Electronically Delivered

May 29, 2025

Licensee
Restful Home LLC
1000 Reaney Avenue
Saint Paul, MN 55106

RE: Project Number(s) SL33425016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 21, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the

resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by MDH within 15 calendar days of the correction order receipt date.

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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

Renee L Anderson

Renee Anderson, Supervisor
State Evaluation Team
Email: Renee.L.Anderson@state.mn.us
Telephone: 651-201-5871 Fax: 1-866-890-9290

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33425	A. BUILDING: _____ B. WING _____	04/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RESTFUL HOME LLC	1000 REANEY AVENUE SAINT PAUL, MN 55106

(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 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: SL33425016-0 On April 7, 2025, through April 21, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 10 residents; 10 receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level pursuant to 144G.31 Subd. 1, 2 and 3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter	0 480		

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0 480	Continued From page 1 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part	0 480		

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0 480	Continued From page 2 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated April 7, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		

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0 550	Continued From page 3	0 550		
0 550 SS=F	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 interview, the licensee failed to post the required information related to the grievance procedure. This had the potential to affect all ten residents receiving assisted living 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	0 550		

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0 550	Continued From page 4 On April 7, 2025, at 10:00 a.m., the surveyor observed the common areas of the facility. The facility lacked a posting of the grievance procedure. On April 7, 2025, at 10:15 a.m., activities director (AD)-A stated they had not posted the grievance procedure. AD-A stated the clients will talk to staff about any concerns, and the concerns will be addressed at that time. AD-A stated the administrative staff did not document the concerns or interventions implemented related to the concerns. The licensee's Complaint Policy/Grievance policy, dated August 1, 2023, indicated, the complaint/grievance policy was developed to ensure complaints regarding the licensee are resolved in a timely and appropriate manner for employees or residents that have concerns or complaints. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about	0 580		

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0 580	Continued From page 5 quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to engage in and maintain documentation of quality management activity. This had the potential to affect all ten residents receiving Assisted Living 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), 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 April 7, 2025, at 10:00 a.m., during the entrance conference, activities director (AD)-A stated they were not able to provide documentation of quality management activity. The licensee's Quality Management Project policy, dated July 1, 2021, indicated the licensee "will have at least one documented quality management project in place at all times, and retain records of such projects for at least two years." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 580		

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

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0 650	Continued From page 7 was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-C was hired on April 6, 2023, to provide assisted living cares and services. On April 8, 2025, at 8:35 a.m., ULP-C was observed to assist residents with medication administration. ULP-C's employee record lacked documentation of an annual performance review that identified areas of improvement needed and any training needs. On April 8, 2025, at 9:40 a.m., clinical nurse supervisor (CNS)-B stated she was recently hired by the licensee, and would be reviewing employee records and providing training for employees, as needed. On April 14, 2025, at 11:35 a.m., administrator (A)-D stated via email that he would send the required information if located in the file. No further information was provided. The licensee's Orientation & Training policy, dated July 1, 2021, indicated the licensee, "will maintain a record of staff training and competency required." TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		

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0 660	Continued From page 8	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 establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which includes a facility TB risk assessment, and a symptom and history screening for one of two employees (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 660		

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0 660	Continued From page 9 The findings include: During the entrance conference on April 7, 2025, at 10:00 a.m., the surveyor requested to review the licensee's TB facility risk assessment. Activities director (AD)-A stated he would provide the risk assessment, if able to locate the form. The TB Facility Risk Assessment was not provided. ULP-C was hired April 6, 2023, and provided direct cares and services to residents. On April 8, 2025, at 8:35 a.m., ULP-C was observed to assist residents with medication administration. ULP-C's employee record included a negative QuantiFERON-TB Gold blood test completed on May 17, 2023. ULP-C's employee record lacked a TB history and symptom screening form completed at the time of hire. On April 7, 2025, at 12:15 p.m., ULP-C stated she completed the TB blood test at a clinic, and was unsure if the TB history and symptom screening was completed at that time. On April 7, 2025, at 10:53 a.m., the licensee's TB policy was requested, but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 775 SS=E	144G.45 Subd. 2. (a) Fire protection and physical environment	0 775		

