Electronically Delivered

March 2, 2026

Licensee
Heart Group Home
4643 7th Street Northeast
Columbia Heights, MN 55421

RE: Project Number(s) SL35608016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 28, 2026, 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.

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 . . ."

IMPOSITION OF FINES

In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement;
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;
Level 3: a fine of $1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 4: a fine of $3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 5: a fine of $5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed

pursuant to this survey:

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

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

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in

a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

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,

Kelly Thorson

Kelly Thorson, Supervisor
State Evaluation Team
Email: Kelly.Thorson@state.mn.us
Telephone: 320-223-7336 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
	35608	A. BUILDING: _____ B. WING _____	01/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEART GROUP HOME	4643 7TH STREET NE COLUMBIA HEIGHTS, MN 55421

(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: SL35608016-0 On January 26, 2026, through January 28, 2026, 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) residents; five (5) 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.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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0 480	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are	0 480		

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated January 28, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.	0 480		

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0 480	Continued From page 3 TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (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 interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for one of three residents (R4). 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: R4 was admitted to the licensee on December 3,	0 630		

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0 630	Continued From page 4 2025, with diagnoses that included bipolar disorder, type II Diabetes, major depression, and generalized anxiety disorder. R4's record lacked an individual abuse prevention plan (IAPP) which included the person's risk of abusing other vulnerable adults and statements of specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. On January 28, 2026, at 11:20 p.m., clinical nurse supervisor (CNS)-D stated he is aware of the requirements and when completing the IAPP for R4 he must have missed the risk of abusing others and specific interventions to minimize the risk. The licensee's Vulnerable Adult policy dated August 1, 2021, indicated an individual abuse prevention plan shall be established for each vulnerable minor or adult for whom assisted living services are provided. - The plan shall contain an individualized assessment of the resident's susceptibility to abuse by another individual, including other vulnerable adults. - The plan shall contain the residents' risk of abusing other vulnerable adults. - The plan shall contain statements of specific measures to 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		

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0 650	Continued From page 5	0 650		
0 650 SS=D	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records included all required content (annual performance review) for one of two personnel (housing manager (HM)-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 resident's health or safety, but was not likely to cause serious injury, impairment, or death and	0 650		

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0 650	Continued From page 6 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). Findings include: HM-B was hired on August 21, 2023, to provide direct care services to residents. HM-B's employee record lacked evidence that an annual performance review was completed. On January 28, 2026, at 10:00 a.m., licensed assisted living director (LALD)-A stated they were unable to find the annual review document for HM-B, the review was done but it may not have been documented, or the document was misplaced. The licensee's Performance Review policy dated August 1, 2021, indicated a formal performance evaluation will be conducted for all staff providing assisted living services at least annually. Documentation of the annual performance evaluation will be maintained in the personnel file. 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	0 680		

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0 680	Continued From page 7 elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to develop an all-hazards risk assessment emergency preparedness program and plan to include Appendix Z required elements. 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 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).	0 680		

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0 680	Continued From page 8 The findings include: The licensee's undated emergency preparedness plan (EPP), lacked the required content: - development and maintenance of the EPP; - maintained annual updates; - a quarterly review of missing resident policy; - development of a communication plan; - names and contact information in the communication plan; and - exercises to test the EPP at least twice per year, including unannounced drills using the EPP. On January 26, 2026, at 1:25 p.m., licensed assisted living facility (LALD)-A stated he agreed some of the required components of the EPP are missing or have not been updated with changes as they have occurred. LALD-A stated he recently took over as the LALD and had not had a chance to update and review the EPP. LALD-A stated he had no evidence of the missing person policy review but he plans on reviewing the missing person policy at the quarterly quality assurance meetings with the staff. The licensee's Emergency Preparedness policy dated September 25, 2023, indicated the licensee will have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services. The emergency preparedness plan/program will be reviewed/updated at least annually. The licensee's Missing Resident policy dated September 25, 2023, indicated missing resident procedure will be reviewed by the director and clinical nurse supervisor at least quarterly.	0 680		

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0 680	Continued From page 9 Per Assisted Living Facilities: Minnesota Rules Chapter 4659, 4659.0110, Subp. 4. Review missing resident plan. The assisted living director and clinical nurse supervisor must review the missing person plan at least quarterly and document any changes to the plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 775 SS=F	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, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. 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:	0 775		

