Electronically Delivered
May 15, 2024

Licensee
Wiltima Assisted Living, LLC
5716 42nd Avenue North
Robbinsdale, MN 55422

RE: Project Number(s) SL39679015

Dear Licensee:

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

The Minnesota Department of Health completed an initial survey on April 10, 2024, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

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

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.31, Subd. 4(a)(5), MDH may impose fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. MDH may impose 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. MDH 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(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 survey:

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program = $500.00

The total amount you are assessed is $500.00. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

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 MDH 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**.

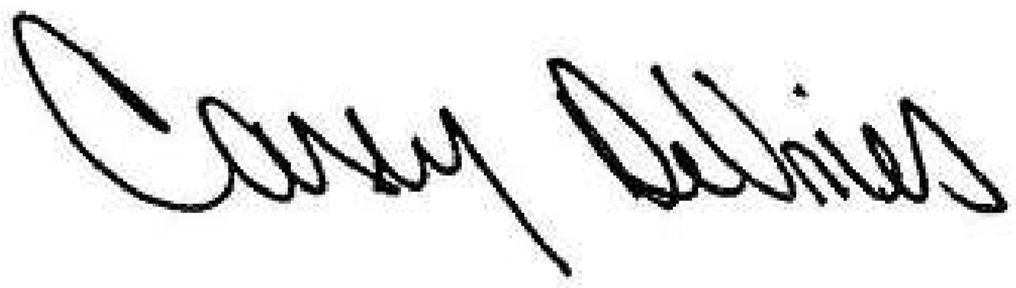
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration or a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39679	A. BUILDING: _____ B. WING _____	04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILTIMA ASSISTED LIVING LLC	5716 42ND AVENUE NORTH ROBBINSDALE, MN 55422

(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: SL39679015-0 On April 8, 2024, through April 10, 2024, the Minnesota Department of Health (MDH) conducted a full routine survey at the above provider, and the following correction orders are issued. At the time of the survey, there were four residents, all of whom received services under the Assisted Living license. ******REVISED******** Based on additional information provided and further review by MDH, tag cited at 0680, is rescinded.	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.	
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that	0 510		

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0 510	Continued From page 1 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 infection control program that complied with accepted health care, medical and nursing standards for infection control. The deficient practice had the potential to affect all residents, employees, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Unlicensed Personnel (ULP)-B ULP-B was hired on August 18, 2023, to provide direct care to residents. ULP-C ULP-C was hired on March 14, 2024, to provide direct care to residents.	0 510		

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0 510	Continued From page 2 On April 9, 2024, at 8:15 a.m., the surveyor observed ULP-B and ULP-C provide cares and services for R1. The surveyor observed R1's brief was soiled with urine. ULP-B and ULP-C performed hand hygiene and donned (put on) gloves. ULP-B and ULP-C removed R1's soiled brief. ULP-C provided perineal (peri) cares (cleaning private areas) to both the front and back side of R1's peri area with wet wipes. ULP-C doffed (removed) their soiled gloves and donned a new pair; ULP-C did not perform hand hygiene between the glove change. ULP-B remained in their soiled gloves. ULP-B and ULP-C then positioned a new brief under R1 and performed additional peri cares but did not yet complete the brief change. ULP-C doffed their soiled gloves and donned a new pair; ULP-C did not perform hand hygiene between the glove change. ULP-C then handled R1's tube of barrier cream and applied it to R1's bottom. ULP-C doffed their soiled gloves and donned a new pair; ULP-C did not perform hand hygiene between the glove change. ULP-B, who was still wearing soiled gloved from assisting with R1's brief change, then picked up R1's oral secretion suctioning device and suctioned R1's oral secretions from their mouth. ULP-B then doffed their soiled gloves, performed hand hygiene, and donned a new pair. ULP-B and ULP-C then completed putting on R1's brief. ULP-B and ULP-C then dressed R1 into a clean pair of pants. ULP-B and ULP-C then used a handed and used a transfer sling to transfer R1 with an electronic Hoyer lift (lifting machine to assist with transfers). At no point did ULP-C perform hand hygiene while providing cares for R1. On April 9, 2024, at 10:03 a.m., ULP-B acknowledged they used R1's suctioning device	0 510		

