Electronically Delivered

June 21, 2023

Licensee
Heart To Home Incorporated
2351 Pagel Road
Mendota Heights, MN 55120

RE: Project Number(s) SL26147015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 1, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the 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. The 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 . . ."

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines and enforcement actions 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 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 the MDH within 15 calendar days of the correction order receipt date.

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

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

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,

Jodi Johnson, Supervisor
State Evaluation Team
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 651-281-9796

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26147	A. BUILDING: _____ B. WING _____	06/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEART TO HOME INCORPORATED	2351 PAGEL ROAD MENDOTA HEIGHTS, MN 55120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL26147015-0 On May 30, 2023, through June 1, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were seven active residents; seven receiving services under the Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480		

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0 480	Continued From page 1 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 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated May 30, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that 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	0 510		

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0 510	Continued From page 2 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 ensure infection control standards were followed for one of two unlicensed personnel (ULP-E) during medication administration. This had the potential to affect all residents receiving medication administration. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On May 30, 2023, at 1:25 p.m. ULP-E was observed to set up medications for R5. During medication set up, ULP-E was observed to don gloves, touch multiple surfaces and dispense medications from medication bubble packs directly to her gloved hands, and then into the medication cup. Additionally, at 1:30 p.m. ULP-E was observed to set up medications for R6 and was observed to don clean gloves, and again touch multiple surfaces and dispense medications into her gloved hands, and then into a medication cup.	0 510		

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0 510	Continued From page 3 On May 30, 2023, at 2:35 p.m. registered nurse (RN)-B stated staff were trained to set up medications without touching tablets/pills. RN-B further stated she would provide some additional training for ULP-E. The licensee's Oral Medication Skills Competency dated 2017, indicated for oral medication set up, to place medications directly into a medication cup or dish. The licensee's glove use policy dated August 2021, indicated removal of gloves and washing hands after touching contaminated surfaces. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents.	0 680		

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0 680	Continued From page 4 (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post emergency exit diagrams in the required areas on each floor. 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 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: During a tour of the facility on May 30, 2023, at 12:15 p.m. the surveyor observed no emergency exit diagrams in the hallways/entryway of either the main floor or the lower level of the licensee's building. On May 31, 2023, at 2:30 p.m. licensed assisted living director (LALD)-A confirmed the licensee lacked visible exit diagrams on each floor as	0 680		

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0 680	Continued From page 5 required, and stated the exit diagram on the main floor of the facility was kept in the locked laundry room. The licensee's emergency preparedness and disaster planning policy dated August 1, 2021, identified postings required: emergency exit diagrams on each floor. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
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. (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	0 810		

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0 810	Continued From page 6 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, record review, and interview, the licensee failed to develop and maintain the fire safety and evacuation plans. 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) 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). Findings include: On May 31, 2023, between 11:30 a.m. and 12:25 p.m., survey staff toured the facility with the licensed assisted living director (LALD)-A. During the facility tour, survey staff observed the following: 1. There was an enclosed deck at the back of the building. 2. The laundry room door was locked and required a key to open.	0 810		

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0 810	Continued From page 7 On May 31, 2023, at approximately 12:25 p.m., records were provided for review by the LALD-A. Records were reviewed by survey staff on May 31, 2023, between 12:25 p.m. and 1:20 p.m. Record review indicated that the fire safety and evacuation plans were not developed and maintained for the facility location: 1. A door was labeled as an exit on the evacuation plans that led to an enclosed deck, which obstructed the path of egress. 2. In the evacuation plans, a door was labeled as an exit that required passage through the laundry room, which was locked and required a key to open. In the event of an evacuation, a locked door requiring a key could delay a safe and quick exit. 3. Smoke compartment doors and fire doors were referenced in the plans but not identified. On May 31, 2023, at approximately 1:20 p.m., the LALD-A verified these deficient conditions. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01750 SS=E	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions	01750		

