Electronically Delivered

October 10, 2024

Licensee
Eden Homes Inc.
3714 Bryant Avenue North
Minneapolis, MN 55412

RE: Project Number(s) SL29433015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on September 5, 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.

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. 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 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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

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

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29433	A. BUILDING: _____ B. WING _____	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDEN HOMES INC	3714 BRYANT AVENUE NORTH MINNEAPOLIS, MN 55412

(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: SL29433015-0 On September 3, 2024, through September 5, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were two (2) residents receiving 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 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.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (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 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 4, 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		
0 650 SS=F	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	0 650		

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0 650	Continued From page 2 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 interview and record review, the licensee failed to ensure the registered nurse (RN) documented competencies for unlicensed personnel ((ULP)-A, ULP-B) who would provide treatments. 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).	0 650		

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0 650	Continued From page 3 The findings include: ULP-A and ULP-B were hired May 15, 2018, and May 21, 2018, respectively. ULP-A's My Transcript dated September 3, 2024, indicated ULP-A was trained for the treatment of blood glucose monitoring on July 31, 2021, but ULP-A's record lacked evidence the RN found ULP-A competent for the treatment. ULP-B's My Transcript dated September 3, 2024, indicated ULP-B was trained for the treatment of oxygen on July 25, 2021, but ULP-B's record lacked evidence the RN found ULP-B competent for the treatment. On September 3, 2024, at 1:15 p.m., clinical nurse supervisor (CNS)-D stated both ULP-A and ULP-B were trained and found competent for each trained treatment, but licensee had failed to document the competencies completed by the RN. CNS-D stated licensee believed the documentation in each ULP's electronic training record would be considered evidence of competencies; however, the training documentation only indicated each ULP was trained, but not found competent by the RN. The licensee's undated Personnel Records policy indicated each employee's record would include documented evidence of competencies completed. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		

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0 810	Continued From page 4	0 810		
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 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	0 810		

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0 810	Continued From page 5 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 September 04, 2024, at 10:15 a.m., licensed assisted living director/ clinical nurse supervisor (LALD)-C 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) but the plan was designed for a building with life safety systems such as fire alarm pull stations. The policy had not been updated to provide complete actions for employees to take in the event of a fire or similar emergency at the licensed facility which did not have life safety systems or a fire-resistant	0 810		

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0 810	Continued From page 6 construction type. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 900 SS=C	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed.	0 900		

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0 900	Continued From page 7 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide the licensee's complete unsigned assisted living contract to the Office of Ombudsman for Long-Term Care (OOLTC). This had the potential to affect all residents and prospective residents. 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: On September 3, 2024, at 3:49 p.m., an email from the OOLTC representative indicated licensee had not provided a blank unsigned assisted living contract to the OOLTC as required. On September 4, 2024, at 9:30 a.m., licensed assisted living director (LALD)-C stated licensee was not aware a blank unsigned complete assisted living contract was required to be provided to the OOLTC. LALD-C stated licensee would contact the OOLTC and provide the blank assisted living contract and any other requested items. The licensee's undated Assisted Living Contracts policy indicated the licensee would provide an unsigned copy of the current assisted living contract to the OOLTC. No further information provided.	0 900		

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0 900	Continued From page 8 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 900		
01290 SS=F	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. (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 interview and record review, the licensee failed to ensure a background study (BGS) was associated with the licensee's current assisted living facility's health facility identification (HFID) number for two of two unlicensed personnel ((ULP)-A, 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	01290		

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01290	Continued From page 9 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's current assisted living HFID issued on August 1, 2021, was 29433. The licensee's previous comprehensive home care license with HFID was 29432. ULP-A and ULP-B were hired May 15, 2018, and May 21, 2018, respectively. ULP-A's Department of Human Services (DHS) Background Study (BGS) Notice dated December 22, 2022, indicated ULP-A was associated with HFID 29432. ULP-B's DHS BGS Notice dated May 21, 2018, indicated ULP-A was associated with HFID 29432. ULP-A and ULP-B's employee records lacked a BGS affiliated with the licensee's HFID 29433. On September 3, 2024, at 11:50 a.m., licensed assisted living director (LALD)-C stated licensee was not aware each employee would need to be affiliated with licensee's current assisted living HFID. LALD-C stated licensee believed since each employee had a cleared BGS from licensee's comprehensive home care license, the employees would not need to be affiliated with the assisted living HFID. LALD-C stated licensee would immediately affiliate every employee with the current assisted living HFID. The licensee's undated Background Studies failed to identify BGS would be conducted	01290		

