



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

May 8, 2025

Licensee

New Hope Health Care LLC
3812 Bass Lake Road North
Brooklyn Center, MN 55429

RE: Project Number(s) SL36404015

Dear Licensee:

On April 14, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on October 3, 2024. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in blue ink, appearing to read 'Jess Schoenecker'.

Jess Schoenecker, Supervisor
State Evaluation Team
Email: Jess.Schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

HHH



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

February 24, 2025

Licensee

New Hope Health Care LLC
3812 Bass Lake Road North
Brooklyn Center, MN 55429

RE: Project Number(s) SL36404015

Dear Licensee:

On January 15, 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 on October 3, 2024. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the October 3, 2024 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on October 3, 2024, found not corrected at the time of the January 15, 2025, follow-up survey and/or subject to penalty assessment are as follows:

0820 - Fire Protection And Physical Environment - 144g.45 Subd. 2 (g)

The details of the violations noted at the time of this follow-up survey completed on January 15, 2025 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

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

DOCUMENTATION OF ACTION TO COMPLY

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

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>

We urge you to review these orders carefully. If you have questions, please contact Casey DeVries at 651-201-5917.

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,

A handwritten signature in black ink that reads "Casey DeVries". The signature is written in a cursive, flowing style.

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

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36404	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 01/15/2025
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3812 BASS LAKE ROAD NORTH BROOKLYN CENTER, MN 55429		
(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 In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been 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: SL36404015-1 On January 15, 2025, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on October 3, 2024. At the time of the survey, there were five residents; five receiving services under the Assisted Living license. As a result of the follow-up survey, the following orders were reissued.	{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.		

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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{0 470}	Continued From page 1	{0 470}			
{0 470} SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by:	{0 470}			
{0 480} SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food	{0 480}	Not reviewed during this survey.		

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

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{0 480}	Continued From page 3 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:	{0 480}	Not reviewed during this survey.		
{0 510} SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by:	{0 510}			
{0 640} SS=F	144G.42 Subd. 7 Posting information for reporting suspected c	{0 640}			

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{0 640}	Continued From page 4 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:	{0 640}	Not reviewed during this survey.		
{0 650} SS=D	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living	{0 650}			

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{0 650}	Continued From page 5 services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by:	{0 650}	Not reviewed during this survey.		
{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:	{0 680}	Not reviewed during this survey.		
{0 700} SS=F	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:	{0 700}			
{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:	{0 800}			
{0 810} SS=F	144G.45 Subd. 2 (b-f) Fire protection and	{0 810}	Not reviewed during this survey.		

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{0 810}	Continued From page 7 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. This MN Requirement is not met as evidenced by:	{0 810}	Not reviewed during this survey.		

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{0 820}	Continued From page 8	{0 820}			
{0 820} SS=F	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure physical facility elements did not constitute a distinct hazard to life. The licensee failed to provide resident bedrooms with the minimum window opening meeting the minimum state standard for egress. This had the potential to affect some 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 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	{0 820}			

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{0 820}	Continued From page 9 On January 15, 2025, at 10:06 a.m., the surveyor observed the following windows: OCCUPIED SLEEPING ROOM: Bedroom 3: Window measured 34 inches clear width, 16.5 inches clear height, and 563 square inches total open area. UNOCCUPIED SLEEPING ROOM: Bedroom 1: Window measured 33.5 inches clear width, 17 inches clear height, and 569.5 square inches total open area. The windows in bedrooms 1 and 3 did not meet the minimum requirements for opening height. The windows in bedrooms 1 and 3 did not meet the minimum requirements for total openable area. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. On January 15, 2025, at 10:10 a.m., contractor person (CP)-M stated they were at the facility to obtain window measurements. CP-M stated the licensee had contacted them December 9, 2024, to start the process of ordering new windows. CP-M stated the windows had not been ordered. On January 15, 2025, at 10:34 a.m., the surveyor observed firelogs completed by staff for the assisted living facility. On January 15, 2025, at 2:16 p.m., owner/agent (O/A)-A stated they were aware of the required timeframe to replace the windows. O/A-A stated	{0 820}			

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{0 820}	Continued From page 10 the windows were not replaced. O/A-A stated their plan of correction was to complete a safety check on each room every 15 minutes. O/A-A stated they had contacted multiple companies for estimates and were, "too high." O/A-A stated they want to be compliant but wanted to save money. No further information was provided.	{0 820}			
{0 950} SS=B	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the	{0 950}			

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{0 950}	Continued From page 11 name and contact information of the designated representative. This MN Requirement is not met as evidenced by:	{0 950}	Not reviewed during this survey.		
{01820} SS=E	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by:	{01820}			
{01870} SS=D	144G.71 Subd. 18 Medications provided by resident or family me When the assisted living facility is aware of any medications or dietary supplements that are being used by the resident and are not included in the assessment for medication management services, the staff must advise the registered nurse and document that in the resident record. This MN Requirement is not met as evidenced by:	{01870}			
{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	{01880}			

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(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	
{01880}	Continued From page 12 according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by:	{01880}	Not reviewed during this survey.		
{02290} SS=F	144G.91 Subd. 2 Legislative intent The rights established under this section for the benefit of residents do not limit any other rights available under law. No facility may request or require that any resident waive any of these rights at any time for any reason, including as a condition of admission to the facility. This MN Requirement is not met as evidenced by:	{02290}			
{02310} SS=F	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by:	{02310}			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

November 12, 2024

Licensee

New Hope Health Care LLC
3812 Bass Lake Road North
Brooklyn Center, MN 55429

RE: Project Number(s) SL36404015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on October 3, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement.

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;

Level 3: a fine of \$3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.

Level 4: a fine of \$5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

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

St - 0 - 2320 - 144g.91 Subd. 4 (b) - Appropriate Care And Services - \$3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$6,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a

hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. to submit a hearing request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

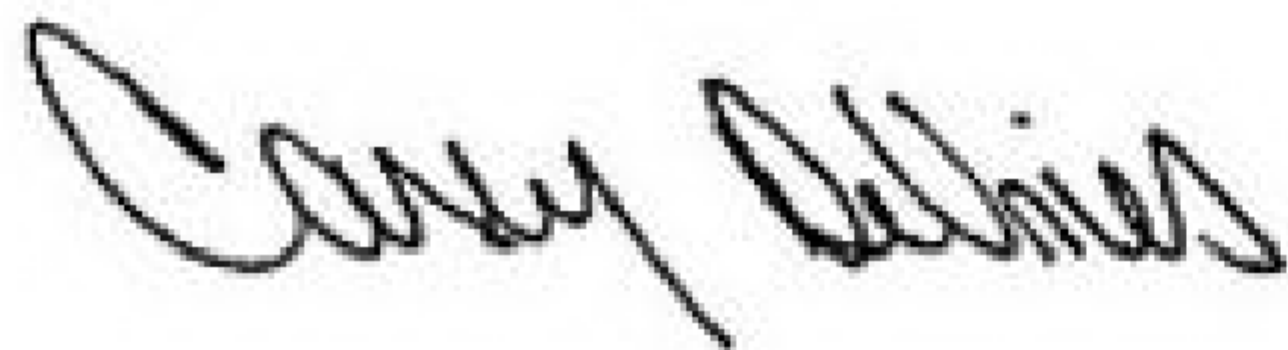
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **<https://forms.office.com/g/Bm5uQEpHV>**. 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

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36404	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/03/2024
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3812 BASS LAKE ROAD NORTH BROOKLYN CENTER, MN 55429		
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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: SL34606015-0 On September 30, 2024, through October 3, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were five resident(s); five receiving services under the Assisted Living Facility license. An immediate order for correction was identified on September 30, 2024, issued for SL34606015-0, tag identification 2320. An immediate order for correction was identified on October 1, 2024, issued for SL34606015-0, tag identification 1290. An immediate order for correction was identified on October 2, 2024, issued for SL34606015-0, tag identification 0820. During the survey, the licensee took action to mitigate the immediate risks. However,	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.		