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0 775	Continued From page 10 Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the requirements of Minnesota State Fire Code Rules, Chapter 7511. This deficient condition had the potential to affect more than a limited number of 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 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 April 8, 2025, at 1:15 p.m., the surveyor toured the facility with activities director (AD)-A. During the facility tour, the surveyor observed the following: CARBON MONOXIDE ALARMS Carbon monoxide alarms were not installed on the second floor. During the facility tour interview, AD-A verified the above listed observation. Carbon monoxide alarms are required to be installed within ten feet of all sleeping rooms in accordance with MSFC in Minnesota Rules Chapter 7511.	0 775		

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0 775	Continued From page 11 SMOKING MATERIAL DISPOSAL A container was provided outside at the back of the building for smoking material disposal. Burnt cigarettes had been disposed of on the ground in the yard. During the facility tour interview, AD-A verified the above listed observation and stated a resident with behavior issues had improperly disposed of these smoking materials. SMOKE ALARM MAINTENANCE - AD-A removed the smoke alarm from the ceiling bracket in resident sleeping room 202. The date on the back of this smoke alarm was 2006. Smoke alarms over 10 years from the date of manufacture shall be replaced. - The smoke alarm installed in resident sleeping room 204 did not work when tested by AD-A. During the tour interview, AD-A verified the above listed smoke alarm observations. OBSTRUCTED EGRESS - The egress window would not stay open in resident sleeping room 204. - The egress window slowly closed to a clear open height of 19 inches after the window was opened by AD-A in resident sleeping room 101. - Personal items in bags were stored on the floor in front of the egress window in resident sleeping room 102. - Vegetation was growing in the egress window well for resident sleeping room 001. During the tour interview, AD-A verified the above listed observations. Egress escape paths are required to be maintained clear of obstructions that prevent immediate and full use of the exit path in the event of a fire or similar emergency. ELECTRICAL HAZARDS - The space heater in resident room 205 did not have a safety certification label, indicating the	0 775		

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0 775	Continued From page 12 product complied with recognized safety standards. - An extension cord was plugged into a powerstrip to supply power in the living room office area. - An extension cord was used to supply power in resident room 105. - The chest freezer and upright refrigerator in the basement storage/mechanical room were plugged into the same powerstrip. - The cover for the wall outlet was missing behind the clothes washer and dryer. - The cover for the exterior electrical outlet was missing on the back of the building. During the tour interview, AD-A verified the above listed observations. CLOTHES DRYER MAINTENANCE There was an accumulation of lint behind the clothes dryer, creating a fire hazard. During the tour interview, AD-A verified the above-listed observation. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775		
0 780 SS=E	144G.45 Subd. 2 (a) (1) Fire protection and physical environment for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics;	0 780		

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	33425	A. BUILDING: _____ B. WING _____	04/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RESTFUL HOME LLC	1000 REANEY AVENUE SAINT PAUL, MN 55106

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0 780	Continued From page 13 (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide interconnected smoke alarms that complied with fire protection requirements. This deficient condition had the potential to affect more than a limited number of 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 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 April 8, 2025, at 1:15 p.m., the surveyor toured the facility with activities director (AD)-A. During the facility tour, the surveyor observed when smoke alarms were tested by AD-A, all of	0 780		

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0 780	Continued From page 14 the required dwelling unit smoke alarms were not actuated. The smoke alarms installed in the following locations did not test as interconnected: - resident sleeping room 104 - in the hallway outside resident sleeping rooms 103, 104, and 105 - resident sleeping room 203 During the facility tour interview, AD-A verified the above-listed observations. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 790 SS=E	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the portable fire extinguishers as required by statute. This deficient condition had the potential to affect more than a limited number of residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 790		

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0 790	Continued From page 15 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). The findings include: On April 8, 2025, at 1:15 p.m., the surveyor toured the facility with activities director (AD)-A. During the facility tour, the surveyor observed inspections were not recorded on the back of the tags attached to the portable fire extinguishers, indicating monthly inspections had not been completed. During the facility tour interview, AD-A verified the above listed observations. Fire extinguisher inspections must be documented and conducted every month to ensure each extinguisher is in its designated place, that it has not been tampered with, and there is no obvious physical damage or condition that would interfere with its use or operation. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire	0 810		

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0 810	Continued From page 16 or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content, and provide required training and drills. This had the potential to directly 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	0 810		

