Electronically Delivered

December 21, 2022

Licensee
Home Partners, LLC
8309 Scott Avenue North
Brooklyn Park, MN 55443

RE: Project Number(s) SL38410015

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 a an initial evaluation on November 15, 2022, for the purpose of assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted iolations of the laws pursuant to Minnesota Statute, Chapter 144G.

The enclosed State Form documents the state licensing orders. The Department of Health documents state licensing 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 . . ."

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

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

§ 144G.20.

In accordance with Minn. Stat. § 144G.20, Subd. 4(a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572. Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4(a)(5)(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

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

St - 0 - 0110 - 144g.10 Subdivision 1a - Assisted Living Director License Required = $500

The total amount you are assessed is $500. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction 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 licensing 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 general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general 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

Free from Maltreatment reconsideration requests should addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

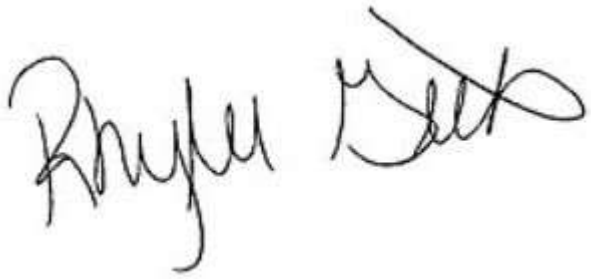
REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration or a hearing, but not both.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,



Rhylee Gilb, Supervisor
State Rapid Response Team
85 East Seventh Place, Suite 220
P.O. Box 64970
St. Paul, MN 55164-0970
Telephone: 218-232-8285 Fax: 651-281-9796

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38410	A. BUILDING: _____ B. WING _____	11/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME PARTNERS LLC	8309 SCOTT 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 Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL38410015 On November 14, 2022 through November 15, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey and investigation, there were 2 clients receiving services under the provider's Provisional 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 issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 110 SS=F	144G.10 Subdivision 1a Assisted living director license required	0 110		

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0 110	Continued From page 1 Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensed assisted living director (LALD) was listed as the Director of Record for the licensee. This had the potential to affect all the licensee's 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). The findings include: During the entrance conference on November 14, 2022, at 9:40 a.m., administrator (A)-A stated he was in the process of obtaining his LALD license and identified LALD-D as the facility's current LALD. The Board of Executives for Long-Term Services and Support (BELTSS) website was confirmed by A-A. The BELTSS website indicated LALD-D held a current assisted living director license (issued July 20, 2021, and expires October 31, 2023). The website did not list LALD-D as the Director of Record for the licensee. The licensee's policy was not provided.	0 110		

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0 110	Continued From page 2 TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
0 470 SS=C	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 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: staff posting	0 470		

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0 470	Continued From page 3 Based on observation and interview, the licensee failed to ensure the staffing plan was posted as required, potentially affecting all the licensee's current residents, staff, and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: On November 14, 2022, at 10:35 a.m., the surveyor did not observe a posted staff schedule during a tour of the facility. During an interview on November 14, 2022, at approximately 10:45 a.m., administrator and registered nurse- (RN)-B verified the licensee did not have a posted staff schedule in the facility. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA)	0 480		

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0 480	Continued From page 4 guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated November 14, 2022, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management	0 580		

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0 580	Continued From page 5 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 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 appropriate to the size and relevant to the type of services provided by the assisted living. This had the potential to affect all 2 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 the residents). The findings include: During the entrance conference on November 14, 2022, at 9:40 a.m., the surveyor asked administrator (A)-A and registered nurse (RN)-B if the licensee had a quality management plan	0 580		

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0 580	Continued From page 6 and/or any audits for the licensee's quality management activities. A-A stated he had not begun any quality management activities. The licensee's Quality Management policy was not provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 580		
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for one of one resident (R1) with records reviewed. This deficient practice also affected R2. 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	0 630		

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0 630	Continued From page 7 resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1's medical record was reviewed. R1 admitted to the assisted living facility on September 14, 2022. R1's record lacked an IAPP. On November 14, 2022, at 9:40 a.m., during the entrance conference, registered nurse (RN)-B and administrator (A)-A stated neither R1 nor the other resident (R2) had an IAPP. The required content was not documented in any other area of the record. The licensee's undated individual abuse prevention plan policy, noted a vulnerability assessment would be completed by an RN for each resident prior to or upon admission, upon significant change in condition, annually, or per state regulations for all residents TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
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	0 660		