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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0 000	Continued From page 1	0 000			
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and	0 470			

Minnesota Department of Health

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0 470	Continued From page 2 implement a written staffing plan that included an evaluation completed by the clinical nurse supervisor (CNS) (as indicated in Minnesota Administrative Rule 4659.0180) at least twice a year. 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: On September 30, 2024, at 9:38 a.m., during the entrance conference, owner/agent (O/A)-A stated two unlicensed personnel (ULP) and house manager worked from 7:00 a.m., until 3:00 p.m., and two ULPs worked from 3:00 p.m., until 11:00 p.m., and 11:00 p.m., until 7:00. The CNS was available 24 hours per day, seven days per week. On September 30, 2024, at 10:25 a.m., during a facility tour, the surveyor observed a document titled [licensee] Staffing Plan updated May 6, 2024, posted on a bulletin board in the dining area. The document lacked a signature and date from the CNS. On September 30, 2024, at 12:18 p.m., CNS-C stated they were unaware the written staffing plan had to be evaluated and signed by the CNS twice a year. On September 30, 2024, at 4:01 p.m., licensed	0 470			

Minnesota Department of Health

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0 470	Continued From page 3 assisted living director (LALD)-D stated they were providing coverage for LALD-B who was on leave from the licensee. On October 2, 2024, at 9:32 a.m., LALD-D stated they were aware the staffing plan was required to be evaluated and signed by the CNS twice a year and was unsure why that had not been completed. The licensee's policy titled Staffing dated April 13, 2022, indicated the CNS would create a staffing plan that is reviewed twice a year. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470			
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a	0 480			

Minnesota Department of Health

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0 480	Continued From page 4 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 September 30, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program that complied with accepted health care, medical	0 510			

Minnesota Department of Health

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0 510	Continued From page 5 and nursing standards for infection control related to gloving and hand hygiene for one of three staff (unlicensed personnel (ULP)-G). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On September 30, 2024, at 1:31 p.m., the surveyor observed unlicensed personnel ULP-G place a pair of gloves on and enter R3's room. ULP-G stated to R3 they wanted to check the adult brief for a bowel movement. ULP-G pulled down the bedcover, rolled R3 on their side, pulled a section of the brief away from the skin, looked into the adult brief, and rolled R3 back. ULP-G stated there was no soiling to the adult brief. Without removing gloves or performing hand hygiene, ULP-G walked out of R3's room into the kitchen. Without performing hand hygiene, ULP-G removed the pair of gloves, and placed a new pair of gloves on. ULP-G walked back into R3's room and asked R3 if they wanted the head of bed raised. R3 stated no. ULP-G left R3's room, immediately removed the gloves, walked to the kitchen, placed the gloves into a trash can, walked downstairs to the basement and performed hand hygiene in the laundry room. On September 30, 2024, at 1:39 p.m., ULP-G stated the registered nurse (RN) trained them to wash hands before and after glove removal.	0 510			

Minnesota Department of Health

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0 510	Continued From page 6 ULP-G stated they washed their hands after removing the gloves. On September 30, 2024, at 1:41 p.m., the surveyor observed owner/agent (O/A)-A state to ULP-G to respond to questions truthfully to the surveyor. On September 30, 2024, at 1:42 p.m., ULP-G stated they did forget to wash hands after glove removal. On October 3, 2024, at 10:09 a.m., clinical nurse supervisor (CNS)-C stated staff were trained to wash hands before and after glove removal. CNS-C stated they did not know why ULP-G did not wash hands, and that situation should not have occurred. The licensee's Infection Control policy dated April 13, 2022, indicated [licensee] would observe precautions for the assisted living as identified by the Center for Disease Control. The policy indicated hand hygiene should be performed before and after treatments and after glove removal. The CDC's Hand Hygiene dated February 27, 2024, recommends washing hands after touching a patient, or patient surroundings and immediately after glove removal. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510			
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c	0 640			

Minnesota Department of Health

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0 640	Continued From page 7 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 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 September 30, 2024, at 10:25 a.m., in the lower level of this split-level home, the surveyor observed a common area with a television, a sofa and a small television console. On the television console were two landline telephones. There	0 640			

Minnesota Department of Health

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0 640	Continued From page 8 were no 911 notices close to the landline telephone. On September 30, 2024, at 4:01 p.m., licensed assisted living director (LALD)-D stated they were providing coverage for LALD-B who was on leave from the licensee. On September 30, 2024, at 11:50 a.m., unlicensed personnel (ULP)-H stated the landline telephone was used by staff and residents. On October 2, 2024, at 11:31 a.m., LALD-D stated the landline telephones were used by residents and they were aware of the requirement to post the 911 emergency number close to the landline telephone. LALD-D was unsure why the 911 was not displayed by the landline telephone. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640			
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including	0 650			

Minnesota Department of Health

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0 650	Continued From page 9 qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records included all required content for one of three employees (unlicensed personnel/house manager (ULP/HM)-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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 licensee's Employee List indicated ULP/HM-E was hired September 29, 2021, to provide direct care services to residents. ULP/HM-E's employee file lack the following content; -annual reviews performed by the supervisor. On October 3, 2024, at 8:13 a.m., owner/agent (O/A)-A stated the clinical nurse supervisor (CNS)	0 650			

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3812 BASS LAKE ROAD NORTH BROOKLYN CENTER, MN 55429			
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0 650	Continued From page 10 and the owner were responsible for completing the annual reviews. O/A-A stated they were aware of the requirement, and was unsure why the documentation was not available. The licensee's Performance Evaluation policy dated April 13, 2022, indicated all employee's, individual contractors, and regularly scheduled volunteers at the facility would receive an annual review and the documentation would be stored in the employee record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650			
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	0 680			

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0 680	Continued From page 11 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 (EP) plan 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 August 1, 2024, lacked evidence of the following required content: -risk assessment of equipment/utility failures, interruption to normal supply of essential resources and medical supplies; -subsistence needs for staff and patients; -procedures for tracking of staff and patients; -policies and procedures for medication documentation that preserves resident information; -protects confidentiality, and secures and maintains availability of records;	0 680			

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0 680	Continued From page 12 -arrangements with other facilities; -emergency official contact information; -name and location of facility receiving relocated residents; -sharing information on occupancy/needs; -long-term care (LTC) family notifications, and; -emergency preparation and testing requirements. On September 3, 2024, at 11:40 a.m., owner/agent (O/A)-A stated they were responsible for the EP plan and was unsure why it was missing content. O/A-A stated the EP Plan should be available for staff at all times. The licensee's Emergency Preparedness policy dated April 13, 2022, indicated the licensee would have a plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 700 SS=F	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	0 700			

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0 700	Continued From page 13 by: Based on observation, interview, and record review, the licensee failed to ensure personal health and medical information was kept private for five of five residents (R1, R2, R3, R4, R5). 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). R1 was admitted to the licensee on December 4, 2023, and began to receive assisted living services. R2 was admitted to the licensee on June 1, 2024, and began to receive assisted living services. R3 was admitted to the licensee on November 8, 2024, and began to receive assisted living services. R4 was admitted to the licensee on April 17, 2024, and began to receive assisted living services. R5 was admitted to the licensee on February 2, 2024, and began to receive assisted living services. On October 2, 2024, at 8:13 a.m., the upper level of the split-level home consisted of a common area, a combined kitchen and dining area, a hallway leading to a medication closet, a bathroom and four resident rooms. In the kitchen	0 700			

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0 700	Continued From page 14 and dining area was a small counter next to the refrigerator. Located on top of the counter were five clear plastic folders. Each folder had the resident first and last name for R1, R2, R3, R4 and R5 on the front of the clear plastic folder. In each folder was a printed medication administration record (MAR). The surveyor observed unlicensed personnel/house manager (ULP/HM)-E remove the printed MAR for R1 to give to ULP-G for medication administration. The medical information was not secured by the licensee as it was located in the common area accessible to staff, residents, and visitors. On October 3, 2024, at 8:36 a.m., owner/agent (O/A)-A stated resident health and medical information was required to be secured and to only allow staff to access the information. O/A-A stated staff were trained to keep resident medical information locked in the medication closet. O/A-A stated the medical documentation should not have been left out and it was an oversight. The licensee's Privacy of Protected Health Information policy dated April 13, 2022, indicated the licensee would protect the privacy of its resident's personal health information. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 700			
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	0 800			

