Electronically Delivered

June 30, 2025

Licensee
Epiphany Care Homes LLC
3704 Cardinal Road
Minnetonka, MN 55345

RE: Project Number(s) SL20517016

Dear Licensee:

On May 6, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on February 20, 2025. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Jessie Chenze, Supervisor
State Evaluation Team
Email: jessie.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290

JMD

Electronically Delivered

March 24, 2025

Licensee
Epiphany Care Homes LLC
3704 Cardinal Road
Minnetonka, MN 55345

RE: Project Number(s) SL20517016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on February 20, 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.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

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

1290 - 144g.60 Subdivision 1 - Background Studies Required - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

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

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

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

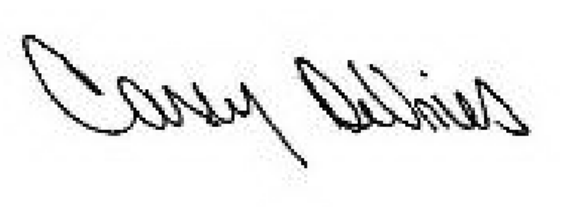
the website listed above.

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

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

If you have any questions, please contact me.

Sincerely,



Casey DeVries, Supervisor
State Evaluation Team
Email: casey.devries@state.mn.us
Telephone: 651-201-5917 Fax: 1-866-890-9290

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20517	A. BUILDING: _____ B. WING _____	02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EPIPHANY CARE HOMES LLC	3704 CARDINAL ROAD MINNETONKA, MN 55345

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL20517016 -0 On February 18, 2025, through February 20, 2025, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were six residents, all of whom received services under the Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food	0 480		

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

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0 480	Continued From page 2 and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated February 18, 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.	0 480		

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0 510	Continued From page 3	0 510		
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program that complied with accepted health care, medical and nursing standards for infection control related to gloving and hand hygiene for one of one unlicensed personnel ((ULP)-A). 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: On February 20, 2025, at 8:05 a.m., the surveyor	0 510		

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0 510	Continued From page 4 observed a tamsulosin pill sitting on top of the medication cart unattended. The pill was directly on the medication cart (not in a medication cup), in the dining room. The surveyor also observed R2 and R3 sitting by the dining table eating breakfast. ULP-A stated they were going to administer the tamsulosin to R2, but they had to go help R1. The surveyor observed ULP-A remove the tamsulosin from the cart without sanitizing their hands, and with ungloved hand put it in a paper cup and gave it to R2. ULP-A stated R2 took all of their medication crushed except tamsulosin, and that was why they put it on the cart. On February 20, 2025, at 8:17 a.m., ULP-A stated they were trained on how to administer medication by the previous and the current owners. ULP-A stated they were told to apply gloves when they touch medications, and they were also trained to not put medication on the cart or leave them unattended, "it was all my mistake I was trying to multitask." On February 20, 2025, at 8:25 a.m., registered nurse (RN)-D stated they taught ULP to use gloves when they touched medication. The licensee's 8.01 Infection Control Policy dated August 1, 2021, indicated the licensee's policy would be consistent with current guidelines from center for disease control (CDC) for infection control and prevention in long term care facilities, where applicable in assisted living facilities. The CDC website titled Clinical Safety: Hand Hygiene for Healthcare Workers dated February 27, 2024, indicated the following recommendation for when to clean hands in health care settings: - Immediately before touching a patient;	0 510		

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0 510	Continued From page 5 - Before performing an aseptic task such as placing an indwelling device or handling invasive medical devices; - Before moving from work on a soiled body site to a clean body site on the same patient; - After touching a patient or patient's surroundings; - After contact with blood, body fluids, or contaminated surfaces; and - Immediately after glove removal. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
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	0 660		

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0 660	Continued From page 6 licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included a two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test, for two of two employees (unlicensed personnel (ULP)-B, ULP-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-B ULP-B was hired on May 16, 2023, to provide direct cares and services to residents. ULP-B's employee record included a Baseline TB Screening Tool for Health Care Workers (HCWs) dated January 11, 2024, with a completed health history and baseline TB symptom screening for ULP-B. The Baseline TB Screening Tool indicated a negative test result read on January 13, 2024, for ULP-B's TST test administered on January 11, 2024. ULP-B's employee record lacked evidence the second step TST was completed or other evidence of TB screening such as a blood test, was completed, within 90 days before hire. ULP-E ULP-E was hired on May 16, 2023, to provide direct cares and services to residents.	0 660		

