Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

October 24, 2023

Licensee
All Hopes Incorporated
7932 Orchard Avenue North
Brooklyn Park, MN 55443

RE: Project Number(s) SL35715015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on October 4, 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.

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

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 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).

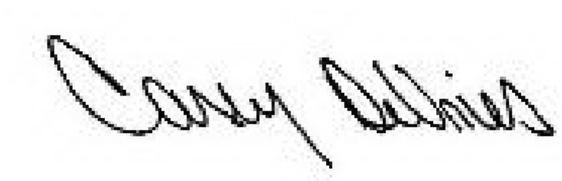
Please address your cover letter for reconsideration requests to:

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,



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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35715	A. BUILDING: _____ B. WING _____	10/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL HOPES INCORPORATED	7932 ORCHARD AVENUE NORTH BROOKLYN PARK, MN 55443

(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: SL35715015-0 On October 3, 2023, through October 4, 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 four active residents; all of whom received services under the Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 460 SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request assistance for health and safety needs 24 hours	0 460		

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0 460	Continued From page 1 per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide a means for residents to request assistance for health and safety needs 24 hours a day, seven days a week. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 3, 2023, at 9:52 a.m., during the	0 460		

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0 460	Continued From page 2 entrance conference, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated the facility was small and "staff are right there." In addition, residents ambulated to staff for assistance or used their personal cell phones to call staff members when assistance was needed, however, some residents had lost their cell phones. On October 3, 2023, at 10:33 a.m., during a facility tour, the surveyor observed a split-level home with three residents located on the upper level and one resident located on the lower level. In addition, the surveyor observed no bells, call lights, or pendants. The licensee's Staffing policy dated August 1, 2021, indicated residents were provided with means to request assistance for health and safety needs 24 hours per day seven days per week. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 460		
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	0 470		

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0 470	Continued From page 3 (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 implement a written staffing plan that included an evaluation completed by a registered nurse (RN) at least twice a year. In addition, the licensee failed to have a daily work schedule posted in a central location accessible to staff, residents, volunteers, and the public as required. 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	0 470		

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0 470	Continued From page 4 a large portion or all of the residents). The findings include: The licensee held an assisted living license. The facility was licensed for a capacity of four residents and had a current census of four residents. STAFFING PLAN On October 3, 2023, at 10:19 a.m., during entrance conference, the surveyor inquired if the licensee developed and implemented a staffing plan and evaluated the plan twice per year. Licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated they did not have a written staffing plan, however, the licensee scheduled one unlicensed personnel (ULP) each shift due to the size and need of the facility. POSTING On October 3, 2023, at 10:20 a.m., during entrance conference, LALD/CNS-C stated the staffing schedule was posted on the main floor, however, the posted staffing schedule was not current because they were creating a new staffing schedule due to new employees. On October 3, 2023, at 10:33 a.m., during facility tour, the surveyor observed a staff schedule posted on the main level dated July 30, 2023, through August 26, 2023. The licensee's Staffing policy dated August 21, 2021, indicated the licensee's staffing plan was based on an evaluation of the appropriateness of the staffing levels in the facility and was reviewed at least twice per year. In addition, the staffing schedule was posted at the beginning of the shift in a central location accessible to staff, residents,	0 470		

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0 470	Continued From page 5 volunteers and the public. 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 according to the Minnesota Food Code. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated October 3, 2023, for the specific Minnesota Food Code violations. The Inspection	0 480		

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0 480	Continued From page 6 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		
0 485 SS=C	144G.41 Subdivision 1. (13)(i)(A)and(C) Minimum Requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (A) menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; and (C) the facility cannot require a resident to include and pay for meals in their contract; (ii) weekly housekeeping; (iii) weekly laundry service; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not require any resident to include and pay for meals as a part of their assisted living package fee for one of one resident (R1). This practice resulted in a level one violation (a violation that has no potential to cause more than	0 485		

