Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF REMOVAL OF CONDITIONAL LICENSE

Electronic Delivery

June 23, 2025

Licensee
Warm Touch Home Care Inc.
3225 Emerson Avenue South
Minneapolis, MN 55408

RE: Initial License Number 415856
Health Facility Identification Number (HFID) 40600
Project Number(s) SL40600015-0

Dear Licensee:

On May 21, 2025, The Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed January 29, 2025. The follow-up survey found the facility to be in substantial compliance. Based on these findings, the condition(s) on the license were removed effective May 21, 2025.

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.

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

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

Sincerely,

Rick Michals

Rick Michals, J.D.
Executive Regional Operations Manager

Minnesota Department of Health
Health Regulation Division

JMD

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF PROVISIONAL EXTENSION AND CONDITIONAL LICENSE

Electronically Delivered

March 28, 2025

Licensee
Warm Touch Home Care Inc.
3225 Emerson Avenue South
Minneapolis, MN 55408

RE: Provisional Conditional License Number 415856
Health Facility Identification Number (HFID) 40600
Project Number(s) SL40600015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 29, 2025, for the purpose of assessing compliance with state licensing statutes. Based on the survey results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, pursuant to Minn. Stat. § 144G.16, Subd. 3(b)(2), MDH is extending the provisional license for 60-days and applying conditions necessary to bring the facility into substantial compliance. The provisional license extension and conditions are due to expire **May 27, 2025**.

STATE CORRECTION ORDERS
The enclosed State Form documents the state correction orders. MDH documents state 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.

MDH may assess fines based on the level and scope of the orders outlined below. The total amount of **potential** fines that may be assessed related to these correction orders is $3,500.00. **MDH is not imposing these fines against your provisional license at this time.**

0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $3,000.00
0780 - 144g.45 Subd. 2 (a) (1) - Fire Protection And Physical Environment - $500.00

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

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the provisional licensee must document actions taken to comply with the correction orders and immediately correct any reissued orders outlined on the state form; however, plans of correction are not required to be submitted for approval. **If corrections are not made, MDH may impose fines as described above and in accordance with Minnesota Statutes 144G.**

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

CONDITIONAL LICENSE ISSUED:
MDH will issue Warm Touch Home Care Inc. a conditional provisional assisted living facility license for 60 calendar days from the date of this notice. At an unannounced point in time, within the 60 calendar days, MDH will conduct a follow-up survey, as defined in Minn. Stat. § 144G.30, Subd. 6. Based on the results of the follow-up survey, MDH will determine if Warm Touch Home Care Inc. is in

substantial compliance.

The following conditions apply on the conditional provisional assisted living facility license:

a. **No new substantiated maltreatment allegations:** If any new investigations begin in the conditional provisional license period, and the allegations are substantiated, MDH may pursue additional enforcement actions up to and including immediate temporary suspension and revocation of the provisional license.

b. **No new admissions:** Warm Touch Home Care Inc. will not admit any new residents under its conditional provisional assisted living facility license until MDH removes the "no new admissions" condition. Warm Touch Home Care Inc. must provide the Department:

    i. A list of the names and birthdates of any individuals Warm Touch Home Care Inc. is currently in the process of admitting. These individuals will be able to continue the admittance process.

    ii. A list of all current residents including:
        1. Name and birthdate of each resident
        2. Current payment source for services
        3. If Elderly Waiver, the name and contact information of the care coordinator/case manager
        4. If the resident is not able to make informed decisions, the name of their representative and how to contact the representative

c. **Consultant:** Warm Touch Home Care Inc. will contract with an RN to provide consultation concerning all resident(s) to whom Warm Touch Home Care Inc. provides provisional licensed assisted living services under the conditional license. <u>The consultant must have access to all resident(s) receiving services from Warm Touch Home Care Inc.. The consultant will conduct initial and ongoing evaluations of the provider. Direct resident observation may be required based on the consultant's judgement or at the discretion of MDH</u>. The RN must not have any affiliation with Warm Touch Home Care Inc. and MDH must review the RN's credentials and approve the selection. Warm Touch Home Care Inc. is responsible for the expense of the contract with the RN. The main purpose of the consultant is to provide guidance to Warm Touch Home Care Inc. in an effort to help Warm Touch Home Care Inc. align their practices with the requirements of Minn. Stat. §§ 144G.01 – 144G.9999 and to provide oral and written reports to MDH noting progress toward substantial compliance and/or concerns about observations. Warm Touch Home Care Inc. will develop and implement policies, procedures, and processes specific to the offered services in accordance with the guidance provided by the consultant to ensure ongoing monitoring and substantial compliance with statutory

requirements.