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0 510	Continued From page 3 with soiled gloves from R1's brief change. ULP-B stated they forgot to change their gloves and stated they should have performed hand hygiene and applied new gloves before they used R1's suctioning device. ULP-B stated they were trained to when and how to perform hand hygiene by director of nursing (DON)-A. On April 9, 2024, at 10:15 a.m., ULP-C acknowledged they did not change gloves or complete hand hygiene appropriately while providing services for R1. ULP-C stated they were trained by DON-A to remove soiled gloves before touching clean items and to perform hand hygiene in between glove changes. On April 9, 2024, at 10:21 a.m., DON-A stated hand hygiene and glove changes should have been completed between tasks performed by ULP-B and ULP-C. DON-A stated they reviewed it yesterday, April 8, 2024, and this morning, April 9, 2024, with staff but clearly further reeducation was required. The Center for Disease Control (CDC) Hand Hygiene Guidance last reviewed on January 30, 2020, indicated The Core Infection Prevention and Control Practices for Safe Care Delivery in All Healthcare Settings recommendations of the Healthcare Infection Control Practices Advisory Committee (HICPAC) include the following strong recommendations for hand hygiene in healthcare settings: "Healthcare personnel should use an alcohol-based hand rub or wash with soap and water for the following clinical indications: -Immediately before touching a patient -Before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices	0 510		

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0 510	Continued From page 4 -Before moving from work on a soiled body site to a clean body site on the same patient -After touching a patient or the patient's immediate environment -After contact with blood, body fluids, or contaminated surfaces -Immediately after glove removal Healthcare facilities should: -Require healthcare personnel to perform hand hygiene in accordance with Centers for Disease Control and Prevention (CDC) recommendations -Ensure that healthcare personnel perform hand hygiene with soap and water when hands are visibly soiled -Ensure that supplies necessary for adherence to hand hygiene are readily accessible in all areas where patient care is being delivered Unless hands are visibly soiled, an alcohol-based hand rub is preferred over soap and water in most clinical situations due to evidence of better compliance compared to soap and water. Hand rubs are generally less irritating to hands and, in the absence of a sink, are an effective method of cleaning hands." The licensee's Infection Control policy dated January 1, 2023, indicated: "3. Hands should be washed at the following times: a. After changing beds b. Before assisting with medications c. Before and after treatments d. After all pet care e. After housekeeping f. After emptying bedpans g. After assisting the resident to the toilet h. After removing items from the floor i. Before preparing food j. Before feeding residents k. After using the bathroom	0 510		

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0 510	Continued From page 5 l. After coughing or sneezing m. After smoking n. After handling plants o. After removing gloves" No further information provided. TIME PERIOD FOR CORRECTION: Two (2) Days	0 510		
0 780 SS=D	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated;	0 780		

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0 780	Continued From page 6 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide a smoke alarm outside and in the immediate vicinity of the resident sleeping room. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). Findings include: On a facility tour on April 09, 2024, at 10:45 a.m. with assisted living director (ALD)-D, it was observed that resident room #1 did not have a smoke alarm installed outside and in the immediate vicinity of the resident sleeping room. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 780		
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	0 800		

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0 800	Continued From page 7 repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility 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 some of the residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On April 09, 2024, at 11:05 a.m., survey staff toured the facility with assisted living director (ALD)-D, it was observed that one of the emergency exit doors exited out into the garage. The means of egress is required to lead and exit directly to a yard or court from occupied spaces within the facility or through a room of equal or less hazard which excludes the garage. This exit door was included in the fire safety evacuation plan. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		