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0 660	Continued From page 8 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 the provider established and maintained a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included completion of a TB plan, employee symptom screens, baseline TB screenings such as a blood test or a two-step tuberculin (TST) and TB education was not completed for one of one employee unlicensed personnel (ULP)-C. This had the potential to affect 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). The findings include: ULP-C's employee record was reviewed. ULP-C had a hire date of June 10, 2022. ULP-C's employee record lacked a completed Baseline TB	0 660		

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0 660	Continued From page 9 symptom Screening Tool for Health Care Workers (HCWs). ULP-C's employee record also lacked a tuberculin two step skin test or a negative QuantiFERON (IGRA-a blood test that aids in the detection of Mycobacterium tuberculosis, the bacteria that causes TB). On November 14, 2022, at 12:12 p.m., registered nurse (RN)-B and administrator (A)-A confirmed ULP-C's record and all other employees lacked the required symptom screen, and the TB test results. RN-B and A-A confirmed TB education was not completed at the time of hire for the employees. RN-B and A-A also confirmed a TB plan was not developed. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines, indicated an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The MDH Tuberculosis (TB) Screening and Education Requirements for Assisted Living Facilities and Home Care Providers dated February 3, 2022, indicated TB risk assessments should be completed annually. In addition, negative IGRA tests can be accepted if dated within 90 days before hire. The licensee's undated infection control policy indicated the facility would develop an annual TB plan and would follow the CDC's recommendation for TB.	0 660		

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0 660	Continued From page 10 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; (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 tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a written emergency preparedness plan (EPP) with all the required content and failed to post an EPP prominently.	0 680		

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0 680	Continued From page 11 This had the potential to affect all residents, staff, and visitors of the facility. 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: During the entrance conference on November 14, 2022, at 9:40 a.m., the surveyor asked for the licensee's EPP, administrator (A)-A confirmed an EEP was not completed to include all of the required elements. On November 14, at 9:50 a.m., a facility tour was conducted with A-A. There was observed signage posted in the common areas for information regarding the licensee's shelter in place guidelines for a disaster, the postings did not include all of the elements of the EPP. On November 14, 2022, at 10:00 a.m., A-A and registered nurse (RN)-B confirmed they did not have an EEP. A-A and RN-B confirmed they had policies provided by a trade organization but had not implemented the policies in their organization or provided any staff training. A-A and RN-B confirmed the licensee had not completed a hazard vulnerability assessment (HVA) to include the required elements. The licensee's EPP did not include the following content: - a description of the population served by the	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38410	A. BUILDING: _____ B. WING _____	11/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME PARTNERS LLC	8309 SCOTT AVENUE NORTH BROOKLYN PARK, MN 55443

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0 680	Continued From page 12 licensee to identify at risk populations - process for EP corporation with state and local EP officials/organizations - post an emergency disaster plan prominently; - provide building emergency exit diagrams to all residents; - have a written policy and procedure regarding missing tenant residents. - the development of policies and procedures to address: - subsistence needs for staff and residents during an emergency to include (food, water, medical supplies, pharmacy supplies, sewer and waste disposal, emergency lighting, fire detection, extinguishing and alarm systems) - shelter in place to meet the needs of the residents - a medical record documentation system to preserve resident information, security, and availability - A communication plan that included: - contact information for federal, state, tribal, local EP staff, ombudsman, state licensing and certification agencies - primary and alternative means for communicating with facility staff, federal, state, regional and local emergency management agencies - a method of sharing information and medical documentation for residents information about their occupancy; and - a method of sharing information from the EPP with residents and their families. In addition, 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	0 680		

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0 680	Continued From page 13 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. On November 14, 2022, at 10:00 a.m., A-A stated he was not familiar with Appendix Z (a section of the Centers for Medicare and Medicaid Services [CMS] state operations manual which includes the emergency preparedness guidelines). A-A and RN-B stated they would get a EPP in place. The licensee's undated Emergency Preparedness policy noted the licensee's EPP will include all required elements of appendix Z. The plan will be in writing and reviewed annually. 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 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 facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors.	0 800		

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0 800	Continued From page 14 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 residents). The findings include: On November 15, 2022, from approximately 12:30 p.m. to 2:00 p.m., survey staff toured the facility with the administrator (A)-A. During the facility tour, survey staff observed the following: 1. Bedroom #2 window hardware was partially stripped and did not easily open and close. 2. Bedroom #1 had a crack in the window pane of the larger bedroom window. 3. Basement bathroom was missing sealant at the toilet base. 4. Bedroom #5 window hardware was partially stripped and did not easily open and close, there was also a crack in the glass of the other bedroom window. A-A verbally confirmed survey staff observations during the facility tour. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The	0 810		

