Electronically Delivered

May 4, 2023

Licensee
Healthguard Living
3126 98th Avenue North
Brooklyn Park, MN 55443

RE: Project Number(s) SL38349015

Dear Licensee:

This is your **official notice** that you have been **granted your assisted living facility license.** Your license effective and expiration dates remain the same as on your provisional license. Your updated status will be listed on the license certificate at renewal and **this letter serves as proof** in the meantime. If you have not received a letter from us with information regarding renewing your license within 60 days prior to your expiration date, please contact us at (651) 201-5273, or by email at Health.assistedliving@state.mn.us.

The Minnesota Department of Health completed an initial survey on April 14, 2023, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

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

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

In accordance with Minn. Stat. § 144G.31, Subd. 4, MDH may assess fines and enforcement actions based on the level and scope of the violations; however, no immediate fines are assessed for this survey of your facility.

DOCUMENTATION OF ACTION TO COMPLY
Per 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 residents/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 issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the Department of Health within 15 calendar days of the correction order receipt date.

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

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

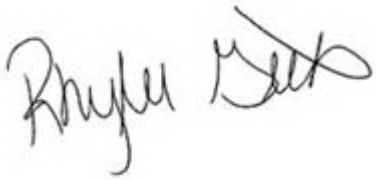
Please address your cover letter for reconsideration requests to:

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

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and/or state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,



Rhylee Gilb, Supervisor
State Rapid Response Team
Email: rhylee.gilb@state.mn.us
Telephone: 218-232-8285 Fax: 651-215-6894

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38349	A. BUILDING: _____ B. WING _____	04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTHGUARD LIVING	3126 98TH AVENUE NORTH BROOKLYN PARK, MN 55443

(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 In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #SL38349015 On April 11, 2023 through April 13, 2023, the Minnesota Department of Health conducted a provisional survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 3 residents receiving services under the provider's Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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.	
0 450 SS=C	144G.41 Subdivision 1 Minimum requirements All assisted living facilities shall:	0 450		

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0 450	Continued From page 1 (1) distribute to residents the assisted living bill of rights; (2) provide services in a manner that complies with the Nurse Practice Act in sections 148.171 to 148.285; (3) utilize a person-centered planning and service delivery process; (4) have and maintain a system for delegation of health care activities to unlicensed personnel by a registered nurse, including supervision and evaluation of the delegated activities as required by the Nurse Practice Act in sections 148.171 to 148.285; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide the Assisted Living Bill of Rights to two of two residents (R1, R2) with records reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). Findings include: R1 admitted to the licensee November 1, 2022. R1's diagnoses included diabetes mellitus and hypertension. R1's service plan dated April 11, 2023, indicated R1 received services including medication administration, and behavior management. R1's record indicated R1 signed but did not date	0 450		

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0 450	Continued From page 2 a copy of the Home Care Bill of Rights. R1's record lacked a signed copy or receipt of acknowledgement of the Assisted Living Bill of Rights. R2 admitted to the licensee October 11, 2022. R2's diagnoses included anxiety and depression. R2's signed service agreement dated October 12, 2022, indicated R2 received services including assistance with managing behaviors. R2's record indicated R2 signed but did not date a copy of the Home Care Bill of Rights. R2's record lacked a signed copy or receipt of acknowledgement of the Assisted Living Bill of Rights. During an interview on April 12, 2023 at 9:28 a.m., licensed assisted living director (LALD)-A stated the licensee did not use the Assisted Living Bill of Rights. The licensee-provided policy titled Bill of Rights, dated August 1, 2022, indicated the licensee would provide each resident with the Assisted Living Bill of Rights. TIME PERIOD FOR CORRECTION: Twenty-One (21) Days	0 450		
0 460 SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and	0 460		

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0 460	Continued From page 3 decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a means for residents to request assistance from staff at any time. This affected all 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) 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). Findings include: R1's diagnoses included diabetes mellitus and hypertension. R1's service plan dated April 11, 2023, included assistance with medication administration.	0 460		