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0 800	Continued From page 15 good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the 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. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 October 02, 2024, at 10:20 a.m. to 11:45 a.m., surveyor toured the facility with unlicensed personnel/house manager (ULP/HM)-E. The following was observed. GENERAL MAINTENANCE: Carpet is soiled on the stairs going to the basement. Hole in the wall in bedroom #1.	0 800			

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0 800	Continued From page 16 Smoking Areas: It was observed that cigarette butts were found in a plastic water bottle in the backyard. The surveyor explained to the ULP/HM-E, that all cigarette butts shall be properly discarded into an approved container and that cigarette smoking should take place outside in the designated area away from the structure. ULP/HM-E stated they understood the above-listed deficiencies. TIME PERIOD FOR CORRECTION: twenty-one (21) days	0 800			
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter.	0 810			

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0 810	Continued From page 17 (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training and drills. This had 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 October 01, 2024, at 12:30 p.m., unlicensed personnel/house manager (ULP/HM)-E provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and	0 810			

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0 810	Continued From page 18 evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The FSEP (fire safety and evacuation plan) included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate) and was very basic. The provided FSEP was from a third-party provider and had not been updated to meet the specific layout of this facility and provide complete actions for employees to take in the event of a fire or similar emergency. Emergency evacuation map did not show location and number of resident rooms. Emergency evacuation map did not have bedroom# 1,2,3,4 and 5 included on the emergency evacuation map. TRAINING: The licensee failed to provide evacuation training to staff and residents as required. ULP-E stated that training were being done but lacked documentation. Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training and drills. This had 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	0 810			

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0 810	Continued From page 19 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 October 01, 2024, at 12:30 p.m., unlicensed personnel/house manager (ULP/HM)-E provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The FSEP (fire safety and evacuation plan) included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate) and was very basic. The provided FSEP was from a third-party provider and had not been updated to meet the specific layout of this facility and provide complete actions for employees to take in the event of a fire or similar emergency. Emergency evacuation map did not show location and number of resident rooms. Emergency evacuation map did not have bedroom# 1,2,3,4 and 5 included on the emergency evacuation map. TRAINING and Drills: The licensee failed to provide evacuation training	0 810			

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0 810	Continued From page 20 to staff and residents as required. ULP-E stated that training were being done but lacked documentation. ULP/HM-E stated they understood the areas of their policy that were incomplete and would work on bringing them into compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
0 820 SS=I	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure physical facility elements did not constitute a distinct hazard to life. The licensee failed to provide resident bedrooms with the minimum window opening meeting the minimum state standard for egress. This had the potential to affect some residents, staff, and visitors.	0 820	During the survey, the licensee took action to mitigate the immediate risk. However, noncompliance remained, and the scope and level remain unchanged.		

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0 820	Continued From page 21 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 October 01, 2024, at 10:20 a.m. to 11:50 a.m., surveyor toured the facility with unlicensed personnel/house manager (ULP/HM)-E. During the tour, survey staff asked HM-C to open the windows in the resident bedrooms for measurement. The noncompliant measurements were as follows: OCCUPIED SLEEPING ROOM: Bedroom 3: Window measured 34 inches clear width, 16.5 inches clear height, and 563 square inches total open area. UNOCCUPIED SLEEPING ROOM: Bedroom 1: Window measured 33.5 inches clear width, 17 inches clear height, and 569.5 square inches total open area. The windows in bedrooms 1 and 3 did not meet the minimum requirements for opening height. The windows in bedrooms 1 and 3 did not meet the minimum requirements for total openable area. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no	0 820			

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0 820	Continued From page 22 less than 648 square inches total of openable area (4.5 square feet) for the window. Survey staff explained to ULP/HM-E that at least one window in each bedroom in a state-licensed facility must meet the minimum state fire code standard for an egress window to be a complying bedroom for resident occupancy. TIME PERIOD FOR CORRECTION: Immediate	0 820			
0 950 SS=B	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding	0 950			

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0 950	Continued From page 23 subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to offer the resident the opportunity to identify a designated representative in writing with the required statutory language for two of three residents (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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly, but is not found to be pervasive). The findings include: R2 R2 was admitted to the licensee on June 1, 2024, and began to receive assisted living services. R3 R3 was admitted to the licensee on November 8, 2024, and began to receive assisted living services. R2 and R3's Assisted Living Contract lacked the required verbatim language for designating a representative. On September 30, 2024, at 4:01 p.m., licensed assisted living director (LALD)-D stated they were	0 950			

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0 950	Continued From page 24 providing coverage for LALD-B who was on leave from the licensee. On September 30, 2024, at 11:32 a.m., the surveyor received a blank contract for the assisted living facility. There was no designated representative language in the contract. On October 2, 2024, at 11:39 a.m., LALD-D stated residents were allowed to designate a representative and verbatim language should be included in each assisted living agreement. LALD-D stated they were unsure why that was missing. LALD-D stated they had not reviewed each resident file as they were a new LALD to the facility. On October 3, 2024, at 8:09 a.m., owner/agent (O/A)-A stated they were aware of the requirement and believed it was included in the assisted living contract. O/A-A stated that they did have residents designate a representative, but the document was misplaced. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 950			
01290 SS=G	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information.	01290			

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01290	Continued From page 25 (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a background study was submitted and received in affiliation with the assisted living license for one of twelve employees (unlicensed personnel/house manager (ULP/HM)-E. 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 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 finding include: ULP/HM-E was hired September 29, 2021, and began to provide direct care and services to residents. On September 30, 2024, at 10:25 a.m., during a facility tour, the surveyor observed a staff schedule. The schedule indicated ULP/HM-E was scheduled to work: Wednesday October 2, 2024, from 7:00 p.m., until 11:00 p.m., Thursday October 3, 2024, from 7:00 a.m., until 3:00 p.m.,	01290	During the survey, the licensee took action to mitigate the immediate risk. However, noncompliance remained, and the scope and level remain unchanged.		

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01290	Continued From page 26 and October 3, 2024, 7:00 a.m., until 3:00 p.m., with several more scheduled shifts through October 2024. On October 1, 2024, at 8:24 a.m., owner/agent (O/A)-A provided the surveyor with health facility identification (HFID) 36404 NETStudy 2.0 roster (a web-based system used to submit background study requests to the Department of Human Services). ULP/HM-E's background study affiliated to licensee's HFID 34606, indicated "Eligible - COVID-19 Study - Expired" with an expiration date of December 31, 2022, on the NETStudy 2.0 website roster page. ULP/HM-E's employee file contained a documented titled A Final Registry Results Form dated August 14, 2024. The documented indicated a NETStudy 2.0 background study was started for ULP/HM-E however, the employee file lacked evidence the background study was completed and established ULP/HM-E had a cleared background study for HFID 36404. On October 1, 2024, at 9:43 a.m., O/A-A stated their spouse was owner of another assisted living facility, HFID 33112. O/A-A stated they believed they had completed a background check for ULP/HM-E and was aware the staff member required a cleared background in order to provide direct staff services to residents. On October 1, 2024, at 10:01 a.m., licensed assisted living director (LALD)-D stated each staff member should have a cleared background check affiliated with the facility they were performing duties. LALD-D stated they were responsible for ensuring staff members had a	01290			