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0 775	Continued From page 10 Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated 1-29-26, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) Days	0 775		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. 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	0 800		

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0 800	Continued From page 11 affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated 1-29-26, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty One (21) Days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The	0 810		

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	35608	A. BUILDING: _____ B. WING _____	01/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEART GROUP HOME	4643 7TH STREET NE COLUMBIA HEIGHTS, MN 55421

(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 12 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 ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. 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: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated 1-29-26, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty One (21) Days	0 810		

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01640	Continued From page 13	01640		
01640 SS=E	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. (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 interview and record review, the licensee failed to ensure a written service plan was implemented no later than 14 days after the date services were first provided for two of three residents (R1 and R4). 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	01640		

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01640	Continued From page 14 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: R1 R1 was admitted to the licensee on October 5, 2022, with diagnoses that included type 2 diabetes mellitus, bipolar disorder, major depressive disorder, and chronic kidney disease. R1's record included a signed service plan dated March 16, 2025, the service plan indicated R1 received services that included medication administration, medication setup, supervision of blood pressure, and supervision of wound care. R1's unsigned service plan printed on January 27, 2026, indicated R1 received services that included bathing assistance, grooming, housekeeping, behavior management, meal assistance, medication administration, medication setup, record blood glucose, record blood pressure, record oxygen saturation, record pulse, record temperature, remove garbage, safety checks, supervision of blood pressure, supervision of wound care, symptom screen, transfer assistance, and wound care. R1's Service Recap Summary for December 2025 and January 2026 included all services listed on the unsigned service plan. R1's record lacked a signed written service plan within 14 days after the date that additional services were first provided.	01640		

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01640	Continued From page 15 R4 R4 was admitted to the licensee on December 3, 2025, with diagnoses that included bipolar disorder, type II Diabetes, major depression, and generalized anxiety disorder. R4's record included a signed service plan dated December 3, 2025, the service plan indicated R4 received services that included medication administration, medication setup, record blood pressure, record oxygen saturation, record pulse, record respiration, record temperature, record weight. R4's unsigned service plan printed on January 27, 2026 indicated R4 received services that included activity assistance, appointment reminders, dressing, grooming, housekeeping, laundry, behavior management, meal assistance, medication administration, medication reminder, medication setup, record blood glucose, record blood pressure, record oxygen saturation, record pulse, record respiration, record temperature, record weight, safety checks, shopping assistance, and transportation assistance. R4's Service Recap Summary for January 1, 2026, through January 25, 2026, included all service listed on the unsigned service plan. R4's record lacked a signed written service plan within 14 days after the date that additional services were first provided. On January 27, 2026, at 11:30 a.m., licensed assisted living director (LALD)-A stated the service plans do not match because they only update the service plans annually and were not aware that the service plans need to be updated within 14 days after a new service is first	01640		

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01640	Continued From page 16 provided. The licensee's Service Plan policy dated August 1, 2021, indicated the service plan will be finalized no later than 14 days after the date home care services are first provided, if not already completed. The service plan must be revised, if needed, based on resident review or reassessment. The initial service plan and any revisions are signed by a representative from licensee and the resident or resident's representative, indication agreement with the services to be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were maintained bearing the original prescription and failed to include the opened or expiration date for time sensitive medications being stored by the licensee. This practice resulted in a level two violation (a	01890		

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01890	Continued From page 17 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 January 28, 2026, at 10:30 a.m., the surveyor observed the medication cart with licensed assisted living director (LALD)-A. The surveyor observed an unlabeled and undated Lantus pen (insulin pen used to treat diabetes) in the top drawer of the medication cart. LALD-A stated this was R4's insulin pen R4 is the only resident receiving insulin and confirmed the pen did not have a prescription label or open date indicated on the insulin pen. The manufacturer's instructions dated August 2022, for Lantus indicated the pen should be disposed of after 28 days, even if it still has insulin left in it. On January 28, 2026, at 11:20 a.m., clinical nurse supervisor (CNS)-D stated he is aware all medications should contain a prescription label and certain medications need a date documented when first used and if the insulin pen is missing the prescription label and the open date it was his mistake and it must have been missed when the pen was opened and taken out of the original box. The licensee's Storage of Medications policy dated August 1, 2021, indicated prescription drugs, prior to being set up for immediate or later	01890		