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0 460	Continued From page 4 R2's diagnoses included a pacemaker/defibrillator and depression. R2's service plan dated October 12, 2022, included assistance with medication administration. During the entrance conference on April 11, 2023 at 9:53 a.m., licensed assisted living director (LALD)-A stated the licensee did not have a system in place for residents to summon staff at any time. The licensee-provided policy titled 24-Hour Emergency Response, dated August 1, 2022, indicated residents had access to 24-hour emergency response by staff, and residents were to press the button on the emergency response button or pull an emergency response cord to activate the response system which would notify a designated staff person. TIME PERIOD FOR CORRECTION: Seven (7) Days	0 460		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster	0 470		

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0 470	Continued From page 5 situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a staffing plan with all required content. This had the potential to affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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). Findings include: R1's diagnoses included diabetes mellitus and hypertension. R1's service plan dated April 11, 2023, included assistance with medication administration. R2's diagnoses included a pacemaker/defibrillator	0 470		

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0 470	Continued From page 6 and depression. R2's service plan dated October 12, 2022, included assistance with medication administration. During an interview on April 12, 2023 at 2:08 p.m., licensed assisted living director (LALD)-A stated the licensee did not have a staffing plan. It was an oversight and planned to reach out to their consultant to get one created. The licensee-provided policy titled Staffing & Scheduling, dated August 1, 2022, indicated the licensee would develop and implement a written staffing plan that provided an adequate number of qualified direct care staff to meet the residents' needs. TIME PERIOD FOR CORRECTION: Twenty-One (21) Days	0 470		
0 490 SS=F	144G.41 Subd 1 (13) (ii)-(vii) Minimum requirements (iv) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for providing this assistance; (v) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance; (vi) provide culturally sensitive programs; and (vii) have a daily program of social and	0 490		

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0 490	Continued From page 7 recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a daily activity program including all required content. This affected all 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 potential to affect a large portion or all of the residents). The findings include: R1's diagnoses included diabetes mellitus and hypertension. R1's service plan dated April 11, 2023, included assistance with medication administration. R2's diagnoses included a pacemaker/defibrillator and depression. R2's service plan dated October 12, 2022, included assistance with medication administration. During an interview on April 12, 2023 at 9:28 a.m., licensed assisted living director (LALD)-A stated the licensee did not have a daily activity program. LALD-A stated the resident's have antisocial diagnoses and the staff tailor to that.	0 490		

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0 490	Continued From page 8 The licensee-provided policy titled Activity Programming, dated August 1, 2022, indicated the licensee would create a monthly activity calendar and make it available to residents. TIME PERIOD FOR CORRECTION: Twenty-One (21) Days	0 490		
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation and record review, the licensee failed to follow manufacturer infection control guidelines during insulin administration for one of one residents (R1) with record review. 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	0 510		

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0 510	Continued From page 9 of staff are involved, or the situation has occurred only occasionally). Findings include: R1 admitted to the licensee November 1, 2022. R1's diagnoses included diabetes mellitus and hypertension. R1's service plan dated April 11, 2023, indicated R1 received services including medication administration, and behavior management. R1's nursing assessment dated January 30, 2023 indicated R1 could correctly administer subcutaneous injections with trained unlicensed personnel (ULP) supervision. R1's medication orders dated April 3, 2023, indicated R1 received Novolog Flexpen 100 units/milliliters (mL) six units subcutaneously (subQ) three times a day before meals. During an observation on April 12, 2023 at 9:16 a.m., R1 set up and administered his Novolog. R1 failed to cleanse the Novolog insulin pen with an alcohol swab prior to attaching the needle. R1 also failed to cleanse the injection site with an alcohol swab prior to administering the medication. A review of the Novolog website www.novologopro.com Novolog Flexpen instructional video indicated an alcohol swab should have been used to wipe the Flexpen's rubber stopper prior to attaching a needle and to cleanse the injection site with an alcohol swab. The licensee-provided policy titled Insulin, dated August 1, 2022 failed to address this requirement.	0 510		

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0 510	Continued From page 10 TIME PERIOD FOR CORRECTION: Seven (7) Days	0 510		
0 550 SS=C	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation and record review, the licensee failed to post information about the licensee's grievance procedure including all required content in a conspicuous place. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 550		

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0 550	Continued From page 11 The findings include: During an observation April 12, 2023 at 9:20 a.m., the licensee had a grievance procedure posted within the nursing office on a wall not observable when standing outside the office door. The licensee resident handbook included information about the grievance process. The licensee-provided policy titled Complaint / Grievance Posting dated August 1, 2022, indicated the licensee would post the required information in a conspicuous place. TIME PERIOD FOR CORRECTION: Twenty-One (21) Days	0 550		
0 640 SS=C	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and record review, the	0 640		

