Electronically delivered

March 2, 2022

Administrator
N&V Helpful Heart Care, Inc.
8159 Mount Curve Boulevard
Brooklyn Park, MN 55445

RE: Project Number(s) SL31111015

Dear Administrator:

On February 15, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine correction of orders found on the evaluation completed on October 29, 2021. The follow-up evaluation determined your agency had not corrected all of the state licensing orders issued pursuant to the October 29, 2021 evaluation.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state licensing orders issued pursuant to the last evaluation completed on October 29, 2021, found not corrected at the time of the February 15, 2022, follow-up evaluation and/or subject to penalty assessment are as follows:

2040-Fire Protection And Physical Environment-144g.81 Subdivision 1 = $500.00

The details of the violations noted at the time of this follow-up evaluation completed on February 15, 2022 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $500.00**. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), by the correction order date, the licensee must document in the provider's records any action taken to comply with the correction order by the correction order date. The commissioner may request a copy of this documentation and the assisted living facility's action to respond to the correction orders in future evaluations, upon a complaint investigation, and as otherwise needed.

IMPOSITION OF FINES:

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in §144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism

authorized in §144G.20.

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

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you have one opportunity to challenge the correction order issued, including the level and scope, and any fine assessed through the correction order reconsideration process. This written request must be received by the Department of Health within 15 calendar days of the correction order receipt date. Please send your written request via email to the following:

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

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both.

We urge you to review these orders carefully. If you have questions, please contact Jonathan Hill at 651-201-3993.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Sincerely,

Jonathan Hill, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-3993 Fax: 651-215-9697

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31111	A. BUILDING: _____ B. WING _____	R 02/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
N&V HELPFUL HEART CARE INC	8159 MOUNT CURVE BOULEVARD BROOKLYN PARK, MN 55445

(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 Initial comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 1144G.08 to 144G.95, this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL31111015 On February 14, 2022 through February 15, 2022, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on October 29, 2021. At the time of the survey, there were 4 active residents receiving services under the Assisted Living license. As a result of the revisit, the following orders are reissued.	{0 000}	Minnesota Department of Health is documenting the State Licensing 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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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{0 480}	Continued From page 1 (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: (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: No Further Action Required	{0 480}		
{02040} SS=F	144G.81 Subdivision 1 Fire protection and physical environment 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.	{02040}		

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{02040}	Continued From page 2 This MN Requirement is not met as evidenced by: Based on document review, the facility failed to provide a hazard vulnerability or safety risk assessment for the facility. This had the potential to directly affect all residents and staff. 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 February 14, 2022, at 10:27 a.m., MDH staff emailed nandvhomecare@yahoo.com requesting a copy of the hazard vulnerability or safety risk assessment. On February 21, 2022, at 9:52 a.m., MDH staff emailed nandvhomecare@yahoo.com again requesting a copy of the hazard vulnerability or safety risk assessment. On February 22, 2022, at 12:23 p.m., the licensee emailed documents to MDH staff. Documents were reviewed by survey staff on February 22, 2022, at 4:00 p.m., a hazard vulnerability or safety risk assessment for the facility was not included. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	{02040}		

Electronically Delivered

November 23, 2021

Administrator
N&V Helpful Heart Care Inc
8159 Mount Curve Boulevard
Brooklyn Park, MN 55445

RE: Project Number(s) SL31111015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on October 29, 2021, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health 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 enclosed State Form documents the state licensing orders. The Department of Health documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Home Care 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 are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

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

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation

that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572. subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5)(b), immediate fine imposition is authorized for both surveys and investigations conducted. When a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, no immediate fines are assessed.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order. A copy of the provider's records documenting those actions may be requested for follow-up surveys. The licensee is not required to submit a plan of correction for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the client(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's clients/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 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 Department of Health within 15 calendar days.