d. Reports: The RN consultant will provide MDH with regular reports at intervals specified by MDH. Reports will begin on a weekly basis until MDH notifies Warm Touch Home Care Inc. and the RN consultant about a change. Each report will be electronically submitted to: Brandon Mueller, State Evaluation Team, Health Regulation Division, at brandon.w.mueller@state.mn.us and can be reached at 651-247-2064 (office) with questions about reports. The content of the reports will include information such as:

i. Progress towards correction of orders;
ii. Observations of staff delivering assisted living services and the level of competency observed;
iii. Conversations with residents and family members about satisfaction with assisted living services;
iv. Conversations with staff about their level of knowledge about the tasks they perform, the people they serve and the health professionals who delegate to them;
v. Overall impressions about the quality of the assisted living services delivered;
vi. Overall impressions about the dignity with which the residents and their family members are treated;
vii. Concerns; and
viii. Any other information requested by the Department or considered important by the RN consultant(s).

e. Monitoring visits: MDH may make unannounced monitoring visits to assess the progress of Warm Touch Home Care Inc. to correct the violations cited during the survey as well as to determine the overall practice of Warm Touch Home Care Inc. in meeting the needs of the people it serves. In addition, the Office of Ombudsman for Long-Term Care (OOLTC) may also make unannounced monitoring visits to determine the level of satisfaction of those people who receive provisional licensed assisted living services. The OOLTC will share their findings with MDH.

f. Follow-up survey: At the time of the follow-up survey, MDH may pursue additional enforcement actions, up to and including immediate temporary suspension or revocation of the provisional license if MDH identifies any level 3 or 4 violations or widespread care related violations.

g. Corrective Action Plan: Warm Touch Home Care Inc. will develop and work within a corrective action plan (CAP). The CAP is a working document that includes at least the following information:

i. A statement of the concern
ii. A description of what will happen to correct the concern

iii. A target date for when each correction will be complete
iv. Who is responsible to make sure it happens
v. Current status of correction work
vi. Description of a plan to monitor and ensure ongoing substantial compliance for each corrected order

RESULTS OF FOLLOW-UP EVALUATION DURING THE CONDITIONAL PROVISIONAL LICENSE PERIOD:
MDH will determine if Warm Touch Home Care Inc. is in substantial compliance based on the results of the follow up survey. MDH will make this determination within the 60-day conditional provisional license period. If MDH determines Warm Touch Home Care Inc. is in substantial compliance on the follow up survey, MDH will remove the conditions and grant the assisted living facility license to Warm Touch Home Care Inc.. If MDH determines Warm Touch Home Care Inc. is not in substantial compliance, MDH may deny the license pursuant to Minn. Stat. § 144G.16, Subd. 3 (b) (2).

REQUEST FOR RECONSIDERATION:
Pursuant to Minn. Stat. §144G.16, Subd. 4, if a provisional licensee whose assisted living facility license has been denied, or extended with conditions, disagrees with the action taken against the provisional license under this section, the provisional licensee may request a reconsideration no later than 15 calendar days after provisional licensee receives notice of the action. **This is your only ability to request a reconsideration under this enforcement action.**

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

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 Casey DeVries directly at: 651-201-5917.