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01750	Continued From page 8 in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure two of two unlicensed personnel (ULP-D, ULP-G) completed insulin administration via a prefilled insulin pen according to manufacturer instructions. 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's diagnoses included diabetes (the body's inability to adequately manage blood sugar), cognitive impairment, and chronic kidney disease. R1's Service Plan dated March 13, 2023, indicated R1 received services to include medication management, insulin injections and blood sugar checks. R1's provider orders dated February 8, 2023, indicated "Check blood sugar before meals. Inject Novolog insulin subcutaneously [just below skin] according to Sliding Scale below: Prior to giving insulin after applying needle, turn pen to 2 units and push out to remove air/prime	01750		

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01750	Continued From page 9	01750		

pen.
If blood sugar is:
Less than 70 - Notify nurse on call
70-149 - No additional Novolog
150-199 - 2 units
200-249 - 4 units
250-299 - 6 units
300-349- 8 units
350-399 - 10 units
Over 400 - 12 units and notify nurse on call."

On May 30, 2023, at 12:00 p.m. unlicensed personnel (ULP)-D washed her hands, gathered equipment for blood sugar check and Novolog insulin injection, completed a blood sugar check (result = 182), removed the insulin cap, placed a new needle on the end of the insulin pen, prepared the insulin pen by priming the pen with two units of insulin, dialed the insulin pen to two units (according to the sliding scale), wiped R1's lower right abdomen with an alcohol wipe and injected the insulin, holding the insulin pen in place the designated time of ten seconds. ULP-D failed to wipe the insulin pen tip with an alcohol wipe prior to placing a new needle on the pen tip and administering insulin.
Additionally, on May 31, 2023, at 12:00 p.m. ULP-G completed R1's blood sugar check (result = 213), prepped the Novolog insulin pen by removing the insulin pen cap, applied a new needle to the pen, primed with two units of insulin, dialed the pen to four units of insulin (according to the sliding scale), wiped R1's right lower abdomen with an alcohol wipe and injected the insulin.
ULP-D and ULP-G failed to follow the proper delegated procedure for insulin pen use and failed to wipe the insulin pen tip with an alcohol wipe prior to placing a new needle on the pen.

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01750	Continued From page 10 On May 31, 2023, at 12:45 p.m. registered nurse (RN)-F stated her expectations were for the ULP to wipe the insulin pen tip with an alcohol wipe prior to placing a new needle on the tip. The licensee's Insulin Administration policy/procedure dated August 1, 2021, indicated "Roll the insulin pen between your hands to gently mix the insulin. Clean the rubber stopper with an alcohol swab and twist on new needle." Novolog manufacturer's instructions dated February 2023, indicated for the user to remove the flex pen cap and wipe the flex pen tip with an alcohol wipe prior to placing a new needle on the flex pen tip. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01770 SS=F	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure documentation of medication setup included the required content for one of one resident (R1). This practice resulted in a level two violation (a	01770		

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01770	Continued From page 11	01770		

violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).

The findings include:

During the entrance conference on May 30, 2023, at 10:30 a.m. registered nurse (RN)-B stated the licensee provided medication management services to their residents, including medication setup.

R1's Service Plan dated March 14, 2022, indicated R1 received medication administration and medication set up services.

R1's prescriber orders dated February 8, 2023, included two medications for diabetes (the body's inability to manage insulin/blood sugar), one for thyroid, three for constipation, one for heart health and stroke prevention, one supplement, one for mild pain management, one for upset stomach, one for cough/chest congestion, one for ear wax, and one for diarrhea.

On May 31, 2023, at 10:00 a.m. the surveyor and licensed practical nurse (LPN)-F reviewed the licensee's medication storage cabinet. R1's medications were noted to be set up in bubble packaging with handwritten labels. LPN-F stated she set up R1's medications in bubble packages as he did not receive his medications from the facility designated pharmacy.