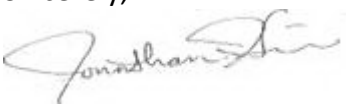
A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general 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

Free from Maltreatment reconsideration requests should addressed 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 this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,



Jonathan Hill, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jonathan.hill@state.mn.us
Telephone: 651-201-3993 Fax: 651-215-9697

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31111	A. BUILDING: _____ B. WING _____	10/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
N&V HELPFUL HEART CARE INC	8159 MOUNT CURVE BOULEVARD BROOKLYN PARK, MN 55445

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0 000	Initial Comments Initial comments *****ATTENTION****** ASSISTED LIVING 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: SL31111015 On October 27 through October 28, 2021, 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 (4) residents receiving services under the provider's Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing 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.	
0 110 SS=F	144G.10 Subdivision 1a Assisted living director license required	0 110		

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0 110	Continued From page 1 Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employment of a licensed assisted living director (LALD). This had the potential to affect all four (4) residents receiving Assisted Living services. 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). This resulted in an immediate correction order. The findings include: The licensee lacked evidence of a LALD as required, in general administrative charge of the facility. Page 2 (two) of the licensee's Application for Assisted Living Licensure signed May 20, 2021, by administrator (A)-C, indicated A-C was the Assisted Living Director for the facility. The application further indicated, on page 1 (one) the license would be for an Assisted Living Facility with Dementia Care (ALFDC).	0 110		

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0 110	Continued From page 2 On October 27, 2021, at 11:22 a.m., A-C stated she did not have her LALD certificate. A-C indicated she did not specifically remember applying for the assisted living director license. On October 27, 2021, at 11:25 a.m. the Minnesota Board of Executives for Long-Term Services and Support (BELTSS) website was checked for verification of the A-C assisted living director licensure verification. A-C was not listed as having a current LALD license. A-C verified her digital signature appeared on the application for Assisted Living Facility with Dementia Care dated May 20, 2021, and that she is listed as the Assisted Living Director on that application. The licensee lacked a LALD to manage and supervise Assisted Living services for the four current residents receiving assisted living services. A policy related to the licensee having a Licensed Assisted Living Director for the facility was requested, but not provided. No further information was provided Time Period to correct: IMMEDIATE October 28, 2021, immediacy removed as confirmed by on-site observations of surveyor on October 28, 2021 and document review of evaluation supervisor on October 28, 2021.	0 110		
0 250 SS=F	144G.20 Subdivision 1. Conditions	0 250		

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0 250	Continued From page 3 (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04;	0 250		

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0 250	Continued From page 4 (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they met the requirements of licensure by attesting the managerial officials who oversaw the day-to-day operations had developed and implemented current policies and procedures as required with records reviewed. 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 the entrance conference on October 27, 2021, at approximately 10:30 a.m., administrator (A)-C confirmed she was responsible for and participated in the day-to-day operations. A-C stated they were familiar with the Assisted Living licensing rules. A-C further stated they were	0 250		

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0 250	Continued From page 5 "working hard to review them." The licensee had attested they read and understood the Assisted Living licensing statutes and rules upon application; however, the following orders were issued: Refer to licensing order at Statute 144G.10, Subd. 1a. The licensee failed to ensure employment of a licensed assisted living director (LALD). Refer to licensing order at Statute 144G.40, Subd 2. The licensee failed to provide a copy of the uniform checklist disclosure of services (UDALSA) with the required content for one of one resident (R1) with record reviewed. Refer to licensing order at Statute 144G.41, Subd. 1. The licensee failed to ensure food was prepared and served according to the Minnesota Food Code. Refer to licensing order at Statute 144G.41, Subd 7. The licensee failed to post the required information related to the grievance procedure and contact information for the Office of Ombudsman for Long-Term Care and Mental Health and Developmental Disabilities. Refer to licensing order at Statute 144G.42, Subd 1. The licensee failed to display the original current license at the main entrance of the assisted living facility as required. Refer to licensing order at Statute 144G.42, Subd 2. The licensee failed to engage in and maintain documentation of ongoing quality management activities relevant to the size and services provided by the assisted living provider.	0 250		