Sincerely,

Rick Michals

Rick Michals, J.D.
Executive Regional Operations Manager

Minnesota Department of Health
Health Regulation Division

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40600	A. BUILDING: _____ B. WING _____	01/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	3225 EMERSON AVENUE SOUTH MINNEAPOLIS, MN 55408

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL40600015-0 On January 27, 2025, through January 29, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were four resident(s); four receiving services under the Provisional Assisted Living Facility 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 Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	

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0 480	Continued From page 1	0 480		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 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;	0 480		

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0 480	Continued From page 2 (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 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 January 27, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.	0 480		

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0 480	Continued From page 3 TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 485 SS=C	144G.41 Subdivision 1.a (a) Minimum requirements; required food services All assisted living facilities must offer to provide or make available 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) guidelines, including seasonal fresh fruit and fresh vegetables. The menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes. The facility must not require a resident to include and pay for meals in the resident's contract. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not require any resident to include and pay for meals as a part of their assisted living package fee for three of three residents (R1, R2, R3) 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	0 485		

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0 485	Continued From page 4 or has potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted to the assisted living facility (ALF) on September 19, 2024, and began receiving assisted living services. R1's [licensee] Assisted Living Contract signed September 19, 2024, page 12 included the following statement, "this Assisted Living Facility offers all of the following (included in the Month Base Fee): at least three meals daily with snacks available seven (7) days per week." R2 R2 was admitted to the ALF on August 9, 2024, and began receiving assisted living services. R2's [licensee] Assisted Living Contract signed August 9, 2024, page 12 included the following statement, "this Assisted Living Facility offers all of the following (included in the Month Base Fee): at least three meals daily with snacks available seven (7) days per week." R3 R3 was admitted to the ALF on August 7, 2024, and began receiving assisted living services. R3's [licensee] Assisted Living Contract signed August 7, 2024, page 12 included the following statement, "this Assisted Living Facility offers all of the following (included in the Month Base Fee): at least three meals daily with snacks available seven (7) days per week." On January 29, 2025, at 12:57 p.m., clinical nurse	0 485		

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0 485	Continued From page 5 supervisor/licensed assisted living director (CNS/LALD)-C stated the assisted living contract was signed when residents move into the facility. CNS/LALD-C stated that statement should not have been included in the contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post the 911 emergency number in common areas and near telephones provided by the assisted living facility. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 640		

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0 640	Continued From page 6 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 January 27, 2025, at 10:24 a.m., during a facility tour of the three-level home, in a small room next to the dining area on the main level, the surveyor observed a landline telephone on a small coffee table. There was no 911 telephone number posted near the landline telephone. On January 28, 2025, at 12:47 p.m., licensed assisted living director (LALD)-D stated the landline telephone was used by residents to make and receive telephone calls. LALD-D stated they were unaware of the required postings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently;	0 680		

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0 680	Continued From page 7 (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a 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: The licensee's emergency disaster preparedness plan dated May 18, 2024, lacked evidence of the following required content:	0 680		

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0 680	Continued From page 8 - population needs: independence, communication, transportation, supervision and medical care; - identify staff specific roles in another's absence through succession planning and delegation of authority; - procedures for tracking staff and patients; - policies and procedure for sheltering; - policies and procedures for medical documentation; - policies and procedures for volunteers; - arrangements with other facilities; - roles under a waiver declared by the secretary; - written communication plan; - names and contact information for staff entities providing services under agreement, residents physicians, other facilities, volunteers; - primary/alternative means for communication; - methods for sharing information; - sharing information on occupancy/needs and; - long-term care (LTC) family notifications. On January 29, 2025, at 1:00 p.m., clinical nurse supervisor/licensed assistance living director (CNS/LALD)-C stated they were responsible for the EPP. CNS/LALD-C stated they were aware of the required information for the EP Plan. CNS/LALD-C declined to answer the surveyor's questions about the EPP requirements. The licensee's Emergency Preparedness policy dated October 2, 2023, indicated the licensee would have an identified plan in place to assure the safety and well-being of clients and staff during periods of an emergency or disaster that disrupts services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 680		

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	40600	A. BUILDING: _____ B. WING _____	01/29/2025

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0 680	Continued From page 9 (21) days	0 680		
0 700 SS=D	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of three resident's (R1) personal health and medical information was kept private. 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 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 was admitted to the assisted living facility (ALF) on September 19, 2024, and began receiving assisted living services. R1's Assisted Living Service Plan dated September 19, 2024, indicated R1 received	0 700		