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0 660	Continued From page 7 ULP-E's employee record included a Baseline TB Screening Tool for Health Care Workers (HCWs) dated November 21, 2023, with a completed health history and baseline TB symptom screening for ULP-E. The Baseline TB Screening Tool indicated a negative test result read on November 24, 2023, for ULP-E's TST test administered on November 22, 2023. ULP-E's employee record lacked evidence the second step TST was completed or other evidence of TB screening such as a blood test, was completed, within 90 days before hire. On February 20, 2024, at 9:07 a.m., registered nurse (RN)-C stated a TST was administered to all employees every two years and upon hire as needed. RN-C stated it was as needed upon hire as most new hires had a TST done with in the last year. RN-C stated their understanding was that a TST was good for up to two years. On February 20, 2024, at 9:14 a.m., RN-C stated new employees could not work with residents until they had negative results for TST or blood test. RN-C further stated they only did one step TST upon hire for all employees who were asymptomatic, and they were not aware they had to do two steps for TST. The CDC Tuberculosis Screening, Testing, and Treatment of U.S. Health Care Personnel dated May 17, 2019, indicated all health personnel should have a baseline screening and an individual risk assessment, which is necessary for interpreting any test result. The Minnesota Department of Health document titled Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013,	0 660		

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0 660	Continued From page 8 indicated baseline TB screening is required for all health care workers. Baseline TB screening consists of three components: 1. Assessing for current symptoms of active TB disease, 2. Assessing TB history, and 3. Testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step TST or single TB blood test (IGRA). An employee may begin working with patients after a negative TB symptom screen (i.e., no symptoms of active TB disease) and a negative IGRA or TST (i.e., first step) dated within 90 days before hire. The second TST may be performed after the HCW starts working with patients. The licensee's 8.16 Tuberculosis Screening policy Employee dated August 1, 2022, indicated the licensee will 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 Morbidity and Mortality Weekly Report (MMWR). New staff will have an IGRA blood test or a two-step Mantoux conducted with results documented on the Baseline TB Screening Tool for HCWs. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment	0 810		

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0 810	Continued From page 9 (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The 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 interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training and drills. This had	0 810		

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0 810	Continued From page 10 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 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 February 19, 2025, clinical nurse supervisor/licensed assisted living director (CNS/LALD)-D site lead (SL)-G 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: The licensee's FSEP, failed to include the following: The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01290 SS=H	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to	01290		

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EPIPHANY CARE HOMES LLC	3704 CARDINAL ROAD MINNETONKA, MN 55345

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01290	Continued From page 11 the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study (BGS) was current and eligible on NETStudy 2.0 (web-based system for submitting background study requests to the Department of Human Services (DHS)) for two of seven employees (housing manger (HM)/unlicensed personnel (ULP)-A, ULP-B). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: HM/ULP-A	01290		

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01290	Continued From page 12 HM/ULP- A was hired on August 2, 2013, to provide direct cares and services to residents. The licensee's work schedule for February 2, 2025, through March 1, 2025, indicated ULP-A was scheduled to work morning-shifts (6:30 a.m., to 2:30 p.m.) Monday through Friday. ULP-A was scheduled to work independently without direct supervision. The licensee's NETstudy2.0 roster printed on February 18, 2025, indicated HM/ULP-A's BGS was initiated on February 18, 2025, affiliated to the licensee's health facility identification number (HFID) 20517 during the survey. The NETstudy2.0 roster indicated the BGS was currently "in process". The "Eligible covid 19 study" status for the BGS was expired on December 31, 2022. The licensee lacked evidence the licensee submitted a new BGS for HM/ULP-A after the covid 19 eligible status had expired and affiliated to HFID 20517. ULP-B ULP-B was hired on March 16, 2023, to provide direct cares and services to residents. The licensee's work schedule for February 2, 2025, through March 1, 2025, indicated ULP-B was scheduled to work night shift (10:30 p.m., to 6:30 a.m.,) and morning-shifts (6:30 a.m., to 2:30 p.m.) on the following dates: February 2, 9, 16, 22, and 23. Morning-shifts (6:30 a.m., to 2:30 p.m.) on the following dates: February 8, 15, and March 1. Night shift (10:30 p.m., to 6:30 a.m.,) on the following dates: February 4, 5, 6, 7, 11, 13, 18, 19, 20, 25, and 27. ULP-B was scheduled to work independently without direct supervision. ULP-B's employee record included a background	01290		

