Inc
4137 Chicago Avenue
Minneapolis, MN55407
Hennepin County, 27

Establishment Info:
ID #: 0038466
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.

5-200C Plumbing: Maintenance, fixture location
5-205.11AB ***** Priority 2 *****
MN Rule 4626.1110AB The handwashing sink must be accessible at all times for employee use, and must be used only for handwashing.
MODULAR HANDWASHING SINK IS SHUT OFF. HANDWASHING SINK MUST BE AVAILABLE AT ALL TIMES.
Comply By: 08/16/23

6-300 Physical Facility Numbers and Capacities
6-301.11 ***** Priority 2 *****
MN Rule 4626.1440 Provide an adequate supply of hand soap at each handwashing sink or group of 2 adjacent handwashing sinks.
NO HAND SOAP AT HANDWASHING SINK. PERSON-IN-CHARGE PROVIDED HAND SOAP, CORRECTED ON SITE.
Comply By: 08/16/23

6-300 Physical Facility Numbers and Capacities
6-301.12 ***** Priority 2 *****
MN Rule 4626.1445 Provide and maintain a supply of individual disposable towels, a continuous towel system, a heated-air hand drying device, or an approved ambient air temperature hand drying device at each handwashing sink or group of adjacent handwashing sinks.
NO PAPER TOWELS AT HANDWASHING SINK. PERSON-IN-CHARGE PROVIDED PAPER TOWELS. CORRECTED ON SITE.
Comply By: 08/16/23

Type: Full
Date: *08/15/23*
Time: 11:45:00
Report: 10392377
Wellness Homes Inc

Food and Beverage Establishment Inspection Report

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.11

MN Rule 4626.1515 Maintain the physical facilities in good repair.
CABINET DOOR IS MISSING BENEATH 3-COMPARTMENT SINK. DOOR SHOULD BE REPLACED.

Comply By: 08/16/23

Food and Equipment Temperatures

Process/Item: TOMATO
Temperature: 41F Degrees Fahrenheit - Location: COLD HOLD, REFRIGERATOR
Violation Issued: No

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

The establishment has a residential kitchen and should serve food for same-day service only.

The kitchen has laminate counter tops, wood laminate cabinets with hollow base, tile backing above sink, painted walls and ceiling and laminate floors.

The kitchen finishes and surfaces show considerable wear.

There is a 3-compartment sink and a separate modular handwashing sink. When the 3-compartment sink is used for food preparation, the sink should be sanitized before and after use.

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 10392377 of 08/15/23.

Certified Food Protection Manager: Maxamed Ismael

Certification Number: FM114868 Expires: 11/03/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
Maxamed Ismael
person-in-charge

Signed: _____
Aron Goodner
Public Health Sanitarian I
Freeman Building
aron.goodner@state.mn.us