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0 700	Continued From page 10 assistance with medication setup, wound care, medication administration, housekeeping, laundry, and medical appointments. On January 28, 2025, at 7:05 a.m., in the dining room on the main level, the surveyor observed unlicensed personnel (ULP)-B looking at R1's electronic medication administration record (EMAR) on a computer program called RTask (a software program for medical information). ULP-B verified the medications that were to be administered to R1. Without securing the EMAR and with no other staff members, residents, or visitors in the room, ULP-B walked from the dining area, through the common area to R1's bedroom and entered R1's bedroom. R1 requested a glass of water from ULP-B. With the medical information still unsecured, ULP-B walked back through the common area, through the dining area into the kitchen and obtained a glass of water. With the medical information still unsecured, ULP-B walked through the dining area to the common area, entered R1's bedroom and administered the medications to R1. On January 28, 2025, at 9:50 a.m., ULP-B stated they were trained to keep medical information secure by closing RTask. ULP-B stated the reason for not securing the information was they were nervous. On January 28, 2025, at 9:56 a.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-C stated staff were trained to secure medical information by closing Rtask when not in use. CNS/LALD-C stated they were unsure why the medical information was not secured. The licensee's Privacy of Protected Health Information policy dated May 2, 2020, indicated	0 700		

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0 700	Continued From page 11 the licensee would protect the privacy of its client's personal health information. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 700		
0 775 SS=I	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with Minnesota State Fire Code under Minnesota Rules 7511. This had the potential to directly affect all residents, staff, and visitors. 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: On January 27. 2025, from approximately 10:58 a.m. to 1:08 p.m., the surveyor toured the facility with clinical nurse supervisor/licensed assisted living director (CNS/LALD)-C and owner/agent	0 775		

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0 775	Continued From page 12 (O/A)-D. During the tour, the surveyor observed the following: The front door of the facility was equipped with two turn locks. O/A-D was informed of the improper locking during the tour and instructed a maintenance worker to have the locks removed by the end of the tour. Surveyor confirmed that one of the turn locks had been removed. O/A-D opened windows in resident rooms during the survey and the surveyor measured the area of openable area. Resident room 4 and 5 are unoccupied, while resident rooms 1, 2, and 3 are occupied. Resident sleeping room 5, resident sleeping room 4, resident sleeping room 3 and resident sleeping room 1 contained a pair of windows with one window containing an air conditioning device which had been screwed into place. In these rooms, O/A-D opened the windows that were not equipped with air conditioning unit and the surveyor measured the openable area. The openable area was not sufficient for these windows to meet requirements. The air conditioning units were unscrewed and removed from the adjacent windows in these rooms and the openable area was measured by the surveyor and the windows were compliant with minimum openable area. Adequately sized emergency escape and recue openings are required in all resident sleeping rooms, and these must not be impeded by air conditioning units or other obstructions. Egress windows in resident sleeping room 2 and resident sleeping room 1 were significantly difficult to open and required special knowledge and effort to open. O/A-D was unable to operate and open the window and requested a maintenance worker open the windows. Egress	0 775		

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0 775	Continued From page 13 windows must be readily openable during normal operation to allow escape during emergency evacuation. There was evidence of burn marks on the floor of resident room 2, which could present a risk for fire. A space heater was present in resident room 2 that was operated without adequate clearance per manufacturer specifications. Extension cords were in use in lieu of permanent wiring in resident room 3 and resident room 1. These deficient conditions were visually verified by CNS/LALD-C and O/A-D accompanying on the tour and O/A-D stated they understood requirements. TIME PERIOD FOR CORRECTION: Two (2) days	0 775		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so	0 780		

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0 780	Continued From page 14 that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain required smoke alarms. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On January 27. 2025, from approximately 10:58 a.m. to 1:08 p.m., the surveyor toured the facility with clinical nurse supervisor/licensed assisted living director (CNS/LALD)-C and owner/agent (O/A)-D. During the tour, the surveyor observed the following: The smoke alarm in resident room 1 was covered over in tape and other materials. Smoke alarms should be maintained in proper working order free	0 780		

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0 780	Continued From page 15 of obstruction. O/A-D visually verified the above listed deficient while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) 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. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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).	0 800		