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0 810	Continued From page 15 plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and maintain fire safety and evacuation plans, failed to provide required training to residents and employees for fire safety and evacuation, and failed to conduct required employee evacuation drills. This had the potential to affect all current residents, staff, and visitors to	0 810		

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0 810	Continued From page 16 the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all residents). The findings include: During interview on November 15, 2022, at 2:00 p.m., the administrator (A)-A stated they did not have a fire safety policy, had not done any training, and had not performed any evacuation drills. Survey staff requested fire safety training and evacuation plan documentation, but the licensee did not provide the requested documentation. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring	01650		

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01650	Continued From page 17 assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure each resident had a service plan which included the required content for one of one resident (R1) with records reviewed. This deficient practice also affected R2. 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:	01650		

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01650	Continued From page 18 R1's medical record was reviewed. R1 admitted to the assisted living facility on September 14, 2022. R1's diagnoses included schizophrenia, and depression. R1's record lacked a signed service plan. On November 14, 2022, at 1:00 p.m., administrator (A)-A and registered nurse (RN)-B confirmed R1, and all of the other resident (R2) lacked a service plan including all of the required elements. The licensee's undated Service Plan policy noted the service plan would include the following: - a description of the services that are to be provided based on the most recent assessment and resident preferences. - the fees for services. - the frequency of services to be provided. - an identification of staff or categories of staff who will be providing services. - the schedule and methods of monitoring assessments of the client - the schedule and methods of monitoring staff providing services - a contingency plan that included the action to be taken if the scheduled service cannot be provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01650		
01770 SS=F	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name	01770		

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01770	Continued From page 19 of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure documentation of medication setup included all the required content for one of one resident (R1). This deficient practice also affected R2. 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: During the entrance conference on November 14, 2022, at 9:40 a.m., registered nurse (RN)-B stated the licensee provided medication management services to include medication setup for both residents. R1's medical record was reviewed. R1 admitted to the assisted living facility on September 14, 2022. R1's diagnoses included schizophrenia, and depression. R1 lacked a service plan. R1's medication administration record (MAR) dated November 1, 2022, included an order for the following: - Omeprazole 20 milligrams (mg) once daily; - Sertraline 100 mg 2 tables daily,	01770		

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01770	Continued From page 20 - Lisinopril 40 mg daily; - Lisinopril 40 mg daily, Metformin 500 mg daily; - Vitamin B12 1000 mg daily; - Levetiracetam 750 mg twice daily; - Rosuvastatin 40 mg daily; - Mirtazapine 15 mg at bedtime; - Doxepin 10 mg at bedtime; - Gabapentin 300 mg 2 capsules three times daily; - Mirtazapine30 mg at bedtime; - Aspirin 81 mg chewable tablet by mouth daily. On November 14, 2022, at 10:00 a.m., during a facility tour with RN-B pharmacy provided medication punch cards were in the resident's plastic container along with plastic weekly pill caddies with medications in them for each day. RN-B stated she removed the medications from the pharmacy provided punch cards and places the medications into the weekly pill caddies under each day. She said she does that, so the unlicensed personnel (ULP) don't have to figure out the cards and which one to punch out for the residents' medications. RN-B stated she does not document the medication set up anywhere for each medication set up. Both resident's get their medications set-up into plastic weekly pill caddies. R1's record lacked medication setup documentation at the time of setup to include the: date of the medication set-up, name of the medication, quantity of dose, times to be administered, route of administration, and the name of the person completing the medication set up. The licensee's undated Medication Management - Dosage Box Setup policy noted for medication	01770		

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01770	Continued From page 21 set up, the following will be documented on the MAR to include any special instructions: a. Medication name b. Quantity of dose c. Times to be administered d. Route of administration e. Visual description of medication f. Drug classification and special precautions The licensed nurse sets up medication on weekly into the dosage boxes. When the licensed nurse has completed setting up the medications into the dosage box, the set-up is documented. The licensed nurse will review the dosage boxes on a weekly basis to assure that all the previous week's medications were administered, and documentation is then made on the MAR. TIME PERIOD FOR CORRECTION: Seven (7) days	01770		
03090 SS=F	144.6502, Subd. 8 Notice to Visitors Subd. 8.Notice to visitors. (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the required notice was posted at	03090		