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0 250	Continued From page 6 Refer to licensing order at Statute 144G.42, Subd. 7. The licensee failed to support protection and safety by not posting information and phone numbers for reporting to the Minnesota Adult Abuse Reporting Center (MAARC) in common areas and near telephones provided by the assisted living facility. Refer to licensing order at Statute 144G.42, Subd. 8. The licensee failed to ensure the employee record contained all the required content. Refer to licensing order at Statute 144G.45, Subd. 2 (a) (1). The licensee failed to provide smoke alarms that complied with fire protection requirements. Refer to licensing order at Statute 144G.45, Subd. 2 (a) (4). The licensee failed to provide a fire extinguisher that complied with fire protection requirements. Refer to licensing order at Statute 144G.45, Subd. 2 (b)-(f). The licensee failed to provide the required training, drills and plans for fire safety and evacuation. Refer to licensing order at Statute 144G.50, Subd. 2. The licensee failed to develop, implement, and provide a contract containing all required content to all residents. Refer to licensing order at Statute 144G.62, Subd. 4. The licensee failed to ensure a registered nurse (RN) conducted direct supervision of staff performing a delegated task within 30 days of providing services for one of one employee.	0 250		

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	31111	A. BUILDING: _____ B. WING _____	10/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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0 250	Continued From page 7 Refer to licensing order at Statute 144G.63, Subd. 2. The licensee failed to ensure employees received orientation to include all required content for one of two employees. Refer to licensing order at Statute 144G.63, Subd. 5. The licensee failed to ensure employees received at least eight hours of annual training for each 12 months of employment for one of two employees. Refer to licensing order at Statute 144G.64. The licensee failed to ensure all employees had completed training in dementia care, as required. Refer to licensing order at Statute 144G.70, Subd. 4. The licensee failed to develop and implement a service plan for all residents with the required content. Refer to licensing order at Statute 144G.81, Subd. 1. The licensee failed to provide a hazard vulnerability or safety risk assessment for the facility. Refer to licensing order at Statute 144G.6502, Subd. 8. The licensee failed to ensure required postings notifying visitors of electronic monitoring was posted at facility entrances. Twenty-two (22) correction orders were issued, which indicated the licensee's understanding of the Minnesota Statutes and Rules were limited or not evident for compliance with sections 144G.08 to 144G.9999. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One	0 250		

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0 250	Continued From page 8 (21) days	0 250		
0 430 SS=D	144G.40 Subd. 2 Uniform checklist disclosure of services (a) All assisted living facilities must provide to prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a). This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide a copy of the uniform checklist disclosure of services (UDALSA) with the required content for one of one resident (R1) with record reviewed. This had the potential to affect all four (4) 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) and was issued at an	0 430		

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0 430	Continued From page 9 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: Review of R1's record lacked evidence of a signature from the resident or resident representative indicating that a UDALSA had been provided, to include: - a disclosure of the categories of assisted living licenses available and the category of license held by the facility; - a written checklist listing all services permitted under the facility's license identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and -an oral explanation of the services offered under the contract. R1's service plan dated January 11, 2021, indicated R1 received services which included medication administration, housekeeping, and standby bathing and grooming assistance as needed. On October 28, 2021, during an 11:18 a.m. interview, administrator (A)-C stated she did not provide a UDALSA to R1. The licensee's Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) policy was requested but not provided. The licensee's Statement of Home Care Services policy, dated January 11, 2020, indicated "[licensee] shall provide a "Statement of Home	0 430		

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0 430	Continued From page 10 Care Services" to clients and client's representatives. This Statement shall be provided prior to the initiation of services." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 430		
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: (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: (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 had the potential to affect all four (4) residents of the facility. This practice resulted in a level two violation (a	0 480		

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0 480	Continued From page 11 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 October 27, 2021, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post the required information related to the grievance procedure and contact information	0 550		

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0 550	Continued From page 12 for the Office of Ombudsman for Long-Term Care and Mental Health and Developmental Disabilities. This had the potential to affect all four (4) residents receiving assisted living services. 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: The licensee lacked a posting in a common area to include the grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. In addition, there was no evidence of a posting in the common area to include contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. On October 27, 2021, at approximately 10:00 a.m., during a tour of the facility, the surveyor observed the facility's common areas and noted no postings of the grievance procedure or Ombudsman contact information. During an interview on October 27, 2021, at 10:33 a.m., administrator (A)-C verified she does not have information posted in a facility common area regarding the grievance process. The provided Client Complaints/Grievances	0 550		

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0 550	Continued From page 13 policy, undated, did not address requirements for posting contact information in common areas. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 570 SS=C	144G.42 Subdivision 1 Display of license The original current license must be displayed at the main entrance of each assisted living facility. The facility must provide a copy of the license to any person who requests it. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to display the original current license at the main entrance of the assisted living facility as required. This had the potential to affect all of the licensee's four (4) current residents, staff and visitors. 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: During a facility tour on October 27, 2021, at approximately 10:00 a.m., the surveyor noted no posting of the original current license at the facility main entrance.	0 570		