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01890	Continued From page 18 administration, must be kept in the original container in which they were dispensed by the pharmacy bearing the original prescription label with legible information. The licensed nurse is responsible for dating time-sensitive medications when opened. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01940 SS=F	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and	01940		

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01940	Continued From page 19 therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for two of two residents (R1 and R4). 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: R1 R1 was admitted to the licensee on October 5, 2022, with diagnoses that included type 2 diabetes mellitus, bipolar disorder, major depressive disorder, and chronic kidney disease. R1's unsigned service plan printed on January 27, 2026, indicated R1 received services that included blood glucose monitoring and wound care. R1's Service Recap Summary for December 2025 and January 2026 included blood glucose monitoring and wound care.	01940		

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01940	Continued From page 20 R1's record included an individualized treatment plan dated April 23, 2025, which included wound care but did not include blood glucose monitoring. R1's individualized treatment plan lacked the following required information for blood glucose monitoring: - statement of the types of services that will be provided; - documentation of specific resident instructions relating to the treatments or therapy administration; - procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and - any resident specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy were administered as prescribed, and monitoring of treatment or therapy to prevent complications or adverse reactions. On January 27, 2026, at 1:35 p.m., licensed assisted living director (LALD)-A stated R1 does not have an updated treatment plan that includes blood glucose monitoring. R4 R4 was admitted to the licensee on December 3, 2025, with diagnoses that included bipolar disorder, type II Diabetes, major depression, and generalized anxiety disorder. R4's unsigned service plan printed on January 27, 2026, indicated R4 received services that included record blood glucose. R4's Service Recap Summary dated January	01940		

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01940	Continued From page 21 2026, included blood glucose monitoring. R4's record lacked an individualized treatment plan for blood glucose monitoring and lacked the required information: - statement of the types of services that will be provided; - documentation of specific resident instructions relating to the treatments or therapy administration; - procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and - any resident specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent complications or adverse reactions. On January 28, 2026, at 10:00 a.m., LALD-A stated R4 does not have a treatment plan for blood glucose monitoring, he was completing this service himself and when the treatment was added the treatment plan was missed. On January 28, 2026, at 11:20 a.m., clinical nurse supervisor (CNS)-D stated he was having a hard time figuring out how to document the treatment plan in the computer system and so he was unable to create new treatment plans for R1 and R4, he had added some information to the resident assessments but is waiting on a reply from the computer system company to advise how he can create treatment plans in the system. The licensee's Treatment and Therapy Management policy dated August 1, 2021, indicated the RN or licensed professional will	01940		

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01940	Continued From page 22 prepare an individualized treatment or therapy management plan for each resident receiving ordered or prescribed treatments or therapy services, which addresses: - type of service to be provided; - procedures For documenting treatments or therapies; - procedures for monitoring treatments or therapies to prevent possible complications or adverse reactions; and - procedures for notifying the RN or licensed health professional when a problem arises related to the treatment or therapy service. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01950 SS=F	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for	01950		

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01950	Continued From page 23 each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure prior to delegating nursing tasks of treatment administration, unlicensed personnel (ULP) had demonstrated competency back to the registered nurse (RN) for two of two employees housing manager (HM)-B and unlicensed personnel (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, 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 the residents). The findings include: During the entrance conference on January 26, 2026, at 11:00 a.m., licensed assisted living director (LALD)-A stated the licensee provided treatment services to residents that included blood glucose monitoring and wound care. HM-B was hired on August 21, 2023, to provide direct care services to residents. ULP-C was hired on November 3, 2025, to provide direct care services to residents. HM-B and ULP-c's employee records lacked evidence that HM-B and ULP-C had demonstrated competency back to the RN for	01950		