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01290	Continued From page 13 study clearance letter dated January 30, 2024, which was run under the licensee's sister facility, health facility identification (HFID) number 30748. The licensee's NETstudy2.0 roster printed on February 18, 2025, did not include ULP-B in the list of employes affiliated. The licensee lacked evidence the licensee submitted a background stud for ULP-B under the current HFID. On February 18, 2025, at 11:05 a.m., human resource personal (HR)-F stated they were not aware ULP-A's BGS was expired until today and they stated they submitted a new BGS study today. HR-F also stated there were no cleared BGS for ULP-A under their sister facility HFIDs. On February 18, 2025, at 11:13 a.m., HR-F stated ULP-B was cleared under ULP-B's primary work location, and they forgot to affiliate ULP-B to the current HFID. On February 18, 2025, at 11:27 a.m., HR-F stated both ULPs did work independently with residents without supervision. The licensee's 4.02 Background studies Policy dated August 1, 2021, indicated, "POLICY: [licensee's name] will conduct a Minnesota Department of Human Services Background Study on all employees and volunteers and contractors at Epiphany Care Homes. No employee may provide direct services and have independent direct contact with any residents until acceptable result of the background study have been received. [Licensee's name] will not employ individuals whose results of the background study indicate disqualification for the position."	01290		

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01290	Continued From page 14 On September 9, 2024, the Minnesota Department of Human Services website indicated the following: - Emergency studies completed during the COVID-19 pandemic were no longer valid. - Individuals who only had an emergency study must have a fully compliant, fingerprint-based background study. Roster maintenance - Individuals with a completed emergency study will remain on the entity's roster unless the entity removes the individual. Entities should remove individuals with emergency studies that are no longer affiliated; - If the individual should no longer be affiliated and has a new fully compliant background study, the entity should wait until the individual is separated and then remove both the emergency study and fully compliant study from their roster at the same time; - All entities are responsible for maintaining their rosters regularly and removing study subjects from their roster when they are no longer affiliated; and - Entities are responsible for identifying who needs to submit a new background study. For help identifying which study subjects still have an emergency study and need a fully compliant study, entities should refer to the instructional guide, "Identifying Emergency Studies" in the help section of NETStudy 2.0. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01290		
01830 SS=F	144G.71 Subd. 14 Renewal of prescriptions	01830		

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01830	Continued From page 15 Prescriptions must be renewed at least every 12 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter 152. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure prescriptions were renewed at least every 12 months for three of three residents (R1, R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted to the licensee on September 11, 2023. R1's diagnoses included hemiplegia and hemiparesis following cerebral infarction, hypertension, dysphagia, and hyperlipidemia. R1's Service Plan dated December 8, 2024, indicated R1 received services including medication administration, toileting assistance, bathing assistance, dressing assistance, oral hygiene, and standby assistance. R1's record included unsigned Order Summary	01830		

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01830	Continued From page 16 Report, which was active as of February 18, 2025. R1's record lacked prescriptions renewed at least every 12 months or more frequently as indicated by the assessment. On February 18, 2025, at 1:45 p.m., registered nurse (RN)-C stated R1's primary care physicians did medication reconciliation every year; RN-C stated they thought the signed medication order was sent to R1's power of attorney. RN-C stated they would request a signed order. On February 18, 2025, at 8:46 p.m., via email correspondence, RN-C provided the surveyor with an Order Summary Report signed and dated by R1's physician on February 18, 2025, during the survey. R2 R2 was admitted to the licensee on October 31, 2022. R2's diagnoses included overactive bladder, type I diabetic, anemia, atrial fibrillation and hyperlipidemia. R2's undated Service Plan, indicated R2 received services including medication administration, toileting assistance, bathing assistance, dressing assistance, oral hygiene, and standby assistance. R2's record lacked prescriptions renewed at least every 12 months or more frequently as indicated by the assessment. On February 20, 2025, at 10:41 a.m., via email correspondence RN-C provided the surveyor with an Order Summary Report signed and dated by	01830		

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01830	Continued From page 17 R2's physician on February 20, 2025, during the survey. R3 R3 was admitted to the licensee on April 2, 2024. R3's diagnoses included autistic disorder, type II diabetic, anemia, hypothyroidism, bipolar disorder, and hyperlipidemia. R3's Service Plan, dated December 30, 2024, indicated R3 received services including medication administration, toileting assistance, bathing assistance, dressing assistance, oral hygiene, and standby assistance. R3's record lacked prescriptions renewed at least every 12 months or more frequently as indicated by the assessment. On February 20, 2025, at 11:27 a.m., RN-C stated they were aware of the requirement for reviewing prescriptions at least every 12 months or more frequently as indicated by the assessment. RN-C stated the prescriptions were reviewed every year by the physicians and were sent directly to the guardians or power of attorney by the physicians, and the licensee had not received a copy. The licensee's 7.18 Medication & Treatment orders - Renewal Refills indicated residents who receive medication management services by licensee will have a current physician prescribed medication or treatment/therapy orders on record. Medication and treatment orders must be renewed at least every 12 months or more frequently as required. No further information was provided.	01830		