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0 510	Continued From page 2 On April 9, 2024, at 8:15 a.m., the surveyor observed ULP-B and ULP-C provide cares and services for R1. The surveyor observed R1's brief was soiled with urine. ULP-B and ULP-C performed hand hygiene and donned (put on) gloves. ULP-B and ULP-C removed R1's soiled brief. ULP-C provided perineal (peri) cares (cleaning private areas) to both the front and back side of R1's peri area with wet wipes. ULP-C doffed (removed) their soiled gloves and donned a new pair; ULP-C did not perform hand hygiene between the glove change. ULP-B remained in their soiled gloves. ULP-B and ULP-C then positioned a new brief under R1 and performed additional peri cares but did not yet complete the brief change. ULP-C doffed their soiled gloves and donned a new pair; ULP-C did not perform hand hygiene between the glove change. ULP-C then handled R1's tube of barrier cream and applied it to R1's bottom. ULP-C doffed their soiled gloves and donned a new pair; ULP-C did not perform hand hygiene between the glove change. ULP-B, who was still wearing soiled gloved from assisting with R1's brief change, then picked up R1's oral secretion suctioning device and suctioned R1's oral secretions from their mouth. ULP-B then doffed their soiled gloves, performed hand hygiene, and donned a new pair. ULP-B and ULP-C then completed putting on R1's brief. ULP-B and ULP-C then dressed R1 into a clean pair of pants. ULP-B and ULP-C then used a handed and used a transfer sling to transfer R1 with an electronic Hoyer lift (lifting machine to assist with transfers). At no point did ULP-C perform hand hygiene while providing cares for R1. On April 9, 2024, at 10:03 a.m., ULP-B acknowledged they used R1's suctioning device	0 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39679	A. BUILDING: _____ B. WING _____	04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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0 510	Continued From page 3 with soiled gloves from R1's brief change. ULP-B stated they forgot to change their gloves and stated they should have performed hand hygiene and applied new gloves before they used R1's suctioning device. ULP-B stated they were trained to when and how to perform hand hygiene by director of nursing (DON)-A. On April 9, 2024, at 10:15 a.m., ULP-C acknowledged they did not change gloves or complete hand hygiene appropriately while providing services for R1. ULP-C stated they were trained by DON-A to remove soiled gloves before touching clean items and to perform hand hygiene in between glove changes. On April 9, 2024, at 10:21 a.m., DON-A stated hand hygiene and glove changes should have been completed between tasks performed by ULP-B and ULP-C. DON-A stated they reviewed it yesterday, April 8, 2024, and this morning, April 9, 2024, with staff but clearly further reeducation was required. The Center for Disease Control (CDC) Hand Hygiene Guidance last reviewed on January 30, 2020, indicated The Core Infection Prevention and Control Practices for Safe Care Delivery in All Healthcare Settings recommendations of the Healthcare Infection Control Practices Advisory Committee (HICPAC) include the following strong recommendations for hand hygiene in healthcare settings: "Healthcare personnel should use an alcohol-based hand rub or wash with soap and water for the following clinical indications: -Immediately before touching a patient -Before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices	0 510		

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0 510	Continued From page 4 -Before moving from work on a soiled body site to a clean body site on the same patient -After touching a patient or the patient's immediate environment -After contact with blood, body fluids, or contaminated surfaces -Immediately after glove removal Healthcare facilities should: -Require healthcare personnel to perform hand hygiene in accordance with Centers for Disease Control and Prevention (CDC) recommendations -Ensure that healthcare personnel perform hand hygiene with soap and water when hands are visibly soiled -Ensure that supplies necessary for adherence to hand hygiene are readily accessible in all areas where patient care is being delivered Unless hands are visibly soiled, an alcohol-based hand rub is preferred over soap and water in most clinical situations due to evidence of better compliance compared to soap and water. Hand rubs are generally less irritating to hands and, in the absence of a sink, are an effective method of cleaning hands." The licensee's Infection Control policy dated January 1, 2023, indicated: "3. Hands should be washed at the following times: a. After changing beds b. Before assisting with medications c. Before and after treatments d. After all pet care e. After housekeeping f. After emptying bedpans g. After assisting the resident to the toilet h. After removing items from the floor i. Before preparing food j. Before feeding residents k. After using the bathroom	0 510		