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0 800	Continued From page 16 The findings include: On January 27. 2025, from approximately 10:58 a.m. to 1:08 p.m., the surveyor toured the facility with clinical nurse supervisor/licensed assisted living director (CNS/LALD)-C and owner/agent (O/A)-D. During the tour, the surveyor observed the following: The paint on the ceiling in the office was chipping and flaking. The door to the supply closet in the front entry way is cracked and deteriorated. Several window screens throughout the facility were missing including resident room 2, resident room resident room 5 and near front entry. An electrical outlet fixture was loose and not properly attached to the wall in the ground level bathroom. Several window frames were deteriorated and had holes including windowsills in resident room 2, and resident room 5. A lamp in resident room 3 had a broken glass cover that had exposed sharp edges and glass shards. There was a hole in the wall in resident room 1 along the base of the wall which exposed the lathe and plaster beneath. Walls should be maintained free of damage and holes. During the facility tour on January 27, 2025, O/A-D verified the above listed physical environment observations while accompanying on the tour.	0 800		

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0 800	Continued From page 17 TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) 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.	0 810		

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0 810	Continued From page 18 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with required content. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive 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 January 27, 2025, at approximately 12:30 p.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-C and owner/agent (O/A)-D provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. The licensee FSEP failed to include the following: The included floor plans in the FSEP included inaccuracies with the facility such as marking the garage as a primary marked exit area and indicated the presence of a fire extinguisher under the stairs to the basement, which was not present in that location in the facility. The FSEP provided resident room numbers for only a small portion of resident room on floor plans, and these numbers did not accurately	0 810		

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0 810	Continued From page 19 correspond to numbers provided on the resident room doors in the facility. All resident rooms should be numbered, and numbers should be consistent, and match provided documents. The FSEP did not include procedures for resident movements during an evacuation. The FSEP included information on fire drills that occurred on 6/5/24 and 1/7/25, but no other recorded fire drills were included in FSEP binder. CNS/LALD-C and O/A-D searched for further documents of drills conducted and stated that they were unable to locate them. As the review continued, CNS/LALD-C printed out further documents which contained exactly the same information, just with separate dates. All of the time and information provided was exactly the same and the drill records did not have specific information about what staff was involved nor how the drills were conducted. Evacuation drills should occur at least once every other month and twice per year per shift. During the record review and interview on January 27, 2025, CNS/LALD-C and O/A-D verified the above listed documents were absent from the FSEP. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01530 SS=D	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics	01530		

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01530	Continued From page 20 specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure direct-care staff received at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date for one of three employees (unlicensed personnel (ULP)-B). 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	01530		

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01530	Continued From page 21 situation has occurred only occasionally) The findings include: ULP-B was hired October 6, 2024, to provide direct care services. ULP-B's timesheet dated November 25, 2024, through February 2, 2025, indicated ULP-B had worked a total of 219 hours. ULP-B's employee file contained a document titled My Transcript. The document indicated ULP-B had received five hours of dementia training. ULP-B lacked the required eight hours of dementia training. On January 29, 2025, at 10:59 a.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-C stated dementia care training was completed when staff were hired. CNS/LALD-D stated they could not remember the exact number of hours of dementia training that was required. The licensee's Dementia Education policy dated February 27, 2021, indicated all staff providing care will be knowledgeable in how to provide safe, effective services related to dementia. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted	01760		

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01760	Continued From page 22 living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain current medication orders for one of three residents (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, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 was admitted to the assisted living facility (ALF) on August 9, 2024, and began receiving assisted living services. R2's Assisted Living Service Plan dated August 9, 2024, indicated R2 received assistance with medication administration.	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40600	A. BUILDING: _____ B. WING _____	01/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	3225 EMERSON AVENUE SOUTH MINNEAPOLIS, MN 55408