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0 640	Continued From page 12 licensee failed to post 911 information by a facility telephone. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During an observation on April 11, 2023 at 10:38 a.m., the landline phone in the living room lacked a posting of the 911 emergency number nearby. The licensee-provided policy titled Vulnerable Adult Maltreatment - Prevention & Reporting dated August 1, 2022, indicated the licensee would post the 911 emergency number in common areas and near telephones provided by the licensee. TIME PERIOD FOR CORRECTION: Twenty-One (21) Days	0 640		
0 650 SS=E	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure,	0 650		

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	38349	A. BUILDING: _____ B. WING _____	04/14/2023

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0 650	Continued From page 13 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 retain documentation of dementia training for one of two employees (RN-B) within the employee record. Additionally, the licensee failed to retain documentation of a 30-day supervision with one of one employees (ULP-C) within the employee record. 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 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). Findings include:	0 650		

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0 650	Continued From page 14 DEMENTIA TRAINING Registered nurse (RN)-B started working at the licensee August 1, 2022. RN-B's employee record lacked evidence of completed dementia training. During an interview on April 12, 2023 at 9:46 a.m., RN-B stated he completed the dementia training upon hire and thought documentation would have been in his employee record. The licensee-provided policy titled Employee Records, dated August 1, 2022, indicated records of training would be kept in the employee record. SUPERVISORY VISIT ULP-C started working at the licensee October 1, 2022. ULP-C's personnel record lacked a 30-day supervisory visit completed by a RN as required in Minnesota Statute 144G.62 Subd. 5. During an interview on April 12, 2023 at 9:46 a.m., RN-B stated he completed a 30-day supervision with ULP-C but did not know if he had the form. The licensee-provided policy titled Supervision of Staff - Delegated Services, dated August 1, 2022, indicated documentation of supervision activities would be retained in the employee's record. TIME PERIOD FOR CORRECTION: Twenty-One (21) Days	0 650		

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0 660	Continued From page 15	0 660		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure documented tuberculosis (TB) screenings were completed for two of two employees (RN-B, ULP-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings included: Registered nurse (RN)-B started working at the licensee August 1, 2022.	0 660		

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0 660	Continued From page 16 The licensee lacked a completed TB screening for RN-B. Unlicensed personnel (ULP)-C started working at the licensee October 11, 2022. The licensee lacked a completed TB screening for ULP-C. During the entrance conference on April 11, 2023 at 9:53 a.m., licensed assisted living director (LALD)-A stated the licensee did not complete a TB screening form and instead just verbally asked questions such as whether they had the Bacille Calmette-Guérin (BCG) vaccine, before sending the employees for a TB test. The licensee-provided policy titled Tuberculosis Screening, dated August 1, 2022, indicated staff would be screened for tuberculosis prior to the staff being exposed to residents. TIME PERIOD FOR CORRECTION: Twenty-One (21) Days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently;	0 680		

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0 680	Continued From page 17 (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop and implement a disaster planning and emergency preparedness plan including all required content. 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) 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). Findings include: During an observation on April 11, 2023 at 10:37 a.m., the licensee failed to post an emergency plan prominently.	0 680		

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0 680	Continued From page 18 During an interview on April 12, 2023 at 1:10 p.m., licensed assisted living director (LALD)-A stated the licensee has not yet completely integrated itself yet, but they have reached out to the local fire department and city hall. The licensee emergency preparedness plan failed to include: -a process for cooperation and collaboration with local, tribal, regional, State and Federal emergency programs -development of arrangements with other facilities/providers to receive residents in the event of limitations/cessation of operations to maintain the continuity of services to residents -a policy and procedure for at minimum food, water, pharmaceutical supplies, as well as sewage and waste disposal The licensee-provided policy titled Emergency Preparedness Plan-Appendix Z Compliance, dated August 1, 2022, indicated the licensee's emergency preparedness plan would include all required elements of appendix Z. Additionally, this policy indicated the licensee would conduct at least two emergency preparedness drills every twelve months. TIME PERIOD FOR CORRECTION: Twenty-One (21) Days	0 680		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of	0 800		