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01950	Continued From page 24 blood glucose monitoring and wound care. On January 28, 2026, at 10:00 a.m., licensed assisted living director (LALD)-A stated they were unable to find the competency checkoff form for blood glucose monitoring and wound care for HM-B and ULP-C's records and the competency checkoff form must have been missed by the nurse. The licensee's Staff Competency policy dated August 1, 2021, indicated unlicensed personnel may not work for the licensee until they have successfully passes the written and demonstration competency evaluation. The following documentation will be maintained related to competency evaluations: - facility name, location and license number; - name of topic and methodology; - date and total time; - name/title of instructor and evaluator with signature and a statement attesting that the employee successfully passes the training and competency evaluation; and - name/title of staff person completing the competency evaluation and a statement attesting that the person successfully completed the training as described. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		

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

HEART GROUP HOME
4643 7th Street NE
Columbia Heights, MN 55421
Anoka County
Parcel:

Phone:
caring2529@gmail.com

License Info

License: HFID 35608

Risk:
License:
Expires on:
CFPM: ABDUKADIR NOR
CFPM #: 107981; Exp: 8/2/2027

Inspection Info

Report Number: F1029261023
Inspection Type: Full - Single
Date: 1/26/2026 Time: 11:31:10 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 4
Total Priority 2 Orders: 5
Total Priority 3 Orders: 7
Delivery:

! **New Order: 3-100 Food Characteristics: unadulterated**
3-101.11 *Priority Level: Priority 1 CFP#: 13*
MN Rule 4626.0125 Remove all unsafe and adulterated foods from the premises.
COMMENT: JAR OF OPENED APPLESAUCE IN FRIDGE WITH SUBSTANTIAL AMOUNT OF BLACK MOLD AND DARK BUILD UP. DISCARDED BY OPERATOR. OPERATOR INSTRUCTED TO BE WATCHFUL FOR SIGNS OF SPOILAGE AND CONTAMINATION.
Comply By: 1/26/2026 Originally Issued On: 1/26/2026

New Order: 3-300B Protection from Contamination: cross-contamination, eggs
3-302.12 *Priority Level: Priority 3 CFP#: 37*
MN Rule 4626.0240 Properly label all working containers holding food or food ingredients that are removed from original packages with the common name of the food. Label the food in English and any other languages used by employees who handle food.
COMMENT: PREPARED FOODS IN FRIDGE NOT LABELED. OPERATOR INSTRUCTED TO LABEL.
Comply By: 1/26/2026 Originally Issued On: 1/26/2026

New Order: 3-300C Protection from Contamination: equipment/utensils, consumers
3-307.11 *Priority Level: Priority 3 CFP#: 39*
MN Rule 4626.0337 Protect food from miscellaneous sources of contamination.
COMMENT: PAINT PEELING ABOVE STOVE TOP AND FOOD PREPARATION AREAS. OPERATOR INSTRUCTED TO REPAIR OR REPLACE.
Comply By: 2/6/2026 Originally Issued On: 1/26/2026

! **New Order: 3-500B Microbial Control: hot and cold holding**
3-501.16A2 *Priority Level: Priority 1 CFP#: 22*
MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.
COMMENT: MAIN KITCHEN REFRIGERATOR NOT COLD HOLDING SAFELY. TEMPERATURE ABUSED ITEMS DISCARDED. REFRIGERATOR ALREADY SET TO 5/5 (COLDEST SETTING). OPERATOR INSTRUCTED TO REPAIR OR REPLACE AND TO VERIFY SAFE HOLDING TEMPERATURES PRIOR TO PLACING ADDITIONAL TCS ITEMS WITHIN. ESTABLISHMENT HAS A SEPARATE FUNCTIONAL EMPTY COMMERCIAL UPRIGHT COOLER AS AN OPTION FOR COLD HOLDING.
Comply By: 1/26/2026 Originally Issued On: 1/26/2026

New Order: 4-100 Equipment Construction Materials
4-101.19 *Priority Level: Priority 3 CFP#: 47*
MN Rule 4626.0495 Remove non-food-contact surfaces of equipment that are exposed to splash, spillage, or other food soiling, or that require frequent cleaning, that are not constructed of a corrosion-resistant, non-absorbent, and smooth material.
COMMENT: PAINT PEELING OFF AND/OR EXPOSED WOOD ON DRAWER AND CABINET SURFACES THAT CONTACT EQUIPMENT/UTENSIL. OPERATOR INSTRUCTED TO REPAIR OR REPLACE.
Comply By: 2/6/2026 Originally Issued On: 1/26/2026