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0 810	Continued From page 17 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 April 8 and April 9, 2025, activities director (AD)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN A room identifier was not posted at the door for resident sleeping room 001 in the basement. Resident sleeping room numbers are required to be posted at the door and correspond with the number labels on the emergency floor plan to provide efficient communication for exiting in the event of a fire or similar emergency. Record review of the available documentation indicated the licensee had not developed and maintained the FSEP with procedures specific to the facility and the building occupants. The FSEP had been created using a template from a third party provider. The FSEP included a 9.06 fire policy dated July 1, 2023. This policy included standard employee procedures, but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The employee actions were limited to the RACE (Remove, Alarm, Confine, Extinguish/Evacuate) acronym. The FSEP inaccurately referenced smoke compartment doors, fire sprinklers, and fire doors on magnetic holders in a building that did not have any fire resistant construction or life safety systems. The FSEP failed to include specific fire protection procedures necessary for residents evident by a lack of these procedures in the plan.	0 810		

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0 810	Continued From page 18 Record review indicated the FSEP failed to provide specific procedures for resident movement and evacuation during a fire or similar emergency including individualized unique needs of residents evident by a lack of these procedures in the plan. During an interview on April 8, 2025, at 2:55 p.m., AD-A stated two residents had been identified that would require staff assistance in an emergency evacuation. Record review indicated these individualized evacuation procedures were not included with the printed copy of the FSEP. During an interview, on April 8, 2025, at 3:00 p.m., AD-A verified the FSEP required revision and site specific procedures needed to be added. TRAINING Record review of the available documentation indicated the licensee failed to provide training to employees on the FSEP at least twice per year evident by a lack of documentation to support this training had been completed. During an interview on April 8, 2025, at approximately 2:40 p.m., the surveyor requested employee FSEP training records for the last year from AD-A. During an interview on April 8, 2025, at 3:00 p.m., AD-A stated FSEP training records were not available onsite and they would email these records to the surveyor on April 9, 2025. The surveyor received an email with fire drill documentation from AD-A on April 9, 2025. No employee FSEP training records were provided. Record review indicated the licensee failed to provide fire safety and evacuation training to residents at least once per year evident by a lack of documentation to support this training had been completed. During an interview on April 8, 2025, at	0 810		

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0 810	Continued From page 19 approximately 2:40 p.m., the surveyor requested records for resident training on fire safety and evacuation completed in the last year from AD-A. During an interview on April 8, 2025, at 3:00 p.m., AD-A stated resident training records were not available onsite and they would email this information to the surveyor on April 9, 2025. The surveyor received an email with fire drill documentation from AD-A on April 9, 2025. No resident fire safety and evacuation training records were provided. DRILLS Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month evident by a review of completed fire drill logs lacking the required frequency. During an interview on April 8, 2025, at approximately 2:40 p.m., the surveyor requested employee evacuation drill records for the past year from AD-A. During an interview on April 8, 2025, at 3:00 p.m., AD-A stated fire drill records were not available onsite and they would email these records to the surveyor on April 9, 2025. The surveyor received an email with fire drill documentation from AD-A on April 9, 2025. Three fire drill reports dated June 12, 2024, September 3, 2024, and October 24, 2024, were provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01370 SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn	01370		

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01370	Continued From page 20 (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices.	01370		

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01370	Continued From page 21 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) trained and competency-tested unlicensed personnel (ULP) in all required skill areas, for one of two employees (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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-C was hired on April 6, 2023, to provide cares and services to the licensee's residents. On April 8, 2025, at 8:35 a.m., ULP-C was observed to assist residents with medication administration. ULP-C's employee training record lacked evidence ULP-C had successfully completed training and competency testing as required in the following areas: -maintenance of a clean and safe environment - appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting;	01370		

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01370	Continued From page 22 -training on the prevention of falls; -standby assistance techniques and how to perform them; -basic nutrition, meal preparation, food safety, and assistance with eating; -preparation of modified diets as ordered by a licensed health professional; -communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; and -awareness of confidentiality and privacy. On April 8, 2025, at 9:40 a.m., clinical nurse supervisor (CNS)-B stated she was recently hired by the licensee, and would be reviewing employee records and providing training for employees, as needed. CNS-B stated she would develop an employee training program to include all required training. On April 14, 2025, at 11:35 a.m., administrator (A)-D stated via email he would send the required information if located in the file. No further information was provided. The licensee's Delegation of Assisted Living Services policy, dated July 1, 2021, indicated, "a registered nurse or licensed health professional at [licensee] may delegate tasks only to staff who are competent and possess the knowledge and skills consistent with the complexity of the tasks and according to the appropriate Minnesota practice act." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		