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0 800	Continued From page 19 good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On a facility tour on April 13, 2023, from approximately 12:00 p.m. to 1:00 p.m. with the Licensed Assisted Living Director (LALD)-A, it was observed that the upper deck was missing a dowel in four locations in the guardrail system and nails were protruding into the openings. The missing dowels increased the size of the space between the vertical members of the guardrail system and could be a falling hazard. LALD-A visually verified these deficient findings at	0 800		

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0 800	Continued From page 20 the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation	0 810		

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0 810	Continued From page 21 drill. This MN Requirement is not met as evidenced by: Based on a record review and interview, the licensee failed to develop a fire safety and evacuation plan with the required elements, failed to provide required employee and resident training on fire safety and evacuation, and failed to conduct required evacuation drills. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A record review and interview were conducted on April 13, 2023, at approximately 1:30 p.m. with the licensed assisted living director (LALD)-A on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review of the available documentation indicated that the licensee did not have employee actions to be taken in the event of a fire or similar emergency. The facility plan indicated to use RACE acronym but was very vague and did not provide complete actions for employees to take in the event of a fire or similar emergency. During interview, LALD-A verified that the fire safety and	0 810		

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0 810	Continued From page 22 evacuation plan for the facility lacked these provisions. Record review of the available documentation indicated that the licensee did not have fire protection procedures necessary for residents included in the fire safety and evacuation plan. During interview, LALD-A verified that the fire safety and evacuation plan for the facility lacked these provisions. Record review of the available documentation indicated that the fire safety and evacuation plan did not include procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. The facility plan did include some provisions for the relocation of residents but did not specify how to move or evacuate residents or identify the unique and unusual needs of the residents. During interview, LALD-A verified that the fire safety and evacuation plan for the facility lacked these provisions. Record review of available documentation indicated that the licensee did not provide employee training on the fire safety and evacuation plan twice per year after the training at initial hire. During interview, LALD-A stated the licensee did not have any documented training of employees. Record review of the available documentation indicated that the licensee did not provide annual training to residents who can assist in their own evacuation on the proper actions to take in the event of a fire including movement, evacuation, or relocation as required by statute. During	0 810		

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0 810	Continued From page 23 interview, LALD-A stated that the facility did not have documentation on offering resident training on the fire safety and evacuation plan. Record review of the available documentation indicated that the licensee did not conduct evacuation drills twice per year per shift and every other month as required by statute. During interview, LALD-A verified that there had been no evacuation drills completed and verified this deficient condition. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 820 SS=E	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure physical facility elements did not constitute a distinct hazard to life. Licensee failed to provide fire-rated ashtrays for resident use in	0 820		

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0 820	Continued From page 24 smoking areas. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On a facility tour on April 13, 2023, from approximately 12:00 p.m. to 1:00 p.m. with the Licensed Assisted Living Director (LALD)-A, it was observed that the lower-level paver patio was being used as a smoking area. The lower-level paver patio is located under the main level wooden deck. The patio was littered with hundreds of cigarette butts, many of the cigarette ends were located along the foundation of the building where dead leaves and miscellaneous yard debris were located. There was a cut-off plastic gallon jug filled with water and additional cigarette butts being used as an ashtray. LALD-A stated that residents would smoke on the patio during the winter and used the cut-off gallon jug or snow cover to extinguish their cigarettes. Survey staff explained to the licensee that a fire-rated ashtray should be provided for resident use and that the discarded cigarette butts were a potential fire hazard if residents were not completely extinguished before discarding them next to the building wall.	0 820		

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0 820	Continued From page 25 It was also observed that the main level wooden deck was being used as a smoking area for residents. There was a cut-off plastic gallon jug filled with water and additional cigarette butts being used as an ashtray. Survey staff reiterated to the licensee that a fire-rated ashtray should be provided for resident use in all outdoor areas designated for smoking. LALD-A visually verified these deficient findings at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 820		
0 920 SS=F	144G.50 Subd. 2 (c) Contract information (c) The contract must include: (1) a disclosure of the category of assisted living facility license held by the facility and, if the facility is not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license; (2) a description of all the terms and conditions of the contract, including a description of and any limitations to the housing or assisted living services to be provided for the contracted amount; (3) a delineation of the cost and nature of any other services to be provided for an additional fee; (4) a delineation and description of any additional fees the resident may be required to pay if the resident's condition changes during the term of the contract; (5) a delineation of the grounds under which the resident may be transferred or have housing or services terminated or be subject to an emergency relocation;	0 920		