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01830	Continued From page 18 TIME PERIOD FOR CORRECTION: Seven (7) days	01830		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide a hazard vulnerability assessment or safety risk assessment of the physical environment on and around the property. This deficient practice had the ability to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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:	02040		

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02040	Continued From page 19 A record review of available documentation and interview were conducted February 19, 2025, at 11:50 a.m., with clinical nurse supervisor/licensed assisted living director (CNS/LALD)-D and site lead (SL)-G, on the hazard vulnerability assessment (HVA) for the physical environment of the facility. Record review of the available documentation indicated that the licensee had not performed a hazard vulnerability assessment with mitigation factors on and around the property. During an interview on February 19, 2025, at 11:50 a.m., LALD-D, stated an HVA had not been performed and documented on and around the property. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
02310 SS=F	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for two of two residents (R1, R3) with hospital bed rails.	02310		

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02310	Continued From page 20 This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted to the licensee on September 11, 2023. R1's diagnoses included hemiplegia and hemiparesis following cerebral infarction, hypertension, dysphagia, and hyperlipidemia. R1's Service Plan dated December 8, 2024, indicated R1 received services including medication administration, toileting assistance, bathing assistance, dressing assistance, oral hygiene, and standby assistance. R1's record included the following required items for bedrail use in R1's 90-day assessment dated January 29, 2025: - purpose and intention of the bed rail including consideration of whether the bed rail has the effect of being an improper restraint; - the resident's bed rail use/need assessment; and - the resident's preferences. R1's record also included a Progress Note with bed rails entrapment zone measurements completed during the survey on February 20, 2025.	02310		

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02310	Continued From page 21 R1's record lacked the following required items completed every 90 days for bedrail use: - measurements; - risk vs. benefits discussion (individualized to each resident's risks); - physical inspection of the bed rail(s) and mattress for areas of entrapment, stability, and correct installation; and - any necessary information related to interventions to mitigate safety risk or negotiated risk agreements. R3 R3 was admitted to the licensee on April 2, 2024. R3's diagnoses included autistic disorder, type II diabetic, anemia, hypothyroidism, bipolar disorder, and hyperlipidemia. R3's Service Plan, dated December 30, 2024, indicated R3 received services including medication administration, toileting assistance, bathing assistance, dressing assistance, oral hygiene, and standby assistance. R3's record included the following required items for bed rail use in R3's 90-day assessment dated January 29, 2025: - purpose and intention of the bed rail including consideration of whether the bed rail has the effect of being an improper restraint; - the resident's bed rail use/need assessment; and - the resident's preferences. R3's record also included a Progress Note with bed rails entrapment zone measurements completed during the survey on February 20, 2025.	02310		

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02310	Continued From page 22 R3's record lacked the following required items completed every 90 days for bedrail use: - measurements; - risk vs. benefits discussion (individualized to each resident's risks); - physical inspection of the bed rail(s) and mattress for areas of entrapment, stability, and correct installation; and - any necessary information related to interventions to mitigate safety risk or negotiated risk agreements. On February 20, 2025, at 9:23 a.m., registered nurse (RN)-C stated they did do the bed rail section of the nursing assessment every 90 days, measured entrapment zones, and posted education and guidelines for bed rails in the resident's rooms. RN-C also stated they did go over the risks and benefits of using bedrails with R1's power of attorney (POA). Although they stated the POA had signed the risk virus benefit documentation, RN-C was unable to provide the signed document. On February 20, 2025, at 10:54 a.m., RN-C stated they were told by another surveyor at another location that the entrapment zone measurements were supposed to be done once and then to document it as reviewed every 90 days. They further stated they had an order to check measurements and document every 90 days, but they did not have it documented for both residents. RN-C stated they did not have the risk virus benefit signed for R3. The Food and Drug Administration's (FDA), A Guide to Bed Safety, dated October 2000, and revised April 2010, indicated following information: "When bed rails are used, perform	02310		