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01380	Continued From page 23	01380		
01380 SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) trained and competency tested unlicensed personnel providing assisted living services, in all skill areas, for one of two employees (unlicensed personnel (ULP-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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).	01380		

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01380	Continued From page 24 The findings include: ULP-C was hired on April 6, 2023, to provide assisted living services to the licensee's residents. On April 8, 2025, at 8:35 a.m., ULP-C was observed to assist residents with medication administration. ULP-C's employee training record lacked evidence ULP-C had successfully completed training and competency testing as required in the following areas: -basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; -reading and recording temperature, pulse, and respirations of the resident; -recognizing physical, emotional, cognitive, and developmental needs of the resident; and -range of motioning and positioning. On April 8, 2025, at 9:40 a.m., clinical nurse supervisor (CNS)-B stated she was recently hired by the licensee, and would be reviewing employee records and providing training for employees, as needed. CNS-B stated she would develop an employee training program to include all required training. On April 14, 2025, at 11:35 a.m., administrator (A)-D stated via email that he would send the required information if located in the file. The training information was not provided. The licensee's Delegation of Assisted Living Services policy, dated July 1, 2021, indicated, "a registered nurse or licensed health professional	01380		

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01380	Continued From page 25 at [licensee] may delegate tasks only to staff who are competent and possess the knowledge and skills consistent with the complexity of the tasks and according to the appropriate Minnesota practice act." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced	01440		

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01440	Continued From page 26 by: Based on observation, interview and record review, the licensee failed to ensure a registered nurse (RN) conducted direct supervision of staff performing a delegated task within 30 days of providing a delegated service, for one of two employees (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-C was hired on April 6, 2023, to provide cares and services to the licensee's residents. On April 8, 2025, at 8:35 a.m., ULP-C was observed to assist residents with medication administration. ULP-C's employee record lacked documentation the RN completed direct supervision within 30 days of ULP-C performing a delegated task. On April 8, 2025, at 9:40 a.m., clinical nurse supervisor (CNS)-B stated she was recently hired by the licensee, and will be reviewing employee records and provide training for employees. CNS-B state she would ensure supervision of unlicensed personnel was completed. On April 14, 2025, at 11:35 a.m., administrator (A)-D stated via email he would send the required	01440		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33425	A. BUILDING: _____ B. WING _____	04/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RESTFUL HOME LLC	1000 REANEY AVENUE SAINT PAUL, MN 55106

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01440	Continued From page 27 information if located in the file. The documentation was not provided The licensee's Supervision of Staff-Delegated Services policy, dated July 1, 2021, verified the direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date the individual begins working for the licensee. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health	01470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01470	Continued From page 28 Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure all	01470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01470	Continued From page 29 employees received orientation to assisted living requirements and regulations prior to providing services to the licensee's residents for one of two employees (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-C was hired on April 6, 2023, to provide cares and services to the licensee's residents. On April 8, 2025, at 8:35 a.m., ULP-C was observed to assist residents with medication administration. ULP-C's employee record lacked evidence ULP-C completed orientation including the following required topics: - an overview of the Assisted Living statutes; - a review of provider's policies and procedures; - handling of emergencies and use of emergency services; - a review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; and - handling of residents' complaints, reporting of complaints, and where to report complaints. On April 8, 2025, at 9:40 a.m., clinical nurse supervisor (CNS)-B stated she was recently hired by the licensee, and would be reviewing	01470		

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01470	Continued From page 30 employee records and providing training for employees, as needed. On April 14, 2025, at 11:35 a.m., administrator (A)-D stated via email he would send the required information if he located it in the file. No further information was provided. The licensee's Orientation & Training policy, dated July 1, 2021, verified the above required training would be completed prior to providing assisted living services to licensee residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor	01500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01500	Continued From page 31 blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview and record	01500		

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01500	Continued From page 32 review, the licensee failed to ensure employees received at least eight hours of annual training for each 12 months of employment for one of two employees (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-C was hired on April 6, 2023, to provide cares and services to the licensee's residents. On April 8, 2025, at 8:35 a.m., ULP-C was observed to assist residents with medication administration. ULP-C's employee record lacked evidence ULP-C had successfully completed annual training as required in the following areas: -training on reporting of maltreatment of vulnerable adults under section 626.557; -review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; -review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment;	01500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01500	Continued From page 33 disinfecting environmental surfaces; and reporting communicable diseases; -effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; -review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. On April 8, 2025, at 9:40 a.m., clinical nurse supervisor (CNS)-B stated she was recently hired by the licensee, and would be reviewing employee records and providing training for employees, as needed. On April 14, 2025, at 11:35 a.m., administrator (A)-D stated via email that he would send the required information if he located it. Annual training documentation was not provided. The licensee's Annual Required Staff Training policy, dated July 1, 2021, indicated, "all staff that perform direct care services at [licensee] will complete at least eight (8) hours of annual training for each 12 months of employment." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to	01640		