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0 920	Continued From page 26 (6) billing and payment procedures and requirements; and (7) disclosure of the facility's ability to provide specialized diets. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract contained all required content for two of two residents (R1, R2) with records reviewed. 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: R1 admitted to the licensee November 1, 2022. R1's diagnoses included diabetes mellitus and hypertension. R1's service plan dated April 11, 2023, indicated R1 received services including medication administration, and behavior management. R1's assisted living contract, signed November 1, 2022, lacked: -a disclosure the licensee did not hold an assisted living facility with dementia care license -a disclosure of the licensee's ability to provide specialized diets R2 admitted to the licensee October 11, 2022. R2's diagnoses included anxiety and depression.	0 920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38349	A. BUILDING: _____ B. WING _____	04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTHGUARD LIVING	3126 98TH AVENUE NORTH BROOKLYN PARK, MN 55443

(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
0 920	Continued From page 27 R2's signed service agreement dated October 12, 2022, indicated R2 received services including assistance with managing behaviors. R2's assisted living contract, signed October 12, 2022, lacked: -a disclosure the licensee did not hold an assisted living facility with dementia care license -a disclosure of the licensee's ability to provide specialized diets During an interview on April 12, 2023 at 2:08 p.m., licensed assisted living director (LALD)-A stated a consulting group created the licensee's assisted living contract, but LALD-A reviewed and edited the contract as needed. TIME PERIOD FOR CORRECTION: Twenty-One (21) Days	0 920		
0 930 SS=F	144G.50 Subd. 2 (d-e; 1-4) Contract information (d) The contract must include a description of the facility's complaint resolution process available to residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints. (e) The contract must include a clear and conspicuous notice of: (1) the right under section 144G.54 to appeal the termination of an assisted living contract; (2) the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer; (3) contact information for the Office of	0 930		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38349	A. BUILDING: _____ B. WING _____	04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTHGUARD LIVING	3126 98TH AVENUE NORTH BROOKLYN PARK, MN 55443

(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
0 930	Continued From page 28 Ombudsman for Long-Term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints; (4) the resident's right to obtain services from an unaffiliated service provider; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract contained all required content for two of two residents (R1, R2) with records reviewed. 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: R1 admitted to the licensee November 1, 2022. R1's diagnoses included diabetes mellitus and hypertension. R1's service plan dated April 11, 2023, indicated R1 received services including medication administration, and behavior management. R1's assisted living contract, signed November 1, 2022, lacked the right under Minnesota Statutes section 144G.54 to appeal the termination of an assisted living contract. R2 admitted to the licensee October 11, 2022. R2's diagnoses included anxiety and depression.	0 930		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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HEALTHGUARD LIVING	3126 98TH AVENUE NORTH BROOKLYN PARK, MN 55443

(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
0 930	Continued From page 29 R2's signed service agreement dated October 12, 2022, indicated R2 received services including assistance with managing behaviors. R2's assisted living contract, signed October 12, 2022, lacked the right under Minnesota Statutes section 144G.54 to appeal the termination of an assisted living contract. During an interview on April 12, 2023 at 2:08 p.m., licensed assisted living director (LALD)-A stated a consulting group created the licensee's assisted living contract, but LALD-A reviewed and edited the contract as needed. TIME PERIOD FOR CORRECTION: Twenty-One (21) Days	0 930		
0 950 SS=D	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney	0 950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38349	A. BUILDING: _____ B. WING _____	04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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0 950	Continued From page 30 ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of two residents (R1) with records reviewed designated a representative or documented a declination to designate a representative. 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). Findings include: R1 admitted to the licensee November 1, 2022. R1's diagnoses included diabetes mellitus and hypertension. R1's service plan dated April 11, 2023, indicated R1 received services including medication administration, and behavior management. R1's assisted living contract and record lacked a	0 950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38349	A. BUILDING: _____ B. WING _____	04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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0 950	Continued From page 31 documented designated representative or declination to designate a representative. During an interview on April 12, 2023, at 2:08 p.m., licensed assisted living director (LALD)-A stated a consulting group created the licensee's assisted living contract, but LALD-A reviewed and edited the contract as needed. During an interview on April 13, 2023, at 2:05 p.m., LALD-A stated R1 did not designate a representative or decline to designate a representative. The licensee-provided policy titled Designated Representative, dated August 1, 2021, indicated a signed Designated Representative form must be filled out, documenting the resident's choice in designating a representative, and the form would be kept in the resident record. TIME PERIOD FOR CORRECTION: Twenty-One (21) Days	0 950		
01760 SS=D	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	01760		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01760	Continued From page 32 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 by: Based on observation and record review, the licensee failed to ensure one of one residents (R1) completed self-administration of in accordance with manufacturer guidelines. 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). Findings include: R1 admitted to the licensee November 1, 2022. R1's diagnoses included diabetes mellitus and hypertension. R1's service plan dated April 11, 2023, indicated R1 received services including medication administration. R1's medication orders dated April 3, 2023, indicated R1 received Novolog Flexpen 100 units/milliliters (mL) six units subcutaneously (subQ) three times a day before meals. During an observation on April 12, 2023 at 9:16 a.m., unlicensed personnel (ULP)-C provided R1 with his Novolog Flexpen for self-administration. R1 asked what dose he will be taking. ULP-C responded, telling him to take six units. R1 failed to prime the needle with two units of insulin prior to dialing to six units and then administering the	01760		