New Order: 4-200 Equipment Design and Construction
4-201.11GMN *Priority Level: Priority 3 CFP#: 47*
MN Rule 4626.0506G Discontinue serving TCS foods that are held for more than same-day service in an adult or child care center or boarding establishment or provide equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.
COMMENT: ITEMS BEYOND SAME DAY SERVICE WINDOW. OPERATOR INSTRUCTED TO DISCONTINUE PRACTICE.
Comply By: 1/26/2026 Originally Issued On: 1/26/2026

New Order: 4-300 Equipment Numbers and Capacities
4-302.12B *Priority Level: Priority 2 CFP#: 36*
MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.
COMMENT: NO SMALL DIAMETER PROBE THERMOMETER. VISUAL EXAMPLE OF SMALL DIAMETER PROBE THERMOMETER PROVIDED DURING INSPECTION. OPERATOR INSTRUCTED TO MAINTAIN SMALL DIAMETER PROBER THEMOMETER ONSITE.
Comply By: 2/6/2026 Originally Issued On: 1/26/2026

New Order: 4-300 Equipment Numbers and Capacities
4-302.13B *Priority Level: Priority 2 CFP#: 48*
MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.
COMMENT: ESTABLISHMENT WITHOUT THERMAL STICKERS OR MIN/MAX THERMOMETER TO TEST HIGH HEAT DISHWASHER. OPERATOR INSTRUCTED TO OBTAIN MEANS OF VERIFYING DISHWASHER SANITIZING TEMPERATURE.
Comply By: 2/6/2026 Originally Issued On: 1/26/2026

New Order: 4-300 Equipment Numbers and Capacities
4-302.14 *Priority Level: Priority 2 CFP#: 48*
MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.
COMMENT: CL ONSITE FOR WIPING CLOTH BUCKETS BUT NO CL TEST STRIPS. OPERATOR INSTRUCTED TO OBTAIN AND USE CL TEST STRIPS IF HAND MIXING SOLUTION. OPERATOR INFORMED PREPACKAGED FOOD CONTACT SURFACE WIPES WERE ALSO AN OPTION FOR THE KITCHEN SURFACES. SMALL SUPPLY OF CL TEST STRIPS PROVIDED. IMAGE TAKEN ON CONCENTRATION COLOR CHART ON TEST STRIP TUBE AND TESTING DEMONSTRATION PROVIDED DURING INSPECTION.
Comply By: 1/26/2026 Originally Issued On: 1/26/2026

! **New Order: 4-500 Equipment Maintenance and Operation**
4-501.114C3 *Priority Level: Priority 1 CFP#: 16*
MN Rule 4626.0805C3 Provide and maintain an approved quaternary ammonium compound sanitizing solution in water with 500 ppm hardness or less, a minimum temperature of 75 degrees F (24 degrees C) and a concentration specified in 21CFR.178.1010 and as indicated by the manufacturer's use directions and label.
COMMENT: QUAT IN SPRAY BOTTLE > 400 PPM. CORRECTED DURING INSPECTION TO 200-400 PPM. OPERATOR INSTRUCTED TO MAINTAIN QUATS AT 200-400 PPM IF USED.
Comply By: 1/26/2026 Originally Issued On: 1/26/2026

New Order: 4-500 Equipment Maintenance and Operation
4-501.11AB *Priority Level: Priority 3 CFP#: 47*
MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.
COMMENT: DISHWASHER RECENTLY STOPPED WORKING. OPERATOR INSTRUCTED TO REPAIR OR REPLACE.
Comply By: 2/6/2026 Originally Issued On: 1/26/2026

! **New Order: 4-700 Sanitizing Equipment and Utensils**
4-702.11 *Priority Level: Priority 1 CFP#: 16*
MN Rule 4626.0900 Sanitize utensils and food contact surfaces of equipment before use, after cleaning.
COMMENT: DISHWASHER NOT WORKING AND CHEMICAL SANITIZER NOT IN USE. OPERATOR INSTRUCTED TO HAVE DISHWASHER REPAIRED OR REPLACED TO ENSURE HIGH HEAT SANITIZING AND TO SANITIZE BY CHEMICAL IN 2ND BASIN OF 2-COMP SINK AS TEMPORARY REMEDY. CL SOLUTION MIXED DURING INSPECTION.
Comply By: 1/26/2026 Originally Issued On: 1/26/2026