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0 485	Continued From page 7 a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 admitted to the licensee on February 3, 2023, and began receiving assisted living services. R1's contract signed February 3, 2023, page 4 included: "Subject to the Resident's needs, All Hopes will provide the following services which are included in the basic monthly fee: 1. Food Service: Three (3) meals/day are served in the dining area as planned and prepared by All Hopes staff at the following times: 8:00 AM -9:30 AM Breakfast 12:00 PM -1:00 PM Lunch 5:30 PM Dinner" On October 4, 2023, at 9:10 a.m. licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated the above content was in all resident contracts. In addition, LALD/CNS-C stated they misunderstood the statue. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled	0 650		

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0 650	Continued From page 8 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 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 observation, interview, and record review, the licensee failed to ensure employee records contained the required content for one of two employees (unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).	0 650		

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0 650	Continued From page 9 The findings include: ULP-B began employment on March 14, 2023, to provide direct services to residents. On October 4, 2023, at 8:02 a.m., the surveyor observed ULP-B administer oral medication to R2. ULP-B's employee record included an Overview of Home Care Statues and Home Care Bill of Rights (BOR) dated March 14, 2023. ULP-B's employee record lacked the following required content: - training for an unplanned time away from home; - orientation to assisted living regulations [144G.63 Subd. 2]which included overview of assisted living statues, and assisted living BOR. On October 4, 2023, at 10:40 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated ULP-B was trained on the content listed above in a in person class however, the licensee did not update the form to reflect the change from home care to assisted living. On October 4, 2023, at 12:43 p.m., ULP-B stated they were trained by the licensee on the topics listed above upon hire. The licensee's Personnel Records policy dated August 1, 2021, indicated a record of each paid employee who provided assisted living services for the licensee would be maintained including documentation of orientation, and competency evaluations. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 650		

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0 650	Continued From page 10 (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 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 develop a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all residents receiving services under the assisted living license.	0 680		

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0 680	Continued From page 11 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, 2021, lacked evidence of the following required content: - quarterly review of missing resident policy; - process for EP collaboration; - subsistence needs for staff and residents including amounts of food, water, medical supplies and pharmaceuticals. - transportation; - policies and procedures for volunteers; - roles under a wavier declared by secretary; and - emergency officials contact information. On October 4, 2023, at 12:10, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated the licensee reviewed the missing residents' policy yearly and emergency officials contact information was missed during completion of the plan. In addition, the licensee had a plan for transportation during an emergency however, the information was not located in the binder. The licensee's Emergency Preparedness policy dated August 1, 2021, indicated the licensee would have an identified plan in place to assure the safety and well-being of resident and staff	0 680		

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ALL HOPES INCORPORATED	7932 ORCHARD AVENUE NORTH BROOKLYN PARK, MN 55443

(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
0 680	Continued From page 12 during periods of an emergency or disaster that disrupts services. Per Assisted Living Facilities: Minnesota Rules Chapter 4659, 4659.0110, Subp. 4. Review missing resident plan. The assisted living director and clinical nurse supervisor must review the missing person plan at least quarterly and document any changes to the plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 800		

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0 800	Continued From page 13 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). Findings include: On a facility tour on October 3, 2023, at approximately 11:45 a.m. with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C it was observed that the ceiling in the basement bathroom was stained and water damaged from a water leak that occurred on the main floor. Ceilings and walls are required to be maintained in a state of good repair. It was also observed that the bi-fold closet door was dislodged and hanging off the track in resident room #3. Closet doors are required to be maintained as installed at the time of construction approval. An electrical box cover was observed as not fitting tightly to the wall in the lower level. Electrical box covers are required to be maintained as installed at the time of construction approval. These deficient conditions were visually verified by LALD/CNS-C accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and	0 810		

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0 810	Continued From page 14 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 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 record review and interview, the licensee failed to maintain the facility's fire safety and evacuation plan with required elements. This had the potential to directly affect all residents, staff, and visitors.	0 810		