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01290	Continued From page 27 cleared background check and was unsure why that was not completed. On October 1, 2024, at 10:34 a.m., the surveyor observed the NETStudy 2.0 website indicated on August 29, 2024, ULP/HM-E received a notice from the Department of Human services which indicated ULP/HM-E's fingerprints and photo was not provided in the time required and the entity (HFID 36404) must remove ULP/HM-E from their position. The notice also indicated the licensee would receive a copy of the same notice. On October 1, 2024, at 11:32, non-employee (N/E)-L stated they were not employed at the facility HFID 36404. N/E-L stated they did not have ownership or links to the facility but stated they were the spouse of O/A-A. On October 1, 2024, at 11:36 a.m., O/A-A stated when they were previously reviewing ULP/HM-E's employee file, they observed the background check was expired. O/A-E registered ULP/H-E for a new NETStudy 2.0 background check for HFID 36404 on August 14, 2024. O/A-E stated they were aware ULP/HM-E was requested to perform finger printing by the Department of Human Services (part of the process for obtaining a cleared background check). O/A-A stated they assumed as ULP/HM-E had a cleared background check for HFID 33112 (O/A-A's spouse's facility), that the background check would have cleared for ULP/HM-E for HFID 36404. On October 1, 2024, at 12:19 p.m., O/A-A stated they received a notification from DHS August 28, 2024, indicating the fingerprints were not submitted from ULP/HM-E for HFID 36404 and the application was closed. O/A-E stated on	01290			

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01290	Continued From page 28 September 20, 2024, another background check was submitted under HFID 33112 and not HFID 36404. O/A-A stated they were aware there was a time limit on how long staff were able to provide fingerprints to DHS. O/A-E stated they received a notice from DHS the background check was not completed. O/A-E stated they probably forgot to start a new background study application. and the background study process should have been started again for ULP/HM-E for HFID 36404. Minnesota Department of Health (MDH) records indicated a renewal Application for Assisted Living License for HFID 36404 electronically signed by O/A-E on December 28, 2023, indicated O/A-E was the sole owner of the assisted living facility. N/E-L was not listed on the application as a direct or indirect owner, managerial official, or authorized agent. In addition, MDH records indicated a renewal Application for Assisted Living License for HFID 33112 electronically signed by N/E-L on May 22, 2024, indicated N/E-L was the sole owner of the assisted living facility. O/A-E was not listed on the application as a direct or indirect owner, managerial official, or authorized agent. Therefore, the two assisted living facilities were not affiliated with one another. Furthermore, NETStudy 2.0 records indicated the two unaffiliated facilities also had separate provider contact information listed with O/A-E listed for HFID 36404 and N/E-L listed for HFID 33112. Thus, a background study for ULP/HM-E completed for HFID 33112 could not be accepted for HFID 36404. The licensee's Recruitment and Hiring policy dated April 13, 2022, indicated the licensee would complete a criminal background check through DHS and the background check would be	01290			

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01290	Continued From page 29 affiliated with the facility where they will work. On October 1, 2024, the Minnesota Department of Human Services website indicated the following: Emergency studies completed during the COVID-19 pandemic were no longer valid. Individuals who only had an emergency study must have a fully compliant, fingerprint-based background study. Roster maintenance - Individuals with a completed emergency study will remain on the entity's roster unless the entity removes the individual. Entities should remove individuals with emergency studies that are no longer affiliated; - If the individual should no longer be affiliated and has a new fully compliant background study, the entity should wait until the individual is separated and then remove both the emergency study and fully compliant study from their roster at the same time; - All entities are responsible for maintaining their rosters regularly and removing study subjects from their roster when they are no longer affiliated; and - Entities are responsible for identifying who needs to submit a new background study. For help identifying which study subjects still have an emergency study and need a fully compliant study, entities should refer to the instructional guide, "Identifying Emergency Studies" in the help section of NETStudy 2.0. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01290			

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01820	Continued From page 30	01820			
01820 SS=E	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain current medication prescriptions for two of three residents (R1, 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 a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 R1 was admitted to the licensee on December 4, 2023, and began to receive assisted living services. R1's diagnoses included hypertension (high blood pressure), low back pain, schizoaffective disorder (a chronic mental illness where a person experience symptoms of a mood disorder and symptoms of schizophrenia (a mental disorder where a person see's and hears information that is not real)), post-traumatic stress disorder	01820			

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01820	Continued From page 31 (PTSD), urinary incontinence (inability to control urine), steroid-induced hyperglycemia (high blood glucose), cocaine overdose, benzodiazepine (class of medication that is used to treat a variety of mental health disorders) overdose, and obtundation (state of decreased responsiveness or alertness). R1's Service Plan (waiver) - Addendum to Contract dated December 4, 2023, indicated R1 received assistance with medication administration. R1's signed medical provider orders dated August 22, 2024, indicated R1 was prescribed the following medications: omeprazole 20 milligram (mg) 1 tablet twice daily, diazepam 5 mg 1 tablet as needed, meclizine 25 mg 1 tablet as needed for vertigo, escitalopram oxalate 5 mg once daily, famotidine 20 mg once daily, gabapentin 900 mg give 3 capsules three times daily, lidocaine ointment 5 percent (%) apply to knees and back once daily, senna-docusate 8.6-50 mg twice daily, Toviaz 8 mg once daily, verapamil 240 mg once daily, Zyrtec 10 mg once daily, Latuda 40 mg once daily, and trazadone 50 mg once daily at bedtime. R1's electronic medication administration record (EMAR) dated October 1, 2024, through October 31, 2024, indicated R1 received the following medications: escitalopram oxalate 5 mg once daily, famotidine 20 mg once daily, gabapentin 300 mg 3 capsules (900) mg three times daily, lidocaine ointment 5 percent (%) apply to knees and back once daily, senna-docusate 8.6-50 mg twice daily, Toviaz 8 mg once daily, verapamil 240 mg once daily, Zyrtec 10 mg once daily, Latuda 40 mg once daily, and trazadone 50 mg once daily at bedtime.	01820			

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01820	Continued From page 32 The following medications were prescribed to R1 but were not on the MAR: diazepam 5 mg 1 tablet as needed for anxiety, and meclizine 25 mg 1 tablet as needed for vertigo. The following medications were listed on R1's EMAR but there were no prescriber orders: famotidine 20 mg. On October 2, 2024, at 8:00 a.m., the surveyor observed unlicensed personnel (ULP)-G prepare to administer medications to R1. R1's EMAR dated October 1, 2024, through October 31, 2024, indicated staff administered famotidine 20 mg on October 1, 2024, and October 2, 2024, to R1. R2 R2 was admitted to the licensee on June 1, 2024, and began to receive assisted living services. R2's diagnoses include multiple sclerosis (a degenerative disease that affects nerve conduction), pulmonary embolism (blood clot in the lungs), gastroesophageal reflux (acid reflux in the stomach), neurogenetic bladder (nonfunctioning bladder), long term use of anticoagulant therapy (blood thinner use), generalized anxiety disorder, depression, and quadriplegia. R2 Service Plan (Waiver) - Addendum to Contract dated September 30, 2024, indicated the R2 received assisted with medication administration. R2's signed medical provider orders dated September 27, 2024, indicated R2 was	01820			

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01820	Continued From page 33 prescribed the following medications: baclofen 10 mg 2 tablets three times once daily, Centrum multivitamin 1 tablet once daily, citalopram 40 mg 1 tablet once daily, Kesimpta injection intramuscular (into the muscle) once monthly, melatonin 3 mg 1 tablet at bedtime, vitamin D3 50 micrograms (mcg) 1 tablet once daily, warfarin sodium 1.5 mg on Tuesday, Thursday, Saturday, and Sunday, docusate sodium 100 mg, Miralax 1 gummy tablet, sodium chloride 3 percent (%) 1 vial via nebulizer (machine that turns the liquid medicine into a breathable mist) and Tylenol 1000 mg 2 tablets every six hours as needed. R2's EMAR date October 1, 2024, through October 31, 2024, indicated R2 received the following medications: baclofen 10 mg 2 tablets three times once daily, Centrum multivitamin 1 tablet once daily, citalopram 40 mg 1 tablet once daily, vitamin D3 50 micrograms (mcg) 1 tablet once daily, Vitamin D1000 25 mg 2 caps once daily, Kesimpta injection intramuscular (into the muscle) once monthly, melatonin 3 mg 1 tablet at bedtime, warfarin sodium 1.5 mg on Tuesday, Thursday, Saturday, and Sunday, and vitamin D3 50 micrograms (mcg) 1 tablet once daily. The following medications were prescribed to R2 but were not on the EMAR: docusate sodium 100 mg, Miralax 1 gummy for constipation, sodium chloride vials 3 % and Tylenol 1000 mg 2 tablets every six hours for pain. On October 2, 2024, at 12:56 p.m., registered nurse (RN)-J stated the medications were discontinued but was not able to find the discontinuation order from the medical provider. RN-J stated the clinical nurse supervisor was responsible for the medication reconciliation for residents.	01820			