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	38349	A. BUILDING: _____ B. WING _____	04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01760	Continued From page 33 medication. A review of the Novolog website www.novologopro.com Novolog Flexpen instructional video indicated the pen needle should have been primed with two units prior to dialing up the dose for administration to remove air for accurate dosing. TIME PERIOD FOR CORRECTION: Seven (7) Days	01760		
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 and record review, the licensee failed to ensure all medications bore the original prescription label and open dates for one of one residents (R1) with record review. 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).	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01890	Continued From page 34 Findings include: R1 admitted to the licensee November 1, 2022. R1's diagnoses included diabetes mellitus and hypertension. R1's service plan dated April 11, 2023, indicated R1 received services including medication administration. R1's medication orders dated April 3, 2023, indicated R1 received Novolog Flexpen 100 units/milliliters (mL) six units subcutaneously (subQ) three times a day before meals, Lantus SoloStar 100 units/mL 30 units subQ daily, and fluticasone propionate 50 micrograms (mcg)/actuation (act) suspension one spray by nasal route daily as needed in each nostril. During an observation on April 12, 2023 at 9:05 a.m., R1's fluticasone nasal spray, Novolog insulin pen, and Lantus insulin pen lacked prescription labels. Additionally, these three medications lacked open dates. The licensee provided policy titled Medications - Prescription Drugs & Prohibitions dated August 1, 2021, indicated the prescription drug must bear the original prescription label. TIME PERIOD FOR CORRECTION: Seven (7) Days	01890		

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

Type: Full
Date: *04/11/23*
Time: 12:15:00
Report: 1025231083

Food and Beverage Establishment Inspection Report

Location:
Healthguard Living
3126 98TH Avenue North
Brooklyn Park, MN55443
Hennepin County, 27

Establishment Info:
ID #: 0041185
Risk:
Announced Inspection: Yes

License Categories:

Expires on: 12/31/23

Operator:

Phone #:
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

No NEW orders were issued during this inspection.

Food and Equipment Temperatures

Process/Item: Milk
Temperature: 41 Degrees Fahrenheit - Location: Refrigerator
Violation Issued: No

Process/Item: Ambient
Temperature: 38 Degrees Fahrenheit - Location: Refrigerator
Violation Issued: No

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

Discussed employee health and hygiene, illness exclusion, food cook temperatures, food source, food recalls, cross-contamination, sink dedication and usage (e.g. dedicate one sink compartment to handwashing only), monitoring temperatures in coolers, no service or raw or undercooked animal food for highly susceptible populations, date marking TCS foods (when packages are opened or food is prepared, date mark and discard after 7 days), chemical storage, food contact surfaces (sanitizing for dishes, cutting boards, knives, handwashing sink basins, and by extension equipment handles, etc; can exclude non-food contact surfaces such as countertops from harsh chemicals if food does not contact them, maintain these surfaces clean with soap and water).