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01640	Continued From page 34 (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to finalize a written service plan within 14 calendar days for one of three residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01640	Continued From page 35 The findings include: R1 began receiving assisted living services on October 30, 2022. R1's record included a Department of Human Services (DHS) Customized Living Rates Worksheet, dated December 6, 2022. The worksheet indicated R1 received services to include assistance with medication administration and insulin injections. R1 lacked a written service plan finalized no later than 14 days after the initiation of services, to document the agreement, between the licensee and R1, on services to be provided. On April 7, 2025, at 11:30 a.m., an email request was sent to administrator (A)-D to email a copy of R1's current signed Service Plan. (A)-D indicated via email, the service plan was located in the computer records, and would have activities director (AD)-A locate and provide the service plan for R1. On April 15, 2025, at 12:31 p.m., (A)-D sent R1's DHS Customized Living Rates Worksheet as the service plan for R1. The worksheet lacked the elements required to be in the licensee's service plan. The licensee's Service Plan policy, dated July 1, 2021, indicated, "a service plan means the written plan between a resident or resident's designated representative and the facility about the services that will be provided to the resident." No further information was provided.	01640		

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01640	Continued From page 36 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide documentation in the resident's record regarding the disposition of medication to include medication name, quantity and names of staff and other individuals involved in the disposition of medications for one of one discharged resident (R2) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or	01910		

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01910	Continued From page 37 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 started services on April 29, 2022, and was discharged on November 10, 2023. R2 had diagnoses to include Type 2 diabetes and Osteomyelitis, and services to include medication and behavior management. R2's record included a Resident Discharge Summary Form, dated November 11, 2023. The form indicated the licensee attached a copy of the medication list and service plan to the discharge form, and that all medications were given to the resident upon discharge. The Discharge Summary Form lacked documentation of R2's disposition of medications to include: -name of the medication, -strength, -prescription number if applicable, -quantity, and -the names of the staff and other individuals involved in the disposition. On April 7, 2025, at 1:40 p.m., activities director (AD)-A provided the discharge summary form for R2, but stated he was not able to locate the disposition of medications for R2. The licensee's Resident Record-Documentation policy, dated July 1, 2021, indicated the resident record will include a record of all medications,	01910		

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01910	Continued From page 38 services, treatments, and therapies for each resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		

Minnesota Department of Health
Food Pools & Lodging Services
P.O. Box 64974
St Paul, MN 55164-0975
651 201 4500

Type: Full
Date: *04/07/25*
Time: 14:46:19
Report: 8058251081

Food and Beverage Establishment Inspection Report

Location:
Restful Home LLC
Restful Home Restaurant
1000 Reaney Avenue
St Paul, MN55106
Ramsey County, 62

Establishment Info:
ID #: 0038988
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6513249591
ID #:

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

The following orders were issued during this inspection.

3-300B Protection from Contamination: cross-contamination, eggs

3-302.11A(1) ***** Priority 1 *****

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

OPENED RAW SAUSAGE KEPT IN DRAWER WITH TOMATOES - COS

Corrected on Site

Surface and Equipment Sanitizers

Hot Water: = --- at 160 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: NOODLE
Temperature: 40 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

Process/Item: CHEESE
Temperature: 41 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

Process/Item: TOMATO
Temperature: 40 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

Type: Full
Date: *04/07/25*
Time: 14:46:19
Report: 8058251081
Restful Home LLC

Food and Beverage Establishment Inspection Report

Process/Item: DELI MEAT
Temperature: 41 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

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

HRD INSPECTOR JOLENE BERTELSON

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 8058251081 of 04/07/25.

Certified Food Protection Manager: YER XIONG

Certification Number: 117399 Expires: 06/21/26

Inspection report reviewed with person in charge and emailed.

Signed: _____
YER XIONG
PIC

Signed: _____
Aaron Gertz
Sanitarian 3
MDH Metro Office
651 201 4500
aaron.gertz@state.mn.us