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01820	Continued From page 34 On October 3, 2024, at 10:13 a.m., via the phone, clinical nurse supervisor (CNS)-C stated they were responsible for the medication reconciliation for the licensee. CNS-C stated the prescriber orders should match the MAR and there should be signed and dated medication prescription orders from the prescriber. CNS-C stated it was an oversight for not having signed orders for all medications and the prescribed orders not matching the MAR. The licensee's Medication Orders policy date April 13, 2024, indicated the licensee would administer medications as prescribed by the authorized prescriber. The policy also indicated [licensee] would maintain a current or electronic record for all prescribed medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820			
01870 SS=D	144G.71 Subd. 18 Medications provided by resident or family me When the assisted living facility is aware of any medications or dietary supplements that are being used by the resident and are not included in the assessment for medication management services, the staff must advise the registered nurse and document that in the resident record. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have awareness of medications stored in a resident room for one of	01870			

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01870	Continued From page 35 three residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: R1 was admitted to the licensee on December 4, 2023, and began to receive assisted living services. R1's diagnoses included hypertension (high blood pressure), low back pain, schizoaffective disorder (a chronic mental illness where a person experience symptoms of a mood disorder and symptoms of schizophrenia (a mental disorder where a person see's and hears information that is not real)), post-traumatic stress disorder (PTSD), urinary incontinence (inability to control urine), steroid-induced hyperglycemia (high blood glucose), cocaine overdose, benzodiazepine (class of medication that is used to treat a variety of mental health disorders) overdose, and obtundation (state of decreased responsiveness or alertness). R1's Service Plan (waiver) - Addendum to Contract dated December 4, 2023, indicated R1 received assistance with activities assistance, activity reminder, appointment reminder, bathing assistance, deep room cleaning, dressing, escorting, grooming, housekeeping, incontinence care, managing behaviors, meal assistance, medication administration, repositioning, blood	01870			

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01870	Continued From page 36 pressure checks, shopping assistance, and transfer assistance. R1's signed medical provider orders dated August 22, 2024, indicated R1 was prescribed the following medications: omeprazole 20 mg 1 tablet twice daily, diazepam 5 mg 1 tablet as needed, meclizine 25 mg 1 tablet as needed for vertigo, escitalopram oxalate 5 mg once daily, famotidine 20 mg once daily, gabapentin 900 mg give 3 capsules three times daily, lidocaine ointment 5 percent (%) apply to knees and back once daily, senna-docusate 8.6-50 mg twice daily, Toviaz 8 mg once daily, verapamil 240 mg once daily, Zyrtec 10 mg once daily, Latuda 40 mg once daily, and trazadone 50 mg once daily at bedtime. R1's electronic medication administration record (EMAR) dated October 1, 2024, through October 31, 2024, indicated R1 received the following medications: escitalopram oxalate 5 mg once daily, famotidine 20 mg once daily, gabapentin 300 mg 3 capsules (900) mg three times daily, lidocaine ointment 5 percent (%) apply to knees and back once daily, senna-docusate 8.6-50 mg twice daily, Toviaz 8 mg once daily, verapamil 240 mg once daily, Zyrtec 10 mg once daily, Latuda 40 mg once daily, and trazadone 50 mg once daily at bedtime. On October 2, 2024, at 8:00 a.m., in R1's room, the surveyor observed the following medications: chlorhexidine gluconate mouth wash 0.12 %. R1 stated they received the medications after oral surgery. The medication required an order from a medical prescriber. R1's resident chart lacked a prescriber order for this medication. R1's assessment dated September 15, 2024, indicated the licensee would store all the	01870			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36404	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/03/2024
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3812 BASS LAKE ROAD NORTH BROOKLYN CENTER, MN 55429			
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01870	Continued From page 37 medications for R1. R1's assessment did not permit R1 to store and self-administer medication and there were no signed orders from a medical prescriber for these medications. The medications in R1's room did not appear on the EMAR. On October 2, 2024, at 10:00 a.m., registered nurse (RN)-J stated staff were trained to remove and report if they find medications in R1's room. RN-J stated the registered nurse should assess if a resident was capable of storing and administering their own medications. RN-J stated there should not be medications in R1's room. On October 2, 2024, at 10:24 a.m., clinical nurse supervisor (CNS)-C stated staff were trained to remove medications from resident's rooms if observed. CNS-C stated a RN was required to assess if it was safe for residents to store medications in their room. CNS-C stated the medications should be listed on the EMAR and the reason for the medications not being listed on the EMAR as they were unaware R1 had the medications. CNS-C stated staff should be looking for medications. The licensee's Storage/Control Medication policy dated April 13, 2022, indicated only authorized staff personnel have access to the stored medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01870			
01880 SS=F	144G.71 Subd. 19 Storage of medications	01880			

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01880	Continued From page 38 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: 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) 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: UNSECURED KEYS On October 1, 2024, at 7:41 a.m., the surveyor observed the facility was a split-level home. The upper level consisted of a common area, combined kitchen and dining area, a hallway leading to a medication closet, four resident bedrooms and a bathroom. Between the common area and dining and kitchen area was a set of stairs leading to the basement. The surveyor observed unlicensed personnel (ULP)-F place the keys to the medication closet onto the kitchen counter while they used an electronic tablet. ULP-G was observed in the kitchen preparing food. On October 1, 2024, at 7:56 a.m., with the keys	01880			

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01880	Continued From page 39 on the counter, the surveyor observed ULP-G leave the kitchen and walk to the hallway. On October 1, 2024, at 7:58 a.m., with the keys on the counter, the surveyor observed ULP-F walk downstairs to the basement. There were no staff members present in the common area, or combined kitchen and dining area, the keys were unsecured. On October 1, 2024, at 8:01 a.m., with the keys on the counter, the surveyor observed ULP-F walk up the stairs and start to use the electronic tablet at the kitchen counter. On October 1, 2024, at 8:10 a.m., ULP-F stated they were trained to keep the keys with them at all times and the medication closet should be locked at all times. ULP-F stated it was a mistake for leaving the keys on the counter. On October 1, 2024, at 10:32 a.m., registered nurse (RN)-J stated staff were trained not to leave the keys unattended, and the med passer for the shift was trained to carry the keys at all times. RN-J stated staff were not trained to leave the keys on the kitchen counter. RN-J stated that should not have happened. On October 2, 2024, at 9:32 a.m., licensed assisted living director (LALD)-A stated staff were trained to carry the keys at all times and medications should be secured by staff. LALD-A stated the keys should not have been left unattended and was unsure why staff left the keys on the counter. MEDICATIONS IN RESIDENT ROOM R1 was admitted to the licensee on December 4, 2023, and began to receive assisted living	01880			

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01880	Continued From page 40 services. R1's diagnoses included hypertension (high blood pressure), low back pain, schizoaffective disorder (a chronic mental illness where a person experience symptoms of a mood disorder and symptoms of schizophrenia (a mental disorder where a person see's and hears information that is not real)), post-traumatic stress disorder (PTSD), urinary incontinence (inability to control urine), steroid-induced hyperglycemia (high blood glucose), cocaine overdose, benzodiazepine (class of medication that is used to treat a variety of mental health disorders) overdose, and obtundation (state of decreased responsiveness or alertness). R1's Service Plan (waiver) - Addendum to Contract dated December 4, 2023, indicated R1 received assistance with medication administration. R1's signed medical provider orders dated August 22, 2024 indicated R1 was prescribed the following medications: omeprazole 20 mg 1 tablet twice daily, diazepam 5 mg 1 tablet as needed, meclizine 25 mg 1 tablet as needed for vertigo, escitalopram oxalate 5 mg once daily, famotidine 20 mg once daily, gabapentin 900 mg give 3 capsules three times daily, lidocaine ointment 5 percent (%) apply to knees and back once daily, senna-docusate 8.6-50 mg twice daily, Toviaz 8 mg once daily, verapamil 240 mg once daily, Zyrtec 10 mg once daily, Latuda 40 mg once daily, and trazadone 50 mg once daily at bedtime. R1's electronic medication administration record (EMAR) dated October 1, 2024, through October 31, 2024 indicated R1 received the following medications: escitalopram oxalate 5 mg once	01880			

