Electronically Delivered

November 12, 2025

Licensee
Fortunate Homes LLC
6124 Lee Avenue North
Brooklyn Center, MN 55429

RE: Project Number(s) SL38524016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on October 23, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

STATE CORRECTION ORDERS

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

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,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: Jess.Schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

KKM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38524	A. BUILDING: _____ B. WING _____	10/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FORTUNATE HOMES LLC	6124 LEE AVENUE NORTH BROOKLYN CENTER, MN 55429

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(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: SL38524016-0 On October 20, 2025, through October 23, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there was one resident; one resident 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.	
0 430 SS=C	144G.40 Subd. 2 Uniform checklist disclosure of services	0 430		

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0 430	Continued From page 1 (a) All assisted living facilities must provide to prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a). This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure each staff person providing assisted living services had cardio-pulmonary resuscitation (CPR) training as stated on the licensee's Uniform Disclosure of Assisted Living Services and Amenities (UDALSA). This had the potential to affect all residents. This practice resulted in a level one violation (a violation that will cause only 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	0 430		

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0 430	Continued From page 2 a large portion or all of the residents). The findings include: R1 admitted for assisted living services on July 12, 2023, and had diagnoses including substance abuse (alcoholism), Crohn's disease (inflammatory bowel disease), depressive disorder, and anti-social personality (pattern of disregarding and violating the rights of others by manipulation and exploitation with little to no remorse). R1's signed UDALSA dated July 12, 2023, noted the facility (house) number was 6401, but the correct number was 6124. Under "Treatments & Therapies Available," it indicated the licensee provided training of and use of CPR by marking an "X" as available. The licensee's website under "Meet Our Staff," indicated each care provider must follow a stringent hiring process including first aid and CPR certifications. During observation from October 20, through October 21, 2025, unlicensed personnel (ULP)-B was providing supervision, medication administration, and meals to R1 at various times. R1's Resident Profile with an as of date June 23, 2025, indicated R1's code status was CPR, meaning provide life saving measures. ULP-B's employee record lacked evidence ULP-B was CPR certified. During interview on October 21, 2025, at 12:55 p.m., licensed assisted living director (LALD)-D,	0 430		

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0 430	Continued From page 3 stated not all staff were CPR certified, except for licensed nursing staff. They would eventually work on getting everyone CPR certified, but it was not currently required. LALD-D stated the website and UDALSA was misleading and needed to update the website. The licensee's 2.13 CPR/DNR (do not resuscitate) policy dated August 1, 2021, noted the staff working would to the best of their ability, to respect the wishes of residents and follow the procedure listed below for the initiation of CPR or DNR orders for each resident, if obtained. The policy lacked a procedure. Minnesota Rule 4659.0090, subpart 1 indicates the licensee must provide the current UDALSA to prospective residents before a contract is executed to enhance understanding of policies and services that are provided and are not provided by the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 430		
0 500 SS=F	144G.41 Subd. 2 Policies and procedures Each assisted living facility must have policies and procedures in place to address the following and keep them current: (1) requirements in section 626.557, reporting of maltreatment of vulnerable adults; (2) conducting and handling background studies on employees; (3) orientation, training, and competency evaluations of staff, and a process for evaluating staff performance;	0 500		

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0 500	Continued From page 4 (4) handling complaints regarding staff or services provided by staff; (5) conducting initial evaluations of residents' needs and the providers' ability to provide those services; (6) conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; (7) orientation to and implementation of the assisted living bill of rights; (8) infection control practices; (9) reminders for medications, treatments, or exercises, if provided; (10) conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; (11) ensuring that nurses and licensed health professionals have current and valid licenses to practice; (12) medication and treatment management; (13) delegation of tasks by registered nurses or licensed health professionals; (14) supervision of registered nurses and licensed health professionals; and (15) supervision of unlicensed personnel performing delegated tasks. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to implement current policies and procedures for one of one resident (R1) as required for reporting incidents.	0 500		

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0 500	Continued From page 5 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). The findings include: On October 20, 2025, at 10:31 a.m., during the entrance conference, licensed assisted living director (LALD)-D stated R1 had fallen while out in the community in July, which required hospitalization. At the end of the conference, the surveyor requested the incident report regarding the fall/hospitalization. Incident #1 R1's resident note dated July 2, 2025, at 10:05 p.m., written by registered nurse (RN)-A, indicated R1 returned to facility escorted by police, appeared very intoxicated and refused to enter the facility, began pacing within the garage then went to sit down, fell and hit his head. Staff contacted the paramedics and R1 was sent to the hospital. R1's resident note dated July 3, 2025, at 6:25 p.m., written by RN-A, indicated R1 returned from the emergency department with a visible bruise to the head. Incident #2 R1's resident note dated August 22, 2025, at 4:30 p.m., written by RN-A, indicated staff reported R1	0 500		