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01290	Continued From page 10 through the DHS's NetStudy program and failed to identify employees would be affiliated with the appropriate HFID. No further information provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01330 SS=F	144G.60 Subd. 4 (b) Unlicensed personnel (b) Unlicensed personnel performing delegated nursing tasks in an assisted living facility must: (1) have successfully completed training and demonstrated competency by successfully completing a written or oral test of the topics in section 144G.61, subdivision 2, paragraphs (a) and (b), and a practical skills test on tasks listed in section 144G.61, subdivision 2, paragraphs (a), clauses (5) and (7), and (b), clauses (3), (5), (6), and (7), and all the delegated tasks they will perform; (2) satisfy the current requirements of Medicare for training or competency of home health aides or nursing assistants, as provided by Code of Federal Regulations, title 42, section 483 or 484.36; or (3) have, before April 19, 1993, completed a training course for nursing assistants that was approved by the commissioner. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure competency evaluations were completed for all required skill areas, prior to providing services, for two of two unlicensed personnel ((ULP)-A, ULP-B).	01330		

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01330	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: ULP-A and ULP-B were hired May 15, 2018, and May 21, 2018, respectively. ULP-A and ULP-B's records lacked evidence competency evaluations were completed and documented in each ULP's respective record. On September 3, 2024, at 1:15 p.m., clinical nurse supervisor (CNS)-D stated licensee had trained each ULP in all required areas, but licensee failed to complete competencies for the required skills. CNS-D stated licensee failed to develop a method to document competencies and licensee failed to identity ULPs did not complete competencies. CNS-D stated each ULP would need to have competencies completed and then documented in each ULP's record. The licensee's undated Competency Evaluations policy indicated each ULP would have the required competency evaluations completed and documented in each ULP's respective record. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01330		

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01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this	01500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29433	A. BUILDING: _____ B. WING _____	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDEN HOMES INC	3714 BRYANT AVENUE NORTH MINNEAPOLIS, MN 55412

(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
01500	Continued From page 13 subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure annual training was provided and included all required topics for each 12 months of employment, for two of two unlicensed personnel ((ULP)-A, 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 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-A and ULP-B were hired May 15, 2018, and May 21, 2018, respectively.	01500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29433	A. BUILDING: _____ B. WING _____	09/05/2024

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01500	Continued From page 14 ULP-A's My Transcript dated September 3, 2024, indicated ULP-A failed to complete any annual training for the 2023 year. ULP-B's My Transcript dated September 3, 2024, indicated ULP-B failed to complete any annual training for the 2023 year. On September 3, 2024, at 12:50 p.m., clinical nurse supervisor (CNS)-D stated licensee failed to assign any ULPs annual training for the 2023 year. CNS-D stated licensee failed to accurately track each ULP's annual training resulting in no training being completed for the 2023 year. The licensee's undated Annual Training Requirements policy indicated all required annual training would be completed for each 12 months of employment and evidence of the training would be maintained in each employee's record. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
01620 SS=F	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	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29433	A. BUILDING: _____ B. WING _____	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDEN HOMES INC	3714 BRYANT AVENUE NORTH MINNEAPOLIS, MN 55412

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01620	Continued From page 15 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 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 a registered nurse (RN) completed a comprehensive reassessment to include all required content identified per Minnesota Administrative Rule (MN Rules) 4659.0150 Uniform Assessment Tool for one of one resident (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 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 on October 6, 2017.	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29433	A. BUILDING: _____ B. WING _____	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDEN HOMES INC	3714 BRYANT AVENUE NORTH MINNEAPOLIS, MN 55412

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01620	Continued From page 16 R2's MD Orders signed by R2's primary care provider on July 31, 2024, read, "oxygen for bedtime use with CPAP/BiPAP [a medical device used to assist with breathing when a person is sleeping]." R2's Assessment dated August 6, 2024, lacked indication R2 had a treatment plan for a CPAP/BiPAP machine. Additionally, the assessment indicated under Self-Admin of Meds, R2 was not able to safely self-administer any medications. R2's Med Admin Summary (MAS) - Actual - Month dated September 2024, indicated R2 was self-administering their fluticasone prop (an inhaler delivered medication) 50 mcg (microgram) every day. Additionally, the MAS indicated the licensee was administering oxygen for R2's CPAP/BiPAP every bedtime. On September 4, 2024, at 9:30 a.m., clinical nurse supervisor (CNS)-D stated licensee had identified R2 as not being to self-administer medications per R2's recent assessment. CNS-D stated they had assessed R2 as capable of self-administration for R2's inhaler medication and oxygen for R2's CPAP/BiPAP but failed to accurately document R2's ability in the current assessment. CNS-D stated the assessment was completed by CNS-D and they would need to re-assess R2 for self-administration of R2's inhaled medication and oxygen use with R2's CPAP/BiPAP in R2's assessment. The licensee's undated Nursing Assessment and Reassessment of Resident policy indicated each assessment would include storage of medications to prevent diversion and content would include all required areas outline in MN Rule 4659.0150.	01620		