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01880	Continued From page 41 daily, famotidine 20 mg once daily, gabapentin 300 mg 3 capsules (900) mg three times daily, lidocaine ointment 5 percent (%) apply to knees and back once daily, senna-docusate 8.6-50 mg twice daily, Toviaz 8 mg once daily, verapamil 240 mg once daily, Zyrtec 10 mg once daily, Latuda 40 mg once daily, and trazadone 50 mg once daily at bedtime. On October 2, 2024, at 8:00 a.m., in R1's room, the surveyor observed the following medications on the dresser; fluticasone nasal spray, acetaminophen 325 mg, and Aleve 220 mg. R1's assessment dated September 15, 2024, indicated the licensee would store all the medications for R1. R1's assessment did not permit R1 to store and self-administer medication and there were no signed orders from a medical prescriber for these medications. The medications in R1's room did not appear on the EMAR. On October 2, 2024, at 10:00 a.m., RN-J stated staff were trained to remove and report if they find medications in R1's room. RN-J stated the nurse should assess if a resident was capable of storing and administering their own medications. RN-J stated there should not be medications in R1's room. On October 2, 2024, at 10:24 a.m., clinical nurse supervisor (CNS)-C stated staff were trained to remove medications from resident's rooms if observed. CNS-C stated a RN was required to assess if it was safe for residents to store medications in their room. CNS-C stated the medications should be listed on the EMAR and the reason for the medications not being listed on the EMAR as they were unaware R1 had the	01880			

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01880	Continued From page 42 medications. CNS-C stated staff should be looking for medications. The licensee's Storage/Control Medication policy dated April 13, 2022, indicated only authorized staff personnel have access to the stored medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880			
02290 SS=F	144G.91 Subd. 2 Legislative intent The rights established under this section for the benefit of residents do not limit any other rights available under law. No facility may request or require that any resident waive any of these rights at any time for any reason, including as a condition of admission to the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee posted signage that used language which limited the rights of all residents residing within the facility for R1, R2, and R3. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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:	02290			

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02290	Continued From page 43 R1 R1 was admitted to the licensee on December 4, 2023, and began to receive assisted living services. R1's Residency Agreement/Assisted Living Contract dated December 8, 2023, page 5, Occupancy and Use of the Room, section C contained the following statement, "While visitors are allowed, there are limitations and occupancy restrictions due to the agency's policies regarding health and safety. The agency enforces visiting hours until 10 pm. You are responsible for the conduct of your guests while they are at the agency." The contract contained language that limited the rights of R1. R2 R2 was admitted to the licensee on June 1, 2024, and began to receive assisted living services. R2's Residency Agreement/Assisted Living Contract dated June 1, 2024, page 5, Occupancy and Use of the Room, section C contained the following statement, "While visitors are allowed, there are limitations and occupancy restrictions due to the agency's policies regarding health and safety. The agency enforces visiting hours until 10 pm. You are responsible for the conduct of your guests while they are at the agency." The contract contained language that limited the rights of R2. R3 R3 was admitted to the licensee on November 8, 2024, and began to receive assisted living services. R3's Residency Agreement/Assisted Living	02290			

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02290	Continued From page 44 Contract dated November 8, 2023, page 5, Occupancy and Use of the Room, section C contained the following statement, "While visitors are allowed, there are limitations and occupancy restrictions due to the agency's policies regarding health and safety. The agency enforces visiting hours until 10 pm. You are responsible for the conduct of your guests while they are at the agency." The contract contained language that limited the rights of R3. On September 30, 2024, at 4:01 p.m., licensed assisted living director (LALD)-D stated they were providing coverage for LALD-B who was on leave from the licensee. On October 2, 2024, at 11:49 a.m., LALD-D stated they were aware [licensee] could not place restrictions on residents. LALD-D stated they were unaware resident contracts contained a visitor hour restriction. LALD-D stated they started employment with [licensee] beginning of September 2024. On October 3, 2024, at 8:09 a.m., owner/agent (O/A)-A stated they were aware the contract could not contain a visitor hour restriction. O/A-A stated they learned that from a previous Minnesota Department of Health (MDH) survey at a sister facility. O/A-A stated they were planning to remove that statement. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02290			
02310 SS=F	144G.91 Subd. 4 (a) Appropriate care and services	02310			

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02310	Continued From page 45 (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medical oxygen tanks were secured and stored properly in noncombustible racks to prevent injury to all residents who resided in the assisted living facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an widespread scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On September 30, 2024, at 4:01 p.m., licensed assisted living director (LALD)-D stated they were providing coverage for LALD-B who was on leave from the licensee. On October 2, 2024, at 10:14 a.m., in R2's room, behind the armchair, the surveyor observed four green oxygen tanks lying flat on the floor. The oxygen tanks were not secured with a rack or chain. On October 2, 2024, at 11:37 a.m., LALD-D	02310			

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02310	Continued From page 46 stated oxygen tanks should not be stored as described. LALD-D stated they were unaware there were oxygen tanks in the assisted living facility. LALD-D stated nursing staff and the house manager were responsible for ensuring oxygen tanks were stored correctly. On October 3, 2024, at 10:18 a.m., clinical nurse supervisor (CNS)-C stated the oxygen tanks were not secured in oxygen tank holders as the oxygen tank supplier did not provide them when the oxygen tanks were delivered to the facility. CNS-C stated they were aware oxygen tanks were required to be stored in a rack or similar holding device. CNS-C stated it was an oversight and would be corrected. The Department of Health (MDH) Oxygen Cylinder Storage Requirements dated June 2020, recommends oxygen tanks must be secured in racks or by chains. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310			
02320 SS=I	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced	02320			

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02320	Continued From page 47 by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical or nursing standards for one of three residents (R2) with the use of mechanical lifting equipment. 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: R2 was admitted to the licensee on June 1, 2024, and began to receive assisted living services. R2's diagnoses include multiple sclerosis (a degenerative disease that affects nerve conduction), pulmonary embolism (blood clot in the lungs), gastroesophageal reflux (acid reflux in the stomach), neurogenetic bladder (nonfunctioning bladder), long term use of anticoagulant therapy (blood thinner use), generalized anxiety disorder, depression, and quadriplegia. R2's Service Plan (Waiver) - Addendum to Contract dated September 30, 2024, indicated R2 received assistance with appointment reminders, bathing assistance, bedmaking, dressing, grooming, housekeeping, incontinence care, laundry, linen change, behavior management, medication administration, oxygen delivery,	02320	During the survey, the licensee took action to mitigate the immediate risk. However, noncompliance remained, and the scope and level remain unchanged.		