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0 500	Continued From page 6 returned to facility with a skin tear to his forehead with dried blood and small amount of blood on his shirt. R1 appeared heavily intoxicated and refused to be assessed by the paramedics. The note also indicated an incident report was done by the staff. Incident #3 R1's resident note dated August 31, 2025, at 8:28 p.m., written by RN-A, indicated staff notified writer R1 was being discharged from the emergency room following a fall in the community. A computerized tomography scan (CT scan) and x-ray were completed and ruled out additional injuries. The note also indicated R1 was reported intoxicated and sustained a head laceration (tear in skin) requiring staples. A follow-up appointment was scheduled for staple removal. Incident #4 R1's resident note dated September 8, 2025, at 12:27 p.m., written by RN-C, indicated RN-C conducted a post-discharge visit with R1 following his release from the hospital. R1 had reported he had gone to the hospital involved emergency room observation for alcohol intoxication. The staples were removed at that time. Incident #5 R1's resident note dated September 15, 2025, at 9:42 p.m., written by RN-A, indicated staff notified writer that R1 was gone for a couple of hours and the hospital emergency room staff notified staff R1 left the hospital AMA [against medical advice]. RN-A contacted the hospital where they confirmed R1 was brought in for alcohol intoxication and disorderly conduct but left AMA.	0 500		

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0 500	Continued From page 7 No injuries noted. Incident #6 R1's resident note dated September 25, 2025, at 11:33 p.m., written by RN-A, indicated RN-A was notified by staff R1 had been missing from the facility since 8:30 p.m. Staff informed RN-A that R1 had left the facility intoxicated and did not sign out. RN-A advised staff to follow the facility's missing person protocol, including contacting 911 and notify the writer if R1 returned. A police report was filed and an incident report was done. R1's resident note dated September 26, 2025, at 3:10 a.m., written by RN-A, indicated R1 returned to the facility around 2:45 a.m., and police were notified of his return. Safety checks were completed and incident report per protocol. On October 22, 2025, at 3:59 p.m., by email addressed to director/administrator (D/A)-E, the surveyor requested incident reports for the recent hospitalizations and falls as they were not received when requested. At 7:20 p.m., D/A-E provided two incident reports dated July 2, 2025, and August 30, 2025. R1's Incident Report dated July 2, 2025, at 7:06 p.m., recorded by unlicensed personnel (ULP)-E, noted R1 fell outside in the presence of staff heavily intoxicated. Staff called 911 and went to the hospital. The report indicated R1's medical provider was notified along with the facility nurse (RN-A). RN-A documented interventions to help prevent future falls and indicated a MAARC (Minnesota Adult Abuse Reporting Center) report was filed. R1's Incident Report was opened on August 30,	0 500		

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0 500	Continued From page 8 2025, at 5:44 p.m. and recorded by ULP-B on September 1, 2025, at 2:55 p.m., noted R1 "went to the store and got drunk," and it happened outside of the facility. The incident report did not indicate if a fall occurred but noted bruises which were unclear where they were located on R1's body. The incident report did not have further documentation made by an RN, as the status of the report was "open." The incident report lacked documentation that notifications were made. Incident reports for incidents #3, 4, 5, and 6 were not provided to the surveyor to review. During phone interview on October 22, 2025, at 10:11 a.m., county case manager (CM)-G explained she was physically at the facility in April 2025, to complete an annual assessment with R1. CM made contact via email with the licensee on July 22, 2025, requesting an unrelated form, but CM-G explained she had not heard from anyone regarding the incidents nor received the incident reports as required. On October 22, 2025, at 1:56 p.m. and 3:35 p.m., a voicemail was left on RN-A's number both times. On October 23, 2025, at 8:44 a.m., the surveyor made another attempt to contact RN-A. The surveyor did not receive a return call for an interview. On October 23, 2025, at 8:45 a.m., RN-C explained she was not involved in R1's incident reports and RN-A would be the best person to ask questions about the process. The licensee failed to notify the county case	0 500		

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0 500	Continued From page 9 manager of each incident as required. The licensee's 2.25 Incident Report policy dated September 1, 2023, indicated the licensee was committed to maintaining a safe and supportive environment. All staff must immediately report and document any incident, accident, injury, error, or unusual occurrence that may affect health, safety, or rights of residents. An incident may include but not limited to: resident fall or injury, unexpected illness or hospitalization, missing resident or elopement, and behavioral incident or altercation. The policy indicated staff involved must complete the incident report form within 2 hours of the event or discovery and the resident's legal representative and case manager are notified within 24 hours of the incident. The licensee's 2.28 Missing Resident-Fort 4 policy revised September 24, 2025, indicated the procedure was to update the resident's emergency contacts and case manager. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 500		
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 and interview, the licensee failed to comply with Minnesota State Fire Code	0 775		

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0 775	Continued From page 10 in Minnesota Rules chapter 7511. This deficient condition had the ability to affect all staff and residents. 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: On October 21, 2025, the surveyor toured the facility with director/administrator (D/A)-E. The following was observed. Inside of the attached garage the surveyor observed cigarette butts and ashes inside of a plastic coffee can. D/A-E stated that they were not aware that smoking was happening inside of the garage. Smoking shall be done safely, and cigarettes discarded into approved non-combustible ash trays placed on a sturdy surface. Lighted matches, cigarettes, cigars or other burning object shall not be discarded in such a manner that could cause ignition of other combustible material. TIME PERIOD FOR CORRECTION: Two (2) days	0 775		
0 790 SS=F	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment	0 790		