(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
01760	Continued From page 23 R2's Medication Administration Record dated January 1, 2025, through January 28, 2025, indicated R2 received the following medications: buprenorphine and naloxone 8-2 mg 1 tablet three times daily, carvedilol 25 mg 1 tablet twice daily, Eliquis 5 mg 1 tablet twice daily, isosorbide mononitrate extended release (ER) 60 mg 1 tablet once daily, nifedipine ER 90 mg 1 tablet once daily, potassium chloride supplement 20 milliequivalent (meq) once daily, torsemide 20 mg 1 tablet once daily, albuterol 2 puffs every 4 hours as needed, Lantus Solostar 100 units (u)/milliliters inject 26 units subcutaneously (under the skin) once daily, diclofenac 1 percent (%) apply to lower back as needed, loperamide 2 mg 1 capsule every 3 hours as needed, loperamide 2 mg capsule every 3 hours as needed, Narcan 4 mg use 1spray in a nostril as needed, and Tylenol 325 mg 2 tablets by mouth every six hours as needed. R2's record contained 10 individual documents titled Prescription Transfer Report dated September 11, 2024, for the following medications which lacked a medical providers manual or electronic signature: Eliquis 5 mg 1 tablet twice daily, isosorbide mononitrate extended release (ER) 60 mg 1 tablet once daily, nifedipine ER 90 mg 1 tablet once daily, Narcan 4 mg use 1spray in a nostril as needed, albuterol 2 puffs every 4 hours as needed, and Lantus Solostar 100 units (u)/milliliters inject 26 units subcutaneously (under the skin) once daily. R2's record lacked manual or electronic signature for the following medications: carvedilol 25 mg 1 tablet twice daily, potassium chloride supplement 20 milliequivalent (meq) once daily, torsemide 20 mg 1 tablet once daily, diclofenac 1 percent (%) apply to lower back as needed and, loperamide 2	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40600	A. BUILDING: _____ B. WING _____	01/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	3225 EMERSON AVENUE SOUTH MINNEAPOLIS, MN 55408

(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
01760	Continued From page 24 mg 1 capsule every 3 hours as needed, loperamide 2 mg capsule every 3 hours as needed, and Tylenol 325 mg 2 tablets by mouth every six hours as needed. In addition, there was a prescription for furosemide 40 mg, but it was not on the MAR. On January 28, 2025, at 11:22 a.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-C stated they would receive a copy of each prescription for the resident from the pharmacy. CNS/LALD-C stated they were aware a copy of each prescription was required to be maintained on file and believed the Transfer Prescription Transfer Report documents met that requirement. The licensee's Prescriber Orders dated October 2, 2020, indicated licensee would maintain a current written or electronic record prescription for all prescribed medications managed for the client. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01760		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by:	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40600	A. BUILDING: _____ B. WING _____	01/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	3225 EMERSON AVENUE SOUTH MINNEAPOLIS, MN 55408

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01880	Continued From page 25 Based on observation, interview, and record review, the licensee failed to store prescription medication securely to permit only authorized personnel to have access. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). R3's Assisted Living Service Plan dated August 7, 2024, indicated R3 received assistance with medication administration. R3's Medication Management Services - Addendum to Service Plan dated August 7, 2024, indicated licensee would store R3's medications. R3's Medication Administration Record dated January 1, 2025, through January 28, 2025, indicated R3 received the following medications: amlodipine 5 milligram (mg) 1 tablet once daily, atorvastatin 20 mg 1 tablet once daily, fluoxetine 20 mg 1 capsule once daily, fluoxetine 60 mg 1 tablet, and take with fluoxetine 20 mg capsule, vitamin D3 50 micrograms (mcg) capsule once daily, pantoprazole 40 mg once daily, quetiapine 50 mg extended release (ER) 50 mg once daily quetiapine 300 mg 1 tablet, and take with quetiapine 50 mg. On January 27, 2025, at 10:26 a.m., on the upper level of the assisted living facility, in R3's room, the surveyor observed an opened medication bubble pack that contained the following:	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40600	A. BUILDING: _____ B. WING _____	01/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	3225 EMERSON AVENUE SOUTH MINNEAPOLIS, MN 55408