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02320	Continued From page 48 positioning/re-positioning, safety check, shopping assistance, skin care, transfer assistance, and wheelchair use. On September 30, 2024, at 2:11 p.m., the surveyor observed a Hoyer lift (a device that used to lift and transfer residents from one position to another position) in R2's room. On the Hoyer lift was the following label "Invicare Reliant 450" and on another label was "Item BAJ00000091". The surveyor observed R2 in their electric wheelchair in their bedroom at their door. Underneath R2 was a green sling that was used connect to the Hoyer lift. The surveyor observed unlicensed personnel (ULP)-H lower the Hoyer sling arm (where the green sling gets attached) from the front of R2 to place the arm closer to R2. From the back of R2, ULP-F and ULP-G attached the left and right straps to the Hoyer sling attachment points (used to secure the sling strap from moving while being operated.) Before attaching the attachment points to the Hoyer, ULP-H looped the sling strap around the sling bar then place the sling into the attachment points on the left and right sides. The sling was not to be looped around the sling bar prior to being connected. On September 30, 2024, 2024 at 2:33 p.m., ULP-H stated they were trained to use the Hoyer lift by a previous staff member that was no longer employed by the licensee. ULP-H could not recall the title or position of the previous staff member. ULP-H stated they looped the sling strap around the sling bar to make the lengths of the front and back sling straps equal. On September 30, 2024, at 2:29 p.m., ULP-F stated they were not trained to loop the sling around the sling arm, and they were unsure if that	02320			

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NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3812 BASS LAKE ROAD NORTH BROOKLYN CENTER, MN 55429		
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02320	Continued From page 49 was the normal process when using the Hoyer lift. On September 30, 2024, at 2:48 p.m., the surveyor requested to see the manufacturer's guidelines for the Hoyer. The surveyor observed owner/agent (O/A)-A enter R2's room to search for the guidelines. There were no guidelines in R2's room. O/A-A stated if they had them, the guidelines would be in R2's room. O/A-A stated they would have to locate and print off the guidelines from the internet. O/A-A stated it was an oversight for not having the guidelines readily available. On September 30, 2024, at 3:27 p.m., ULP-G stated they were trained by a previous staff member to loop the sling around the sling arm. ULP-G stated the looping was done because otherwise R2 would be too low. ULP-G stated they were unable to recall the person who trained them to loop the sling around the sling arm. ULP-G stated all staff looped the sling around the sling arm. On September 30, 2024, at 3:50 p.m., clinical nurse supervisor (CNS)-C stated staff were not trained to loop the sling around the sling arm attachment. CNS-C stated they trained staff using the manufacturer's guidelines. CNS-C stated they were unsure why the manufacturer's instructions were not available at the assisted living facility, and they were unsure why staff used the sling as the surveyor observed. On September 30, 2024, at 4:01 p.m., licensed assisted living director (LALD)-D stated they were providing coverage for LALD-B who was on leave from the licensee. LALD-D stated the CNS was responsible for training staff to use the Hoyer lift and was unaware of the specifics on the training	02320			

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3812 BASS LAKE ROAD NORTH BROOKLYN CENTER, MN 55429		
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02320	Continued From page 50 provided. On September 30, 2024, at 4:13 p.m., the surveyor observed registered nurse (RN)-J with ULP-I move the Hoyer lift in front of R2. ULP-I lowered the sling arm down in front of R2. Without looping the sling, RN-J placed the sling loops into the back left and right sling attachment arms. ULP-I placed the front left and right sling into the sling arm attachments. On September 30, 2024, at 4:20 p.m., RN-J stated they did not know why a staff member would loop the sling strap around the sling arm and that was not how Hoyer slings should be used. ULP-H's employee file included a Practical Skills Evaluation sheet that indicated ULP-H was trained and was observed as competent in the use of the Mechanical lift/Hoyer by a RN on May 30, 2024. On September 30, 2024, at 4:18 p.m., the surveyor observed the undated Invacare Reliant 450 Hoyer lift instruction, page 29, illustration for the safe attachment of the sling. The illustration did not indicate the strap should be looped around the sling arm. The instructions indicated, "1 place the straps of the sling over the hooks of the swivel bar, 2 match the corresponding colors on each side of the sling for an even lift of the patient." The licensee's Equipment Safety policy dated April 13, 2022, indicated staff would follow manufacturer's guidelines for equipment operation and safety. No further information was provided.	02320			

Minnesota Department of Health

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02320	Continued From page 51 TIME PERIOD FOR CORRECTION: Immediate Additionally, based on observation, interview, and record review, the licensee failed to ensure one of three employees (ULP-G) followed appropriate medication administration procedures during an internet outage, and the licensee failed to ensure measures were in place to prevent skin breakdown for one of three residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: MEDICATION ADMINISTRATION PROCEDURES R1 was admitted to the licensee on December 4, 2023, and began to receive assisted living services. R1's diagnoses included hypertension (high blood pressure), low back pain, schizoaffective disorder (a chronic mental illness where a person experience symptoms of a mood disorder and symptoms of schizophrenia (a mental disorder where a person see's and hears information that is not real)), post-traumatic stress disorder (PTSD), urinary incontinence (inability to control urine), steroid-induced hyperglycemia (high blood glucose), cocaine overdose, benzodiazepine (class of medication that is used to treat a variety	02320			

Minnesota Department of Health

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02320	Continued From page 52 of mental health disorders) overdose, and obtundation (state of decreased responsiveness or alertness). R1's Service Plan (waiver) - Addendum to Contract dated December 4, 2023, indicated R1 received assistance with medication administration. R1's signed medical provider orders dated August 22, 2024, indicated R1 was prescribed the following medications: omeprazole 20 mg 1 tablet twice daily, diazepam 5 mg 1 tablet as needed, meclizine 25 mg 1 tablet as needed for vertigo, escitalopram oxalate 5 mg once daily, famotidine 20 mg once daily, gabapentin 900 mg give 3 capsules three times daily, lidocaine ointment 5 percent (%) apply to knees and back once daily, senna-docusate 8.6-50 mg twice daily, Toviaz 8 mg once daily, verapamil 240 mg once daily, Zyrtec 10 mg once daily, Latuda 40 mg once daily, and trazadone 50 mg once daily at bedtime. On October 2, 2024, at 8:04 a.m., the surveyor observed ULP-G remove a plastic container from the medication closet and place it on the kitchen counter. In the plastic container was a bubble pack medication card for R1. ULP-G removed a perforated bubble tab section that had the following information on the label, "[R1] October 2, 2024, morning, 1-cetirizine 10 mg tablet, 1-toviaz 8 mg tablet, 1-escitalopram 5 mg tablet, 1-senna-time s 8.6-50 mg tablet, 1-verapamil 240 ER tablet, 1-famotidine 20 mg tablet, 3-gabapentin 300 mg capsule." There were a total of 9 pills in the bubble tab section. With the bubble tab section removed from the bubble pack medication card, ULP-G walked to the kitchen, took a small medication cup, walked downstairs, and entered R1's room. Without verifying the	02320			

Minnesota Department of Health

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02320	Continued From page 53 medications against the electronic medication record (EMAR), ULP-G opened the bubble tab section and placed the medications into R1's hand. In the interest of safety, the surveyor intervened and requested ULP-G verify the medications to be administered to R1. On October 2, 2024, at 8:13 a.m., ULP-G stated they were unable to open the computer program RTasks (electronic medical record) to verify the EMAR for R1 as the internet was not working at the facility. ULP-G stated they were trained to look at the medication administration record (MAR) prior to medication administration. The surveyor inquired how they would verify the medications were accurate without use of the MAR. ULP-G stated they would verify the medications to be administered with R1. The surveyor then observed unlicensed personnel/house manager (ULP/HM)-E remove a printed MAR from a clear plastic folder stored by the refrigerator. ULP-G stated they forgot the printed MAR was available for use. On October 2, 2024, at 8:20 a.m., with the medication cup, and printed MAR in hand, the surveyor observed ULP-G walk downstairs to R1's room. ULP-G asked R1 what medications they should be receiving. R1 looked at the medication cup and stated, "the Latuda is not there." Again, without verifying the medications against the printed MAR, ULP-G handed the medication cup to R1. In the interest of safety, the surveyor again intervened and asked R1 to hand the medication cup back to ULP-G. The surveyor and ULP-G walked upstairs to the kitchen and dining area. R1's printed MAR dated June 19, 2024, that ULP/HM-E gave to ULP-G, indicated R1 was to	02320			