R1's record lacked documentation by the licensed nurse at the time of setup to include the name of

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01770	Continued From page 12 medication, quantity of dose, times to be administered, and route of administration. On May 31, 2023, at 10:15 a.m. LPN-F stated she only documented in R1's nurse's notes when she sets his medications in bubble packs every one to two weeks, and she did not document what medications, quantity of dose, times, or route. LPN-F further stated this was the process used for all medication set ups she managed and was not aware of this requirement. The licensee's Medication Management-Dosage Box set up policy dated August 1, 2021, indicated, "When the licensed nurse has completed setting up the medications into the dosage box, the set-up is documented on the EMAR." No further information was provided. TIME PERIOD TO CORRECT: Seven (7) Days	01770		
01890 SS=E	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an insulin pen for one of one resident (R1) included an opened date, failed to ensure medications bore a proper label (R1, R2), and failed to monitor for	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26147	A. BUILDING: _____ B. WING _____	06/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEART TO HOME INCORPORATED	2351 PAGEL ROAD MENDOTA HEIGHTS, MN 55120

(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
01890	Continued From page 13 expired medications for one of seven residents (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 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 On May 30, 2023, at 12:00 p.m. unlicensed personnel (ULP)-D was observed to set up R1's 12:00 p.m. medications. R1's Novolog flex pen (insulin used to treat his diabetes) was noted to be in a zip lock baggy which contained only his name (written with a sharpie marker) and lacked a complete label. On May 31, 2023, at 10:00 a.m. the surveyor and licensed practical nurse (LPN)-F observed the contents of the medication cabinet/medication closet. R1's Lantus Solostar flex pen (insulin used to treat his diabetes) was found in a zip lock baggy, lacked a proper label and lacked a date to indicate when the Lantus flex pen was opened. LPN-F stated the expectation was that staff included a proper label for all medications, which included an open date for time sensitive medications (R1's insulin). The Lantus manufacturer's storage instructions dated 2020, indicated once the Lantus Solostar flex pen is opened, store at room temperature and discard after 28 days.	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26147	A. BUILDING: _____ B. WING _____	06/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEART TO HOME INCORPORATED	2351 PAGEL ROAD MENDOTA HEIGHTS, MN 55120

(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
01890	Continued From page 14 R2 On May 31, 2023, at 10:00 a.m. the surveyor and LPN-F observed the medication cabinet/closet and observed R2's eye drops sitting in the drawer which included R2's name, but the eye drops lacked a proper label. LPN-F stated the expectation was for all medications to include a proper label. R3 On May 31, 2023, at 10:00 a.m. the surveyor and LPN-F observed the contents of the medication cabinet/closet. R3's Ventolin inhaler (used for shortness of breath) was noted to contain an expiration date of April 2022; LPN-F confirmed the expiration date and removed the inhaler from the medication closet, stated she would order a new inhaler. The licensee's Medication Storage Policy dated August 1, 2021, indicated "When [licensee name] receives a prescription drug, prior to being set up for immediate or later administration, the prescription drug must be kept with the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug." No further information provided. TIME PERIOD FOR CORRECTION: seven (7) days.	01890		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment	02040		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26147	A. BUILDING: _____ B. WING _____	06/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEART TO HOME INCORPORATED	2351 PAGEL ROAD MENDOTA HEIGHTS, MN 55120

(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
02040	Continued From page 15 An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide a safety risk assessment or hazard vulnerability assessment of the physical environment with mitigation factors on and around the property. This deficient practice had the ability to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include: On May 31, 2023, at approximately 12:25 p.m., records were provided for review by the licensed assisted living director (LALD)-A. Records were reviewed by survey staff on May 31, 2023, between 12:25 p.m. and 1:20 p.m. A hazard	02040		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26147	A. BUILDING: _____ B. WING _____	06/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEART TO HOME INCORPORATED	2351 PAGEL ROAD MENDOTA HEIGHTS, MN 55120

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02040	Continued From page 16 vulnerability analysis had been completed that identified natural, technological, and human hazards. The licensee had not performed a safety risk assessment or hazard vulnerability assessment with mitigation factors on and around the property for the physical environment. On May 31, 2023, at approximately 1:20 p.m., the LALD-A verified this deficient condition. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		