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01880	Continued From page 26 - one capsule with the identifier of E 91 that Drugs.com website indicated was fluoxetine 20 mg; - R333 which RXlist.com website identified as pantoprazole 40 mg; and - F60 which RXlist.com website identified as fluoxetine 60 mg. On the floor was a white pill with the identifiers of A 54 which drugs.com website identified as benazepril hydrochloride 40 mg. On January 28, 2025, at 11:22 a.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-C stated staff were trained to observe residents receive medications. CNS/LALD-C stated those medications should not have been in R3's bedroom and that situation should not have occurred. The licensee's Storage/Control of Medications policy dated October 2, 2020, indicated licensee would only allow authorized personnel to have access to stored medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
02410 SS=F	144G.91 Subd. 13 Personal and treatment privacy (a) Residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Staff must respect the privacy of a resident's space by knocking on the door and seeking consent before entering, except in an emergency or unless otherwise documented in	02410		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40600	A. BUILDING: _____ B. WING _____	01/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARM TOUCH HOME CARE INC	3225 EMERSON AVENUE SOUTH MINNEAPOLIS, MN 55408

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02410	Continued From page 27 the resident's service plan. (b) Residents have the right to have and use a lockable door to the resident's unit. The facility shall provide locks on the resident's unit. Only a staff member with a specific need to enter the unit shall have keys. This right may be restricted in certain circumstances if necessary for a resident's health and safety and documented in the resident's service plan. (c) Residents have the right to respect and privacy regarding the resident's service plan. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide a working locking mechanism on a communal bathroom used by all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On January 28, 2025, at 10:29 a.m., on the main level was R2's bedroom, and a common area with a door leading from the common area into a bathroom. In the bathroom was a door that led	02410		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40600	A. BUILDING: _____ B. WING _____	01/29/2025

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02410	Continued From page 28 into R2's bedroom. There was no lock on the door that led from the bathroom into R2's bedroom. On January 28, 2025, at 10:29 a.m., unlicensed personnel (ULP)-B stated the bathroom was a communal bathroom used by residents and staff. On January 28, 2025, at 12:27 p.m., owner/agent (O/A)-D stated the bathroom was communal and was used by residents and staff. O/A-D stated the door from the bathroom to R2's bedroom was required to be lockable and was unaware the locking mechanism was not working. The surveyor first observed the bathroom door lacked a locking mechanism on January 28, 2024. During an additional interview with management personnel on January 28, 2024, at approximately 12:30 p.m., the surveyor pointed out the missing lock and conducted an interview about it. Despite the conversation that took place the previous day, the surveyor observed the bathroom door still lacked a locking mechanism on January 29, 2024. On January 31, 2025, at 12:51 p.m., the licensee emailed additional information to the survey supervisor, which was considered in the review of this deficient practice. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02410		

Minnesota Department of Health
Food, Pools, and Lodging Services
625 Robert Street North
St. Paul
6512014500

Type: Full
Date: *01/27/25*
Time: 13:15:13
Report: 1029251031

Food and Beverage Establishment Inspection Report

Location:

WARM TOUCH HOME CARE INC
3225 EMERSON AVENUE SOUTH
Minneapolis, MN55408
Hennepin County, 27

Establishment Info:

ID #: 0043952
Risk:
Announced Inspection: Yes

License Categories:

Expires on: 12/31/24

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.

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

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

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

RAW ANIMAL PROTEINS NOT ADEQUATELY SEPARATED FROM READY TO EAT FOODS IN REFRIGERATOR. REP INSTRUCTED TO HOLD IN DIFFERENT FASHION TO ELIMINATE THE POSSIBILITY OF CROSS-CONTAMINATION. FOOD SEPARATION AND STRATIFICATION INFORMATION PROVIDED WITH REPORT.

Comply By: 01/27/25

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.

DATE MARKING ABSENT FROM OPEN PACKAGES OF SHREDDED CHEESE AND HOT DOGS. DATE MARKING REQUIREMENTS AND THE DANGERS OF L. MONOCYTOGENES COVERED WITH REP. DATE MARKING INFORMATION PROVIDED WITH REPORT.

Comply By: 01/27/25

Type: Full
Date: *01/27/25*
Time: 13:15:13
Report: 1029251031
WARM TOUCH HOME CARE INC

Food and Beverage Establishment Inspection Report

4-300 Equipment Numbers and Capacities

4-302.12B ***** Priority 2 *****

MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.

NO SMALL DIAMETER PROBE THERMOMETER. REP TOOK PICTURE OF SMALL DIAMETER PROBE THERMOMETER DURING INSPECTION. REP INSTRUCTED TO OBTAIN SMALL DIAMETER PROBE THERMOMETER.