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02310	Continued From page 23 an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." The March 10, 2006, FDA Side Rail Entrapment Zones and Dimensional Recommendations indicated to reduce the risk of entrapment, zone 1 (within the rail) should not exceed 4 and 3/4 inches, zone 2 (under the rail, between rail supports or next to a single rail support) should not exceed 4 and 3/4 inches, zone 3 (between the rail and the mattress), should not exceed 4 and 3/4 inches, and zone 4 (under the rail, at the ends of the rail) should not exceed 2 and 3/8 inches or be greater than a 60 degree angle. The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently Asked Questions (FAQs) indicated the need for assistive devices, such as bed rails, must be assessed upon initial installation, with each 90-day assessment and change of condition. (Please refer to Rule 4659.0150 where it directs assessment of mobility, including ambulation, transfers, and assistive devices.) The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as	02310		

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EPIPHANY CARE HOMES LLC	3704 CARDINAL ROAD MINNETONKA, MN 55345

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02310	Continued From page 24 they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint. Additionally, the licensee must ensure the bed rail measurements are documented and that the bed rail has not shifted and is securely attached to the bed frame per manufacturer recommendations." Also included, documentation about a resident's hospital bed rail should include, but is not limited to: -Purpose and intention of the bed rail; -Measurements; -The resident's bed rail use/need assessment; -Risk vs. benefits discussion (individualized to each resident's risks); -The resident's preferences; -Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and -Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements. The licensee's 6.28 Side Rails Policy dated August 1, 2021, indicated the licensee will assess the use, educate the resident, and when appropriate, the responsible person, regarding the risks and benefits of side rails and verify that the side rail in use is of a safe design and utilized consistent with the manufacturer's directions. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2)	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20517	A. BUILDING: _____ B. WING _____	02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EPIPHANY CARE HOMES LLC	3704 CARDINAL ROAD MINNETONKA, MN 55345

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02310	Continued From page 25 days	02310		

Minnesota Department of Health
Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975
6512014500

Type: Full
Date: *02/18/25*
Time: 11:00:00
Report: 1047251039

Food and Beverage Establishment Inspection Report

Location:
Epiphany Care Homes Llc
3704 Cardinal Road
Minnetonka, MN55345
Hennepin County, 27

Establishment Info:
ID #: 0038835
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 9524758093
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.

4-300 Equipment Numbers and Capacities

4-302.14 ***** Priority 2 *****

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

NO TEST STRIPS AVAILABLE TO VERIFY CONCENTRATION OF QUATERNARY AMMONIUM SANITIZER SOLUTION. TEST STRIPS WERE FOR PH LEVELS.

Comply By: 02/18/25

4-600 Cleaning Equipment and Utensils

4-601.11A ***** Priority 2 *****

MN Rule 4626.0840A Equipment food-contact surfaces and utensils must be clean to sight and touch.

AIR FRYER HAD BUILD UP OF CRUMBS/FOOD DEBRIS. CORRECTED ON SITE- FRYER BASKET WAS CLEANED.

Corrected on Site

4-500 Equipment Maintenance and Operation

4-501.11C

MN Rule 4626.0735C Maintain the cutting or piercing parts of can openers in a sharp condition to minimize the creation of metal fragments that can contaminate food when the container is opened.

METAL FRAGMENTS OBSERVED ON OUTISDE OF MECHANICAL CAN OPENER. CORRECTED ON SITE- CAN OPENER REMOVED

Corrected on Site

Surface and Equipment Sanitizers

Hot Water: = at >160F Degrees Fahrenheit
Location: Dishmachine
Violation Issued: No

Quaternary Ammonia: = 400 ppm at Degrees Fahrenheit
Location: Brush holder
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 38 Degrees Fahrenheit - Location: Refrigerator- pizza
Violation Issued: No

Process/Item: Cold Holding
Temperature: 37 Degrees Fahrenheit - Location: Refrigerator- cheese
Violation Issued: No

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

The inspection was completed with the operator and reviewed with MDH Nurse Evaluator D. Mosissa.

The establishment has a residential kitchen and serves food that is prepared that day. The kitchen has wood cabinets, laminate floor, painted & tiled walls, solid counter top, and a painted ceiling.

A single basin sink is located in the kitchen that is designated for handwashing. A residential dish machine is located in the kitchen.

Discussed hand washing, ware washing, staff illness policy, temperature control, final cook temperatures, cleaning, serving highly susceptible populations, and food handling procedures.

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 1047251039 of 02/18/25.

Certified Food Protection Manager: Alpha M Bah

Certification Number: FM102413 Expires: 01/30/26

Inspection report reviewed with person in charge and emailed.

Signed: _____
Alpha Bah
House Manager

Signed: _____
Holly Sievers
Public Health Sanitarian 2
Metro Office
6512015946
Holly.Sievers@state.mn.us