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01620	Continued From page 17 No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01620		

Minnesota Department of Health
Food, Pools, & Lodging Services
P.O. Box 64975
Saint Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *09/04/24*
Time: 14:03:13
Report: 1021241258

Food and Beverage Establishment Inspection Report

Location:
Eden Homes Inc
3714 Bryant Avenue North
Minneapolis, MN55412
Hennepin County, 27

Establishment Info:
ID #: 0037524
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 6122454140
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.

7-200 Toxic Supplies and Applications

7-204.11 ***** Priority 1 *****

MN Rule 4626.1620 Discontinue using chemical sanitizers, including chemical sanitizing solutions generated on site and other chemical antimicrobials on food-contact surfaces that do not meet the requirements specified in 40 CFR part 180, section 180.940, or part 180, subpart E, section 180.2020.

THE CHLORINE CONCENTRATION IN TWO KITCHEN SANI SPRAY BOTTLES EXCEEDED 200PPM. DURING INSPECTION, THE LEVELS WERE ADJUSTED TO THE APPROVED CONCENTRATION OF 100PPM. CORRECTED ON-SITE.

Comply By: 09/04/24

2-100 Supervision

2-102.12AMN

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

ESTABLISHMENT DOES NOT HAVE A CERTIFIED FOOD PROTECTION MANAGER (CFPM) CERTIFICATE. AILEEN VILLANUEVA HAS AN APPROVED FOOD SAFETY CERTIFICATE POSTED ON-SITE. INFORMATION ON HOW TO OBTAIN CFPM SENT WITH REPORT.

Comply By: 10/07/24

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.11

MN Rule 4626.1515 Maintain the physical facilities in good repair.

THE LAMINATE COUNTERTOP LOCATED ABOVE THE KITCHEN HANDWASHING SINK HAS WATER DAMAGE AND IS NO LONGER ATTACHED TO THE WALL. REPAIR.

Comply By: 09/16/24

Food and Beverage Establishment Inspection Report

Surface and Equipment Sanitizers

Chlorine: > 200PPM at Degrees Fahrenheit
Location: SANI SPRAY BOTTLE #1
Violation Issued: Yes

Chlorine: = 100PPM at Degrees Fahrenheit
Location: SANI SPRAY BOTTLE #1 *CORRECTED
Violation Issued: No

Chlorine: > 200PPM at Degrees Fahrenheit
Location: SANI SPRAY BOTTLE #2
Violation Issued: Yes

Chlorine: = 100PPM at Degrees Fahrenheit
Location: SANI SPRAY BOTTLE #2 *CORRECTED
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 41 Degrees Fahrenheit - Location: MILK - FRIGIDAIRE REFRIGERATOR
Violation Issued: No

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: YOGURT - FRIGIDAIRE REFRIGERATOR
Violation Issued: No

Process/Item: Ambient Temperature
Temperature: 36 Degrees Fahrenheit - Location: FRIGIDAIRE REFRIGERATOR
Violation Issued: No

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

ALL FINDINGS ON THIS REPORT WERE DISCUSSED WITH LALDs, RAMON AND AILEEN VILLANUEVA.

THIS FACILITY IS A RESIDENTIAL HOME AND THEY CURRENTLY HAVE 2 CLIENTS AND THE FACILITY CAN HAVE UP TO 4 CLIENTS.

PER CONVERSATION WITH RAMON AND AILEEN VILLANUEVA, FOOD IS MADE FOR SAME DAY SERVICE. NO LEFTOVERS ARE KEPT.

THE KITCHEN HAS RESIDENTIAL EQUIPMENT, PAINTED DRYWALL, WOOD CABINETS, LAMINATE COUNTERTOPS AND WOOD FLOORING. PHYSICAL FACILITY ITEMS WILL BE MONITORED DURING FUTURE INSPECTIONS.

Type: Full
Date: *09/04/24*
Time: 14:03:13
Report: 1021241258
Eden Homes Inc

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1021241258 of 09/04/24.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed:_____
RAMON AND AILEEN VILLANUEVA
LALDs

Signed:_____
Melissa Ramos
Environmental Health Specialist
Metro District Office
651-201-4495
Melissa.Ramos@state.mn.us