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03090	Continued From page 22 the main entry way of the establishment to display statutory language to disclose electronic monitoring activity, potentially affecting all current residents in the assisted living facility, staff, and any visitors to the facility. This practice resulted in a level one violation (a violation that has not 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: On November 14, 2022, at 10:35 a.m., during a tour of the facility, the surveyor observed the facility's front door and common areas and noted the lack of the required posting of the electronic monitoring notice to visitors. During an interview on November 14, 2022, at approximately 10:45 a.m., administrator-A and registered nurse (RN)-B verified the licensee did not have an electronic monitoring notice to visitors sign posted near the entrance of the facility. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	03090		

DEPARTMENT OF HEALTH

Type: Full
Date: *11/14/22*
Time: 11:00:00
Report: 1036221103

Food and Beverage Establishment Inspection Report

Location:
Home Partners LLC
8309 Scott Ave N
Brooklyn Park, MN55443
Hennepin County, 27

Establishment Info:
ID #: 0040944
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

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.

The following orders were issued during this inspection.

3-500C Microbial Control: date marking

3-501.17B ** Priority 2 **

MN Rule 4626.0400B Mark the refrigerated, ready-to-eat, TCS food prepared and packaged in a processing plant and opened and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded. The date must not exceed the manufacturer's use-by-date.

OBSERVED SOME PACKAGED LUNCH MEAT THAT WAS OPENED IN THE FRIDGE WITH NO DATE LABEL. ISSUE CORRECTED ON SITE.

Comply By: 11/21/22

4-100 Equipment Construction Materials

4-101.17

MN Rule 4626.0490 Discontinue using wood and wood wicker as a food contact surface.

OBSERVED SOME WOODEN SPOONS IN KITCHEN DRAWER. WOODEN SPOONS WERE REMOVED FROM FACILITY.

Corrected on Site

4-200 Equipment Design and Construction

4-201.11GMN

MN Rule 4626.0506G Discontinue serving TCS foods that are held for more than same-day service in an adult or child care center or boarding establishment or provide equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

Type: Full
Date: *11/14/22*
Time: 11:00:00
Report: 1036221103
Home Partners LLC

Food and Beverage Establishment Inspection Report

OBSERVED SOME LEFT OVER LASAGNA IN THE FRIDGE. ITEM DISCARDED ON SITE.
Corrected on Site

Surface and Equipment Sanitizers

Hot Water: = at >160dF Degrees Fahrenheit
Location: DISHWASHER
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Hold/MILK
Temperature: 40 Degrees Fahrenheit - Location: FRIDGE
Violation Issued: No

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

INSPECTION COMPLETED WITH ADMINISTRATOR GABRIEL MERCHANT. INSPECTION WAS REVIEWED WITH HRD NURSE EVALUATOR, CAROL MORONEY.

IN ADDITION TO ORDERS ON REPORT, DISCUSSED:
-EMPLPOYEE ILLNESS POLICY AND LOG
-HANDWASHING PROCEDURES
-GLOVE USE AND NO BARE HAND CONTACT WITH RTE FOODS
-COOK TEMPS FOR RAW ANIMAL FOODS
-DATE LABELING

THERMOLABELS WERE LEFT ON SITE. OPERATOR WILL RUN THEM THROUGH THE DISHWASHER AND SEND PICTURES TO INSPECTOR TO VERIFY THAT THE MACHINES ARE PROVIDING A UTENSIL SURFACE TEMPERATURE OF 160dF OR ABOVE.

THIS FACILITY HAS RESIDENTIAL EQUIPMENT AND FINISHES. ALL FOOD PREPARED IS FOR SAME-DAY SERVICE.

CABINETRY IS WOOD CABINETS WITH HOLLOW ENCLOSED BASES. ALL CABINETS ARE CURRENTLY IN GOOD CONDITION. THEY WILL BE MONITORED AT FUTURE INSPECTIONS AND COULD BE REQUIRED TO BE REPLACED TO MEET CODE IF THEY ARE NO LONGER IN GOOD REPAIR.

Type: Full
Date: *11/14/22*
Time: 11:00:00
Report: 1036221103
Home Partners LLC

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the inspection report number 1036221103 of 11/14/22.

Certified Food Protection Manager: Gabriel N. Merchant

Certification Number: FM113610 Expires: 10/15/25

Inspection report reviewed with person in charge and emailed.

Signed: _____ Signed: _____

Gabriel Merchant
Administrator

Jeff Johanson