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0 810	Continued From page 15 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). Findings include: A record review of available documentation and phone interview were conducted on October 4, 2023, at approximately 9:45 a.m. of documents provided by licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review of the available documentation indicated that the licensee provided room numbers identifying the resident rooms on the fire safety and evacuation floor plan but not on or adjacent to the door of each resident room. Room numbers are required to be installed on or adjacent to the resident room doors and the fire safety and evacuation floor plan in order to provide efficient communication for exiting in the event of a fire or similar emergency. Record review of the available documentation indicated that the licensee did not include fire protection procedures necessary for residents of this specific facility in the event of a fire or similar emergency. Record review of the available documentation indicated the licensee did not have unique and	0 810		

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0 810	Continued From page 16 unusual needs for individual resident movement or evacuation during a fire or similar emergency. Documentation of unique and unusual needs for evacuation of each resident in the facility is required to be kept with the fire safety and evacuation plan for reference in the event of a fire or similar emergency. Record review of the available documentation indicated that employees received training at the same time and along with the fire drills. Training of employees is required at hire and twice per year thereafter on the facility fire safety and evacuation plan and procedures of this facility. Facility fire safety and evacuation plan employee training is required to be completed and documented separately from drills. Record review of the available documentation indicated that the facility did not offer specific training based on the facility fire safety and evacuation plan to the residents. Resident training based on the facility fire safety and evacuation plan is required to offered to the residents at least annually. Record review of the available documentation indicated that evacuation drills had been conducted but not in the required sequence. Documentation for three fire drills was provided for January 2023, March 2023, and September 2023. Evacuation drills are required to be completed and documented every other month and twice per shift per year and separately from employee training records. All deficiencies were verified by LALD/CNS-C during the interview. TIME PERIOD FOR CORRECTION: Twenty-one	0 810		

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0 810	Continued From page 17 (21) days.	0 810		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property of a resident for one of one resident (R1). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 admitted to the licensee on February 3, 2023, and began receiving assisted living services. R1's contract signed February 3, 2023, included a section titled Miscellaneous Provisions which	0 970		

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0 970	Continued From page 18 read, "The resident agrees that All Hopes will not be liable to the resident for any personal injury or property damage (including, without limitation, damage to, or loss or theft of, automobiles or personal property of resident) suffered by the resident or the resident's agents, guests or invitees, unless and to the extent that the injury or damage is caused by the negligence of All Hopes or its employees or agents. The resident hereby releases All Hopes from liability for any personal injury or property damage suffered by the resident ... unless caused by the negligence of All Hopes or its employees or agents." On October 4, 2023, at 9:10 a.m. licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated the above content was in all resident contracts. On October 4, 2023, at 9:16 a.m., LALD/CNS-C stated they were unaware the contract could not include language for waving the facilities liability. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01530 SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of	01530		

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01530	Continued From page 19 employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure supervisors of direct-care staff received at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date for one of one employee (registered nurse (RN)-A). In addition, the licensee failed to ensure direct-care staff completed at least eight hours of initial dementia care training within 160 working hours of the employment start date for one of one unlicensed personnel ((ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic	01530		

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01530	Continued From page 20 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: RN-A RN-A began full time employment on December 22, 2022, to provide supervision and oversite to ULP and provide direct services to residents. RN-A record included 4.5 hours of dementia care training completed between December 2022 and January 17, 2023. RN-A's record lacked eight hours of initial dementia care training within 120 working hours of employment start date. ULP-B ULP-B began employment on March 14, 2023, to provide direct services to residents. On October 4, 2023, at 8:02 a.m., the surveyor observed ULP-B administer oral medication to R2. ULP-B's record included 0.5 hours of dementia care training completed on March 15, 2023. ULP-B's record lacked eight hours of initial dementia care training within 160 working hours of employment start date. On October 4, 2023, at 10:40 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated the licensee provided six hours of dementia care training upon hire to all staff and the licensee was unaware eight hours of dementia training were required. In addition, LALD/CNS-C stated ULP-B worked 820 hours since the date of hire. The surveyor inquired if the licensee changed dementia training since they changed from a comprehensive home care	01530		