New Order: 6-300 Physical Facility Numbers and Capacities
6-301.12 *Priority Level: Priority 2 CFP#: 10*
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.
COMMENT: PAPER TOWELS NOT BY HANDWASHING STATION. CORRECTED DURING INSPECTION.
Comply By: 1/26/2026 Originally Issued On: 1/26/2026

New Order: 6-500 Physical Facility Maintenance/Operation and Pest Control
6-501.12A *Priority Level: Priority 3 CFP#: 55*
MN Rule 4626.1520A Clean and maintain all physical facilities clean.
COMMENT: GREASE BUILDUP ON WALL BEHIND STOVE TOP. OPERATOR INSTRUCTED TO CLEAN AND MAINTAIN CLEAN.
Comply By: 2/6/2026 Originally Issued On: 1/26/2026

New Order: 6-500 Physical Facility Maintenance/Operation and Pest Control
6-501.19 *Priority Level: Priority 3 CFP#: 53*
MN Rule 4626.1555 Keep the toilet room doors closed except during cleaning and maintenance operations.
COMMENT: TOILET ROOM DOOR OPEN. CLOSED DURING INSPECTION. OPERATOR INSTRUCTED TO KEEP TOILET ROOM DOOR CLOSED WHEN NOT CLEANING OR MAINTAINING.
Comply By: 1/26/2026 Originally Issued On: 1/26/2026

New Order: 7-100 Toxic Labeling
7-102.11 *Priority Level: Priority 2 CFP#: 28*
MN Rule 4626.1595 Clearly label all working containers used for storing poisonous or toxic materials from bulk supplies such as sanitizers and cleaners, with the common name of the product.
COMMENT: HAND MIXED QUAT IN SPRAY BOTTLE WITHOUT IDENTIFIER. CORRECTED DURING INSPECTION WITH PERMANENT MARKER. OPERATOR INSTRUCTED TO LABEL SANITIZERS AND CHEMICALS WHEN REMOVED FROM THEIR ORIGINAL CONTAINERS.
Comply By: 1/26/2026 Originally Issued On: 1/26/2026

Food & Beverage General Comment

FOOD AND BEVERAGE INSPECTION CONDUCTED AS PART OF HRD NURSING SURVEY OF ALF.

ESTABLISHMENT RESIDENTIAL IN NATURE AND SERVING 5 CLIENTS NOT PART OF A HIGHLY SUSCEPTIBLE POPULATION.

INSPECTION CONDUCTED IN THE PRESENCE OF ESTABLISHMENT REPRESENTATIVES ZAKARIE WEHLIE, MANAGER, HAFSO ABDI, HOUSE KEEPER, AND OTHER STAFF. IDENTIFIED ISSUES REVIEWED WITH ESTABLISHMENT REPRESENTATIVES AND NURSING SURVEYOR.

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 F1029261023 from 1/26/2026

Trevor McCliment

ZAKARIE WEHLIE
MANAGER

Trevor McCliment,
Public Health Sanitarian 3
651-201-3957
trevor.mccliment@state.mn.us

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

Temperature Observations/Recordings

Establishment Info

HEART GROUP HOME
Columbia Heights
County/Group: Anoka County

Inspection Info

Report Number: F1029261023
Inspection Type: Full
Date: 1/26/2026
Time: 11:31:10 AM

New Record: **Product/Item/Unit:** COOKED CHICKEN**; Temperature Process:** Cold-Holding
Location: FRIDGE at 48 Degrees F.
Comment:
Violation Issued?: Yes

New Record: **Product/Item/Unit:** COOKED POTATOES**; Temperature Process:** Cold-Holding
Location: FRIDGE at 51 Degrees F.
Comment:
Violation Issued?: Yes

New Record: **Product/Item/Unit:** COOKED RICE**; Temperature Process:** Cold-Holding
Location: FRIDGE at 45 Degrees F.
Comment:
Violation Issued?: Yes