Comply By: 02/28/25

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

NEBIYU ASHAGRE WITH SERVSAFE COMPLETION CERTIFICATE 3/17/22-3/17/27 BUT NO CFPM. REP INSTRUCTED TO HAVE ESTABLISHMENT EMPLOY CFPM. CFPM CERTIFICATE ATTAINMENT INFORMATION PROVIDED WITH REPORT.

Comply By: 03/28/25

6-100 Physical Facility Construction Materials

6-101.11A1

MN Rule 4626.1325A1 Provide smooth, durable, and easily cleanable floor, wall and ceiling surfaces.

PONY WALL WITH CRACKING AND CHIPPING. REP INSTRUCTED TO KEEP CLEAN AND IN GOOD CONDITION AND TO REPAIR OR REPLACE IF WALL CAUSES UNSANITARY CONDITIONS OR HARBORAGE PEST ISSUES, OR IF A REMODEL OCCURS.

Comply By: 03/28/25

Surface and Equipment Sanitizers

HOT WATER: = at 160 Degrees Fahrenheit
Location: DISHWASHER
Violation Issued: No

Food and Equipment Temperatures

Process/Item: COLD HOLDING/MILK
Temperature: 39 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: No

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

TOPICS COVERED:
- HIGH HEAT AND CHEMICAL SANITIZING
- TEMPERATURE CONTROL
- PROTECTION FROM CONTAMINATION
- EMPLOYEE ILLNESS LOGGING
- ILLNESS EXCLUSION REQUIREMENTS
- REPORTING REQUIREMENTS

Food and Beverage Establishment Inspection Report

- COMMON FOODBORNE ILLNESS PATHOGENS
- VOMIT/FECAL MATTER CLEANUP PROCEDURE
- DATE MARKING AND LISTERIA MONOCYTOGENES
- HIGHLY SUSCEPTIBLE POPULATION
- EMPLOYEE HYGIENE AND HANDWASHING
- GLOVE/UTENSIL USE AND BARE-HAND-CONTACT
- PEST CONTROL

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 1029251031 of 01/27/25.

Certified Food Protection Manager: VACANT

Certification Number: _____ Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed: _____

ZAINABU OCHANDA
RN/LALD

Signed: Trevor McCliment

Trevor McCliment
Public Health Sanitarian
Metro District Office
651-201-3957
trevor.mccliment@state.mn.us

Food Establishment Inspection Report

Report #: 1029251031

DEPARTMENT OF HEALTH

Minnesota Department of Health
Food, Pools, and Lodging Services
625 Robert Street North
St. Paul

No. of RF/PHI Categories Out	3	**Date**	01/27/25
No. of Repeat RF/PHI Categories Out	0	**Time In**	13:15:13
Legal Authority MN Rules Chapter 4626		**Time Out**	

WARM TOUCH HOME CARE INC	**Address** 3225 EMERSON AVENUE SOUTH	**City/State** Minneapolis, MN	**Zip Code** 55408	**Telephone**
License/Permit # 0043952	**Permit Holder**	**Purpose of Inspection** Full	**Est Type**	**Risk Category**

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

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

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

Risk factors (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is **not** in compliance — Mark "X" in appropriate box for COS and/or R — **COS=** corrected on-site during inspection **R=** repeat violation

		Safe Food and Water	COS	R
30	IN OUT N/A	Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32	IN OUT N/A	Variance obtained for specialized processing methods		
		Food Temperature Control		
33		Proper cooling methods used; adequate equipment for temperature control		
34	IN OUT N/A N/O	Plant food properly cooked for hot holding		
35	IN OUT N/A N/O	Approved thawing methods used		
36	X	Thermometers provided & accurate		
		Food Identification		
37		Food properly labled; original container		
		Prevention of Food Contamination		
38		Insects, rodents, & animals not present		
39		Contamination prevented during food prep, storage & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

		Proper Use of Utensils	COS	R
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
		Utensil Equipment and Vending		
47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48		Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
		Physical Facilities		
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55	X	Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls: _____

Person in Charge (Signature) **Date:** 02/07/25

Inspector (Signature) Trevor McClimont