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01530	Continued From page 21 provider to an assisted living provider. LALD/CNS-C stated they had continued to use the same training. The licensee's Dementia Education policy dated August 1, 2021, indicated supervisors of direct-care staff must have at least eight hours of initial dementia education within 120 working hours of employment start date on the required topics. In addition, direct care employee must have completed at least eight hours of initial dementia care training within 160 working hours of the employment start date on the required topics. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90	01620		

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01620	Continued From page 22 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident assessment and reassessment, not to exceed 90 calendar days from the last date of the assessment for one of two 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 admitted to the licensee on February 3, 2023, and began receiving assisted living services. R1's diagnoses included schizoaffective disorder (complex mental illness that combines schizophrenia and a mood disorder), bipolar (mental illness characterized by extreme mood swings), and polysubstance abuse of methamphetamine, cannabis, and lysergic acid diethylamide (LSD).	01620		

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01620	Continued From page 23 R1's Service Plan (Wavier) - Addendum to Contract signed February 3, 2023, indicated R1 received bathing reminders, bedmaking, dressing reminders, behavior management, meal assistance and reminders, medication administration, vital signs (VS), garbage removal, safety checks, and activities. R1's record included 90-day nursing assessments dated April 6, 2023, and July 9, 2023, which indicated the July 9, 2023, assessment was four days late. On October 4, 2023, at 9:52 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated assessments were completed upon admission, 14-days, 90-days, and if there was a change of condition. On October 4, 2023, at 9:21 a.m., the surveyor inquired why R1 assessment was completed after 90 calendar days from the previous assessment. LALD/CNS-C stated, "I don't know what was going on. We usually try to be on time." The licensee's Assessment and Reassessment policy dated August 1, 2021, indicated ongoing resident reassessments must be conducted by a RN and cannot exceed 90 days from the last date of assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		

Minnesota Department of Health
Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *10/03/23*
Time: 11:00:00
Report: 103923116

Food and Beverage Establishment Inspection Report

Location:
All Hopes Incorporated
7932 Orchard Avenue North
Brooklyn Park, MN55443
Hennepin County, 27

Establishment Info:
ID #: 0039344
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7634821487
ID #:

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

The following orders were issued during this inspection.

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

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

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

EGGS ARE STORED ABOVE READY TO EAT DELI MEATS AND PRODUCE IN GARAGE REFRIGERATOR. PERSON-IN-CHARGE MOVED READY TO EAT FOODS ABOVE EGGS, CORRECTED ON SITE.

Comply By: 10/03/23

Food and Equipment Temperatures

Process/Item: MILK
Temperature: 41 Degrees Fahrenheit - Location: COLD HOLD REFRIGERATOR
Violation Issued: No

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

The inspection was completed with the person in charge and reviewed with MDH nurse evaluator Ashley Crews.

The establishment has a residential kitchen and should serve food for same-day service only.

The kitchen has wood cabinets with hollow base, wood laminate floor, painted walls and popcorn ceiling and laminate countertops.

The kitchen finishes and surfaces are clean and well maintained.

The kitchen refrigerator/freezer are of residential grade.

A chest freezer and 2nd refrigerator are in the garage of the home.

A 2-compartment sink is present in kitchen. 1 compartment is designated for hand washing only.

A residential dish machine is located in the kitchen and the person-in-charge states the dish machine utensil surface temperature reaches 165 degrees F by color changing test strips.

A supply of single-use gloves is present in kitchen.

Discussed the following with the person-in-charge: minimum cook temps for animal proteins, sanitizing surfaces, food source, foodborne illness symptoms and exclusion of ill employees, avoiding bare hand contact with ready to eat foods.

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 103923116 of 10/03/23.

Certified Food Protection Manager: Beatrice R. Awosika

Certification Number: FM107683 Expires: 08/16/24

Inspection report reviewed with person in charge and emailed.

Signed: _____

Victor Awosika
Person-in-charge

Signed: _____

Aron Goodner
Public Health Sanitarian I
Freeman Building
aron.goodner@state.mn.us