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0 790	Continued From page 11 (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 the portable fire extinguishers. 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 the potential to affect a large portion or all of the residents). The findings include: On October 21, 2025, the surveyor toured the facility with director/administrator (D/A)-E. The portable fire extinguishers throughout the facility lacked records to show the required annual certification was completed. The fire	0 790		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38524	A. BUILDING: _____ B. WING _____	10/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FORTUNATE HOMES LLC	6124 LEE AVENUE NORTH BROOKLYN CENTER, MN 55429

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0 790	Continued From page 12 extinguishers had service tag indicating that they were last serviced August of 2024. The fire extinguishers were also mounted approximately 5'6" above the finished floor. D/A-E stated that they had a company scheduled to service the fire extinguishers this month. Documentation is required to demonstrate fire extinguishers have been annually replaced with a new extinguisher or serviced annually by a certified technician. Portable fire extinguishers shall be permanently mounted in a conspicuous location at least four inches off the floor and no higher than five feet above the floor to the top of the extinguisher. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
01760 SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01760	Continued From page 13 by: Based on observation, interview, and record review, the licensee failed to document as needed (PRN) medication administration for one of one resident (R1) receiving medication management services. 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). The findings include: During entrance conference on October 20, 2025, at 10:31 a.m., registered nurse (RN)-A explained unlicensed personnel (ULP) notified the RN if a PRN was requested. RN-A also explained R1's medications were delivered via mail from R1's pharmacy. R1 had diagnoses including substance abuse (alcoholism), Crohn's disease (inflammatory bowel disease), depressive disorder, and anti-social personality (pattern of disregarding and violating the rights of others by manipulation and exploitation with little to no remorse). R1's Service Plan-Modification signed June 1, 2025, indicated R1 received medication administration three times daily and various behavior management up to three times per day. R1's Assessment dated September 26, 2025,	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01760	Continued From page 14 indicated under section "Medication Management;" noted any PRN medications would be ordered when low, and the RN would complete weekly medication setups and review all ULP charting related to medications daily. The assessment also indicated the ULP would follow through with documentation after each medication pass per licensee policy. During observation on October 20, 2025, at 1:17 p.m., ULP-B set up R1's gabapentin 400 milligram (mg) capsule, one capsule three times daily for anxiety and administered it to R1. ULP-B then documented the administration on R1's electronic medication administration record (EMAR). R1's provider orders signed June 18, 2025, ordered hydroxyzine 25 mg tablet, one tablet by mouth every 6 hours (up to 4 tablets in 24 hours) PRN for anxiety (last filled on June 3, 2025). During medication cart review on October 21, 2025, at 9:45 a.m., ULP-B opened R1's drawer and the surveyor noted an empty pharmacy bottle of hydroxyzine 25 mg, one tablet by mouth every six (6) hours as needed (PRN) for anxiety. The pharmacy label indicated 90 tablets of hydroxyzine were dispensed on August 29, 2025. At 9:57 a.m., the surveyor showed RN-A and RN-C the empty bottle of hydroxyzine. RN-A stated she was notified a week before last Friday that the hydroxyzine was running low, so she contacted R1's provider and requested a refill. RN-A stated R1's medication often required a new order from the provider and mail delivery took approximately three days so that was the reason it was not available yet.	01760		

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01760	Continued From page 15 R1's EMAR dated September 1-30, 2025, indicated R1 received 11 tablets of PRN hydroxyzine 25 mg. R1's EMAR dated October 1-19, 2025, indicated R1 received 5 tablets of PRN hydroxyzine 25 mg. R1's September and October EMARs documented a total of 16 doses where the remaining 74 tablets were not documented. On October 21, 2025, at 12:00 p.m., RN-A and licensed assisted living director (LALD)-D stated they did not have additional documentation available to account for the missing documentation. LALD-D stated they would need to provide re-training. The licensee's 7.27 PRN Medication policy dated August 1, 2021, read the licensee would document on the medication record or in the PRN medication notes sheet: -when the PRN medication was given -why the PRN medication was given -any unusual reactions or symptoms following the administration of the medication -follow up communication with resident and -report any reactions or side effects to the nurse. Communicate to the nurse that a PRN medication was given. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		

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

FORTUNATE HOMES LLC
6124 LEE AVENUE NORTH
Brooklyn Center, MN 55429
Hennepin County
Parcel:

Phone:

License Info

License: HFID 8524

Risk:
License:
Expires on:
CFPM: NELSON KANYI WANJU
CFPM #: 60020; Exp: 7/20/2028

Inspection Info

Report Number: F8058251131
Inspection Type: Full - Single
Date: 10/21/2025 Time: 2:47:18 PM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

No orders were issued for this inspection report.

Food & Beverage General Comment

RESIDENTIAL HOME WITH NON COMMERCIAL APPLIANCES AND FINISHES

HAM 41 COOLER
MELON 41 COOLER

160 DISH TEMP

HRD INSPECTOR ANNA BOHNEN

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 F8058251131 from 10/21/2025

NELSON KANYI WANJU
PIC

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