4626.0506 -- alternate equipment and finish requirements for adult care facilities which TCS foods for same-day service only (discontinue any cooling and reservice of cooked food)

Dishwasher has a sanitizing rinse option (NSF/ANSI Standard 184) – use for sanitizing utensils; provide an alternate means of sanitizing for instances where power may be out, or the dishwasher might not be working (e.g. a bus tub or container, and a bleach/water solution 50-100 PPM (~1 tsp per gallon), look for a bleach container at the store that says "Sanitizing Food Contact Surfaces" on the label to make sure it's appropriate for food and not just laundry; provide an appropriate test kit).

Food and Beverage Establishment Inspection Report

Please search
"MDH Highly Susceptible Population"
https://www.health.state.mn.us/communities/environment/food/docs/fs/highsuspopfs.pdf
"MDH TCS Foods"
https://www.health.state.mn.us/communities/environment/food/docs/fs/tcsfoodfs.pdf
"MDH Sanitizing"
https://www.health.state.mn.us/communities/environment/food/docs/fs/cleansanfs.pdf

TMD and test strip for dishwasher available

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 1025231083 of 04/11/23.

Certified Food Protection Manager: Nebiha S Mohammed

Certification Number: FM113597 Expires: 11/05/25

Signed:_____
Establishment Representative

Signed: Casey Kipping
Casey Kipping
Public Health Sanitarian II
Freeman Building St Paul
651-201-4513
casey.kipping@state.mn.us

Report #: 1025231083

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

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

No. of RF/PHI Categories Out	0
No. of Repeat RF/PHI Categories Out	0
Legal Authority MN Rules Chapter 4626	

Date 04/11/23
Time In 12:15:00
Time Out

Healthguard Living	Address: 3126 98TH Avenue North	City/State: Brooklyn Park, MN	Zip Code: 55443	Telephone
License/Permit #: 0041185	Permit Holder	Purpose of Inspection: Full	Est Type	Risk Category

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item — Mark "X" in appropriate box for COS and/or R

IN= in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

Compliance Status		COS	R
Supervision			
1	IN OUT — PIC knowledgeable; duties & oversight		
2	IN OUT N/A — Certified food protection manager, duties		
Employee Health			
3	IN OUT — Mgmt/Staff;knowledge,responsibilities&reporting		
4	IN OUT — Proper use of reporting, restriction & exclusion		
5	IN OUT — Procedures for responding to vomiting & diarrheal events		
Good Hygenic Practices			
6	IN OUT N/O — Proper eating, tasting, drinking, or tobacco use		
7	IN OUT N/O — No discharge from eyes, nose, & mouth		
Preventing Contamination by Hands			
8	IN OUT N/O — Hands clean & properly washed		
9	IN OUT N/A N/O — No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10	IN OUT — Adequate handwashing sinks supplied/accessible		
Approved Source			
11	IN OUT — Food obtained from approved source		
12	IN OUT N/A N/O — Food received at proper temperature		
13	IN OUT — Food in good condition, safe, & unadulterated		
14	IN OUT N/A N/O — Required records available; shellstock tags, parasite destruction		
Protection from Contamination			
15	IN OUT N/A N/O — Food separated and protected		
16	IN OUT N/A — Food contact surfaces: cleaned & sanitized		
17	IN OUT — Proper disposition of returned, previously served, reconditioned, & unsafe food		

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

Risk factors (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) 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" 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	IN OUT N/A — Pasteurized eggs used where required		
31	Water & ice obtained from an approved source		
32	IN OUT N/A — Variance obtained for specialized processing methods		
Food Temperature Control			
33	Proper cooling methods used; adequate equipment for temperature control		
34	IN OUT N/A N/O — Plant food properly cooked for hot holding		
35	IN OUT N/A N/O — Approved thawing methods used		
36	Thermometers provided & accurate		
Food Identification			
37	Food properly labled; original container		
Prevention of Food Contamination			
38	Insects, rodents, & animals not present		
39	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 & used		
46	Gloves used properly		
Utensil Equipment and Vending			
47	Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48	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	Toilet facilities: properly constructed, supplied, & cleaned		
54	Garbage & refuse properly disposed; facilities maintained		
55	Physical facilities installed, maintained, & clean		
56	Adequate ventilation & lighting; designated areas used		
57	Compliance with MCIAA		
58	Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) **Date:** 04/11/23

Inspector (Signature) Cory Kline