Minnesota Department of Health

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02320	Continued From page 54 receive the following medications: gabapentin 300 mg 2 capsules three times daily, Latuda 40 mg tablet once daily in the evening, lidocaine ointment 5 percent (%) apply to knees and lower back once daily, lurasidone hydrochloride 40 mg once daily in the evening, omeprazole 20mg once daily, senna-docusate 8.6-50mg once daily, Toviaz 4 mg once daily, trazadone 50 mg once daily at bedtime, verapamil 240 mg once daily, Zyrtec 10 mg once daily and meclizine 25 mg once daily. The following medications were prescribed to R1 but were not on the printed MAR: escitalopram oxalate 5 mg, and diazepam 5 mg as needed. In addition, the medical provider ordered three gabapentin capsules 300 mg (900mg) total, but the printed MAR indicated R1 was to receive two gabapentin capsules 300 mg (600mg). On October 2, 2024, at 8:27 a.m., via phone interview, RN-J stated the policy was for staff to obtain a current printed MAR for the medication administration in the event of an internet outage. RN-J stated they had instructed ULP/HM-E to leave the facility, drive to the off-site facility office, print the current MARs for each resident and return to the assisted living facility. On October 2, 2024, at 8:31 a.m., the surveyor observed ULP/HM-E leave the assisted living facility. On October 2, 2024, at 8:42 a.m., via the phone on loud speaker RN-J verbalized to staff not to administer medications until ULP/HM-E had returned with the printed MARs. On October 2, 2024, at 8:52 a.m., the surveyor inquired to ULP-G where the facility emergency	02320			

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02320	Continued From page 55 preparedness plan was located. The surveyor observed ULP-G search the kitchen, dining, and common area. ULP-G stated they did not know where it was located. On October 2, 2024, at 8:52 a.m., the surveyor observed ULP/HM-E arrive at the assisted living facility with the printed MARs. ULP/HM-E stated to ULP-G to remove the medication boxes from the medication closet. ULP/HM-E looked at the laptop computer on the kitchen counter. ULP/HM-E stated the internet was working and proceeded to use the EMAR on the laptop to verify the medications for R1 and R3. On October 2, 2024, at 9:07 a.m., ULP-G stated they were trained to look at the printed MAR for medication administration if the internet was not working. ULP-G stated they forgot there were printed MARs located in the facility to use to verify medications. ULP-G stated they had contacted O/A-A but did not receive instruction to contact the nurse. On October 2, 2024, at 9:19 a.m., LALD-D stated staff were trained to verify medications prior to administration. LALD-D stated if staff could not access the EMAR, they were trained to contact the registered nurse for direction. LALD-D stated they were unsure why staff did not contact the registered nurse when they realized the EMAR was not accessible. On October 2, 2024, at approximately 09:45 a.m., the surveyor observed RN-J arrive to the assisted living facility. On October 2, 2024, at 10:02 a.m., RN-J stated staff were trained to verify medication against the EMAR. RN-J stated staff were trained to contact	02320			

Minnesota Department of Health

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02320	Continued From page 56 the RN to verify what medications should be administered if the EMAR was not available. RN-J stated the situation should not have occurred and staff were probably stressed during the situation. On October 3, 2024, at 8:20 a.m., O/A-A stated staff were trained to use the EMAR to verify each medication before they administered to residents. O/A-A stated if the EMAR was not available, staff were trained to contact the registered nurse for direction. O/A-A stated they were unsure why staff did not contact the RN for direction. O/A-A stated they were unsure why staff did not use the emergency preparedness plan. On October 3, 2024, at 10:13 a.m and 10:17 a.m., CNS-C stated they were responsible for ensuring the prescribed orders match the EMAR for each resident. CNS-C stated it was an oversight and should not be like that. CNS-C stated staff were trained to verify medications prior to administration. CNS-C was unsure why staff did not contact the RN when the EMAR was not working. CNS-C stated staff need to be retrained. The licensee's emergency preparedness plan dated August 1, 2024, lacked a policy or direction for staff when there was an internet outage. The licensee's Medication Administration policy dated April 13, 2024, indicated staff administering medications should have access to information about the medication being administered, including but not limited to "purpose, dosage, route, frequency, instructions related to the medication and specific to the residents as appropriate, side effects and resident allergies to medications."	02320			

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02320	Continued From page 57 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320			



Minnesota Department of Health

625 Robert Street North
St Paul
651-201-4500

Type: Full
Date: 09/30/24
Time: 12:04:29
Report: 7994241181

Food and Beverage Establishment Inspection Report

Page 1

Location:

New Hope Health Care Llc
3812 Bass Lake Road North
Brooklyn Center, MN55429
Hennepin County, 27

Establishment Info:

ID #: 0038083
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7634004350
ID #:

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

The following orders were issued during this inspection.

4-300 Equipment Numbers and Capacities

4-302.13A **** Priority 2 ****

MN Rule 4626.0710A Provide a readily accessible temperature measuring device for measuring the washing and sanitizing temperatures in manual warewashing operations.

NO APPROVED TEMPERATURE MEASURING DEVICE WAS FOUND ON SITE FOR THE DISHWASHER. COVERED VARIOUS WAYS FOR FACILITY TO TEST THE DISHWASHER.

Comply By: 09/30/24

4-200 Equipment Design and Construction

4-204.112A

MN Rule 4626.0620A Provide a temperature measuring device located in the warmest part of mechanically refrigerated units and coolest part of hot food storage units that are capable of measuring air temperature or a simulated product temperature.

FRIDGE THERMOMETER FOUND WITH DEAD BATTERY. REPLACE BATTERY.

Comply By: 09/30/24

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

INSPECTION CONDUCTED IN THE PRESENCE OF HRD STAFF AND FINDINGS SHARED AT THE END OF INSPECTION.

WILL EMAIL SUPPORTING DOCUMENTS AND LINKS TO HRD STAFF AT THE END OF THE DAY.

KITCHEN IS RESIDENTIAL AND FOOD IS PREPARED FOR SAME DAY SERVICE.

Type: Full
Date: 09/30/24
Time: 12:04:29
Report: 7994241181
New Hope Health Care Llc

Food and Beverage Establishment Inspection Report

Page 2

FLOOR IS LAMINATE, CABINETS ARE WOOD WITH HALLOWED ENCLOSED BASES, GRANITE COUNTER TOPS AND TEXTURED CEILING. ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT ANY TIME THERE IS FOUND TO BE A RISK OF CONTAMINATION OR CONCERN THE PHYSICAL FACILITIES WILL BE REQUIRED TO BE BROUGHT UP TO CODE.

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 7994241181 of 09/30/24.

Certified Food Protection Manager: Muntaha Y Issa

Certification Number: 121465 Expires: 02/17/27

Inspection report reviewed with person in charge and emailed.

Signed: _____

Establishment Representative

Signed: 

Crystal Elva
Public Health Sanitarian 3
St Paul
651-201-3981
Crystal.Elva@state.mn.us

Report #: 7994241181		Food Establishment Inspection Report							
m DEPARTMENT OF HEALTH Minnesota Department of Health 625 Robert Street North St Paul		No. of RF/PHI Categories Out		0		Date 09/30/24			
		No. of Repeat RF/PHI Categories Out		0		Time In 12:04:29			
		Legal Authority MN Rules Chapter 4626				Time Out			
New Hope Health Care Llc		Address 3812 Bass Lake Road North		City/State Brooklyn Center, MN		Zip Code 55429		Telephone 7634004350	
License/Permit # 0038083		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					
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									
				COS		R			
Safe Food and Water									
30 ☐ IN ☐ OUT ☒ N/A				Pasteurized eggs used where required					
31 ☐ IN ☐ OUT ☐ N/A				Water & ice obtained from an approved source					
32 ☐ IN ☐ OUT ☒ N/A				Variance obtained for specialized processing methods					
Food Temperature Control									
33 ☐ IN ☐ OUT ☐ N/A ☐ N/O				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 ☐ IN ☒ OUT ☐ N/A ☐ N/O				Thermometers provided & accurate					
Food Identification									
37 ☐ IN ☐ OUT ☐ N/A ☐ N/O				Food properly labeled; original container					
Prevention of Food Contamination									
38 ☐ IN ☐ OUT ☐ N/A ☐ N/O				Insects, rodents, & animals not present					
39 ☐ IN ☐ OUT ☐ N/A ☐ N/O				Contamination prevented during food prep, storage & display					
40 ☐ IN ☐ OUT ☐ N/A ☐ N/O				Personal cleanliness					
41 ☐ IN ☐ OUT ☐ N/A ☐ N/O				Wiping cloths: properly used & stored					
42 ☐ IN ☐ OUT ☐ N/A ☐ N/O				Washing fruits & vegetables					
Food Recalls:									
Person in Charge (Signature)									
Date: 09/30/24									
Inspector (Signature)									