New Record: **Product/Item/Unit:** GRAVY**; Temperature Process:** Cold-Holding
Location: FRIDGE at 48 Degrees F.
Comment:
Violation Issued?: Yes

New Record: **Product/Item/Unit:** TOMATO SAUCE WITH MEAT**; Temperature Process:** Cold-Holding
Location: FRIDGE at 49 Degrees F.
Comment:
Violation Issued?: Yes

New Record: **Product/Item/Unit:** BUTTER**; Temperature Process:** Cold-Holding
Location: FRIDGE DOOR at 51 Degrees F.
Comment:
Violation Issued?: Yes

Equipment Temperature: **Product/Item/Unit:** INTERNAL THERMOMETER**; Temperature Process:** Cold-Holding
Location: FRIDGE INTERIOR at 50 Degrees F.
Comment:
Violation Issued?: No

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

Sanitizer Observations/Recordings

Establishment Info

HEART GROUP HOME
Columbia Heights
County/Group: Anoka County

Inspection Info

Report Number: F1029261023
Inspection Type: Full
Date: 1/26/2026
Time: 11:31:10 AM

Sanitizing Chemical: Product: QUATERNARY AMMONIUM**; Sanitizing Process:** Spray Bottle
Location: Greater Than 400 PPM
Comment:
Violation Issued?: Yes

Sanitizing Chemical: Product: Chlorine**; Sanitizing Process:** SANITIZING SINK
Location: Equal To 100 PPM
Comment:
Violation Issued?: No

Sanitizing Chemical: Product: QUATERNARY AMMONIUM**; Sanitizing Process:** Spray Bottle
Location: Less Than 400 PPM
Comment:
Violation Issued?: No

Minnesota (MDH) Version
EH Manager; RPT: F1029261023

Food Establishment Inspection Report

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

No. of Risk Factor/Intervention/Violations	4	Date: 1/26/2026
No. of Repeat Risk Factor/Intervention/Violations		Time: 11:31:10 AM
Score (optional)		Dur: min

Establishment:	Address:	City/State:	Zip:	Phone:
HEART GROUP HOME	4643 7th Street NE	Columbia Heights, MN	55421	
License/Permit #:	**Permit Holder:**	**Purpose of Inspection:**	**Est. Type:**	**Risk Category:**
HFID 35608		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Designated compliance status (IN, OUT, N/O, N/A) for each numbered item

IN=in compliance **OUT**=not in compliance **N/O**=not observed **N/A**=not applicable

Mark "X" in appropriate box for COS and/or R

COS=corrected on-site during inspection **R**=repeat violation

	Compliance Status		COS	R
	Supervision			
1	IN	Person in charge present, demonstrate knowledge and performs duties		
2	IN	Certified Food Protection Manager		
	Employee Health			
3	IN	knowledge, responsibiities, and reporting		
4	IN	Proper use of restriction and exclusion		
5	IN	Response to vomiting, diarrheal events		
	Good Hygienic Practices			
6	N/O	Proper eating, tasting, drinking, tobacco use		
7	IN	No discharge from eyes, nose, and mouth		
	Preventing Contamination by Hands			
8	N/O	Hands clean and properly washed		
9	N/O	No bare hand contact with RTE foods, alternatives		
10	OUT	Adequate handwashing sinks supplied and access		
	Approved Source			
11	IN	Food obtained from approved source		
12	N/O	Food Received at proper temperature		
13	OUT	Food in good condition, safe & unadulterated		
14	N/A	Records available: shellstock tags, parasite dest.		
	Protection From Contamination			
15	IN	Food separated and protected		
16	OUT	Food-contact surfaces; cleaned & sanitized		
17	IN	Proper Disposition of returned, previously served, reconditioned,& unsafe food		