DEPARTMENT OF HEALTH

Environmental Health
Food, Pools, and Lodging
625 Robert St. N
St. Paul
651-201-5000

Type: Full
Date: *05/30/23*
Time: 14:11:31
Report: 1031231142

Food and Beverage Establishment Inspection Report

Location:
Heart To Home Incorporated
2351 Pagel Road
Mendota Heights, MN55120
Dakota County, 19

Establishment Info:
ID #: 0039067
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6514545250
ID #:

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

The following orders were issued during this inspection.

3-500B Microbial Control: hot and cold holding
3-501.16A2 ***** Priority 1 *****

MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

MULTIPLE ITEMS IN UPSTAIRS REFRIGERATOR MEASURED OVER 41F. ***ALL TCS ITEMS DISCARDED. STAFF SAID TEMP WAS ACCIDENTALLY ADJUSTED TO ABOVE 41F. TEMP RAISED TO 35F. MONITOR TEMPERATURES.

Comply By: 05/30/23

Food and Equipment Temperatures

Process/Item: Cold Hold/Pudding
Temperature: 46 Degrees Fahrenheit - Location: Upstairs Refrigerator
Violation Issued: Yes

Process/Item: Cold Hold/Tomato
Temperature: 48 Degrees Fahrenheit - Location: Upstairs Refrigerator
Violation Issued: Yes

Process/Item: Cold Hold/Cheese
Temperature: 38 Degrees Fahrenheit - Location: Downstairs Refrigerator
Violation Issued: No

Process/Item: Cold Hold/Lemonade
Temperature: 47 Degrees Fahrenheit - Location: Upstairs Refrigerator
Violation Issued: Yes

Type: Full
Date: *05/30/23*
Time: 14:11:31
Report: 1031231142
Heart To Home Incorporated

Food and Beverage Establishment Inspection Report

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

Inspection conducted by Chris F.

All violations discussed with Josh and Rane during the inspection.

NOTES:

- Establishment has a residential kitchen (4626.0506(G)(2)) Same-day service only. No saving and reheating of foods or preparation of foods the day prior to eating. Any remaining food from meals to be removed/discarded at end of day.

- Eggs currently in kitchen are NOT PASTEURIZED. Do not undercook. Pasteurized eggs will have a "P" stamped on each individual egg.

- Discontinue use of concentrated spray cleaners and cleaning whipes; these are TOO STRONG for kitchen purposes.

- Staff must prepare SANITIZER BUCKET and store a wiping rag in it daily. Check concentration of sanitizer throughout day with test strips. Dump and replace sanitizer solution as needed.

- Establishment does not have 3-comp sink or commercial dishwasher - can use residential dishwasher to wash, rinse, and sanitize (use sanitize setting on washer).

- When preparing food, make sure to use a thin-probe thermometer to check temperatures.

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

I acknowledge receipt of the Environmental Health inspection report number 1031231142 of 05/30/23.

Certified Food Protection Manager Rane Nyaki Washington

Certification Number: FM111913 Expires: 06/10/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
Rane Nyaki Washington
Person in Charge

Signed: _____
Chris Foster
Public Health Sanitarian I
Freeman Office Building
651-983-8760
chris.j.foster@state.mn.us

Report #: 1031231142

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Environmental Health
Food, Pools, and Lodging
625 Robert St. N
St. Paul

No. of RF/PHI Categories Out	1	Date	05/30/23
No. of Repeat RF/PHI Categories Out	0	Time In	14:11:31
Legal Authority MN Rules Chapter 4626		Time Out	

	Address	City/State	Zip Code	Telephone
Heart To Home Incorporated	2351 Pagel Road	Mendota Heights, MN	55120	6514545250

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
0039067		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

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

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

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

GOOD RETAIL PRACTICES

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

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

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

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

Food Recalls:

Person in Charge (Signature) **Date:** 05/30/23

Inspector (Signature)