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0 510	Continued From page 5 l. After coughing or sneezing m. After smoking n. After handling plants o. After removing gloves" No further information provided. TIME PERIOD FOR CORRECTION: Two (2) Days	0 510		
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 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.	0 680		

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0 680	Continued From page 6 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop written emergency preparedness plan (EPP) with all the required content. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On April 10, 2024, at 9:14 a.m., the surveyor reviewed the licensee's Emergency Preparedness Manual, created on August 5, 2023, which lacked the following information: -identified the quantity of food, water, medical and pharmaceutical supplies required to sustain its residents following evacuation or shelter in place for staff and residents. On April 10, 2024, at 9:35 a.m., assisted living director (ALD)-D and director of nursing (DON)-A stated they were aware of the requirement to identify the quantity of food, water, medical and pharmaceutical supplies required to sustain its residents following evacuation or shelter in place for staff and residents. ALD-D stated the identified quantities should be in the EPP and would search for the information. On April 10, 2024, at 10:42 a.m., during the exit conference, ALD-D stated they would find the	0 680		

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0 680	Continued From page 7 required supplies documentation and send it to the surveyor. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 780 SS=D	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by:	0 780		

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0 780	Continued From page 8 Based on observation and interview, the licensee failed to provide a smoke alarm outside and in the immediate vicinity of the resident sleeping room. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). Findings include: On a facility tour on April 09, 2024, at 10:45 a.m. with assisted living director (ALD)-D, it was observed that resident room #1 did not have a smoke alarm installed outside and in the immediate vicinity of the resident sleeping room. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 780		
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.	0 800		

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0 800	Continued From page 9 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility 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 some of the residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On April 09, 2024, at 11:05 a.m., survey staff toured the facility with assisted living director (ALD)-D, it was observed that one of the emergency exit doors exited out into the garage. The means of egress is required to lead and exit directly to a yard or court from occupied spaces within the facility or through a room of equal or less hazard which excludes the garage. This exit door was included in the fire safety evacuation plan. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		

Minnesota Department of Health
Environmental Health, FPLS
P.O Box 64975
Saint Paul
651-201-4500

Type: Full
Date: *04/08/24*
Time: 12:11:03
Report: 1018241058

Food and Beverage Establishment Inspection Report

Location:
Wiltima Assisted Living LLC
5716 42nd Avenue North
Robbinsdale, MN55422
Hennepin County, 27

Establishment Info:
ID #: 0039064
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 9522426146
ID #:

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

No NEW orders were issued during this inspection.

Food and Equipment Temperatures

Process/Item: Cold Holding/ CHEESE
Temperature: 40 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

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

ESTABLISHMENT DOES ALL SAME DAY SERVICE OF FOOD.

KITCHEN HAS A TWO BASIN SINK FOR DISH WASHING AND HAND WASHING.

DISHWASHER HAS SANITIZE FUNCTION.

FLOORS, WALLS, CEILINGS AND EQUIPMENT OBSERVED TO BE IN GOOD CONDITION.

DISCUSSED PEST CONTROL AND ILLNESS REPORTING.

VIEWED EMPLOYEE ILLNESS LOG.

Type: Full
Date: *04/08/24*
Time: 12:11:03
Report: 1018241058
Wiltima Assisted Living 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 Minnesota Department of Health inspection report number 1018241058 of 04/08/24.

Certified Food Protection Manager: SUMAYO J MOHAMUD

Certification Number: FM117754 Expires: 05/23/26

Inspection report reviewed with person in charge and emailed.

Signed: _____
FATIMA MOHAMUD
MANAGER

Signed: _____
Rebecca Prestwood
Sanitarian 3
6512013777
rebecca.prestwood@state.mn.us