	Compliance Status		COS	R
	Time/Temperature Control for Safety			
18	N/O	Proper cooking time & temperatures		
19	N/O	Proper reheating procedures for hot holding		
20	N/O	Proper cooling time and temperature		
21	N/A	Proper hot holding temperatures		
22	OUT	Proper cold holding temperatures		
23	IN	Proper date marking & disposition		
24	N/A	Time as public health control;procedures & record		
	Consumer Advisory			
25	N/A	Consumer advisory provided for raw or undercooked foods		
	Highly Susceptible Populations			
26	IN	Pasteurized foods used; prohibited foods not offered		
	Food/Color Additives and Toxic Substances			
27	N/A	Food additives; approved & properly used		
28	OUT	Toxic substances properly identified;stored;used		
	Conformance with Approved Procedures			
29	N/A	Compliance with variance, specialized processes & HACCP plan		

Risk factors are improper practices or procedures identified as the most prevalent contributing factors of foodborne illness or injury. Public Health Interventions are control measures to prevent foodborne illness or injury

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" or OUT in box if numbered item is **not** in compliance Mark "X" in appropriate box for COS and/or R **COS**=corrected on-site during inspection **R**=repeat violation

			COS	R
		Safe Food and Water		
30	N/A	Pasteurized eggs used where required		
31		Water & ice from approved source		
32	N/A	Variance obtained for specialized processing methods		
		Food Temperature Control		
33		Proper cooling methods used; adequate equipment for temperature control		
34	N/A	Plant food properly cooked for hot holding		
35	N/O	Approved thawing methods used		
36	X	Thermometers provided & accurate		
		Food Identification		
37	X	Food properly labeled; original container		
		Prevention of Food Contamination		
38		Insects, rodents, & animals not present; no unauthorized person		
39	X	Contamination prevented during food prep, storage, & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
		Proper Use of Utensils		
43		In-use utensils; Properly stored		
44		Utensils, equipment & linens; properly stored, dried, handled		
45		Single-use & single-service articles, properly stored and used		
46		Gloves used properly		
		Utensils, Equipment and Vending		
47	X	Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48	X	Warewashing facilities: installed, maintained, used; test strips		
49		Non-food contact surfaces clean		
		Physical Facilities		
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53	X	Toilet facilities; properly constructed, supplied & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55	X	Physical facilities installed, maintained & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing and plan review		

Person in Charge (signature)

Inspector (signature) Trevor McClime

Follow-up: Follow-up Date:

Physical Environment Inspection Report

ASSISTED LIVING | ASSISTED LIVING WITH DEMENTIA CARE

Project No: SL35608016-0	**Date:** 1/29/2026
Facility Name: Heart Group Home	
Facility Address: 4643 7th St NE Columbia Heights	

☒ **TAG IDENTIFICATION: 0775**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Seven (7) days

1. Each assisted living facility must comply with the provisions of the Minnesota State Fire Code (MSFC) in Minnesota Rules chapter 7511. [Minn. Stat. 144G.45 subd. 2]

2. The means of egress shall be maintained free of obstructions or impediments to full instant use in case of fire or other emergency. [Minn. Stat. 144G.45 subd. 2; MSFC 1031.2]

   Comments: The door to the deck was identified as an emergency exit. The deck was obstructed by snow, and there was no clear path to the public way being maintained.

3. Lighted matches, cigarettes, cigars or other burning objects shall not be discarded in such a manner that could cause ignition of other combustible material. [Minn. Stat. 144G.45 subd. 2; MSFC 310.7]

   Comments: Cigarette butt receptacle was filled with paper trash.

☒ **TAG IDENTIFICATION: 0800**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Twenty One (21) days

1. The physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment are in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. [Minn. Stat. 144G.45 subd.2]

   Comments: The light in resident room 4 was not secured, and wiring was exposed.

   The main level shower had caulking at the shower that was degraded, peeling and missing around the base.

The lower-level bathroom toilet and shower were missing caulking.

The lower-level bathroom fan did not work when tested.

The lower-level bathroom walls had water damage and were degraded.

The lower-level bathroom door hinges were loose and not secured to the door frame

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☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Twenty One (21) days

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1. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that include the location and number of resident rooms. [Minn. Stat. 144G.45 subd.2]

   Comments: The posted evacuation plans did not include the egress routes from each space to the designated exits.

   The posted evacuation plans were not included in the licensee's FSEP.

2. Each assisted living facility shall develop and maintain fire safety and evacuation plans that include fire protection procedures necessary for residents. [Minn. Stat. 144G.45 subd.2]

   Comments: No resident policy was provided by the licensee when requested.