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0 570	Continued From page 14 On October 27, 2021, during a 10:27 a.m. interview, administrator (A)-C verified the facility license was not posted in the establishment. A-C stated the physical license had not been sent to her yet. The licensee's Home Care License policy, revised October 28, 2021, indicated "The original current license shall be displayed at the principal business office of [licensee]. Copies must be displayed at any branch office of [licensee]." The policy had not been updated to include current Assisted Living Licensure requirements. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 570		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by:	0 580		

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0 580	Continued From page 15 Based on interview and record review, the licensee failed to engage in and maintain documentation of ongoing quality management activities relevant to the size and services provided by the assisted living provider. This had the potential to affect all four (4) residents receiving assisted living services. 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 an interview on October 27, 2021, at 11:18 a.m., administrator (A)-C stated they have not documented quality management meetings yet, but indicated it is something they would be implementing. A-C further indicated some correction activities were documented in response to a previous survey, but the documentation of those activities was not provided. The licensee's Quality Improvement Project policy dated January 20, 2021, indicated, "[licensee] will have at least one documented quality improvement project in place at all times and retain records of such projects for at least two years." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One	0 580		

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0 580	Continued From page 16 (21) days	0 580		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to support protection and safety by not posting information and phone numbers for reporting to the Minnesota Adult Abuse Reporting Center (MAARC) and by not posting the 911 emergency number in common areas and near telephones provided by the assisted living facility. This had the potential to affect all four (4) residents receiving assisted living services, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all	0 640		

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0 640	Continued From page 17 of the residents). The findings include: The licensee lacked a posting of the 911 emergency number in common areas and near telephones provided by the assisted living. There was no evidence of the contact information or reporting number for the MAARC. On October 27, 2021, at approximately 10:00 a.m., during a tour of the facility, an observation noted the lack of the required postings in common areas of the 911 emergency number and information related to reporting suspected maltreatment to MAARC. During an interview on October 27, 2021, at 10:33 a.m., administrator (A)-C verified she does not have 911 emergency information or the MAARC number posted in the facility. The provided Maltreatment - Communication, Prevention, and Reporting policy dated November 23, 2016, did not address requirements for posting emergency and maltreatment reporting information in common areas. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640		
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must	0 650		

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0 650	Continued From page 18 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. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the employee record contained the required content to include an annual performance evaluation for one of two employees (registered nurse (RN)-A) with records reviewed. 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	0 650		

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0 650	Continued From page 19 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: RN-A had a hire date of August 18, 2013. RN-A's record included a performance evaluation dated April 27, 2017. During an interview on October 28, 2021, at 12:35 p.m., administrator (A)-C verified the last performance evaluation for RN-A was dated April 27, 2017. The licensee's Personnel Files/Employee Records policy dated December 1, 2021, indicated employee personnel files would include "Documentation of annual performance review, which identify areas of improvement and training recommendations". No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code:	0 780		

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0 780	Continued From page 20 (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that complied with fire protection requirements. 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 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: On October 27, 2021, between 11:50 a.m. and 12:20 p.m., survey staff toured the facility with	0 780		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
N&V HELPFUL HEART CARE INC	8159 MOUNT CURVE BOULEVARD BROOKLYN PARK, MN 55445

(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
0 780	Continued From page 21 administrator (A)-C. During the tour, the following observations were made: -The power light was not illuminated on smoke alarm in basement sleeping room; this smoke alarm did not work when tested. A-C confirmed during tour interview that the smoke alarm did not work. -Smoke alarms were not provided on each story of the facility. During tour interview with A-C, it was confirmed that smoke alarms were not installed in common areas of basement and on main floor of the facility. During the exit interview on October 27, 2021, at approximately 12:50 p.m., it was discussed with A-C that all newly installed and pre-existing smoke alarms are required to be interconnected so that actuation of one alarm causes all alarms in the dwelling unit to operate. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee	0 800		

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0 800	Continued From page 22 failed to provide a fire extinguisher that complied with fire protection requirements. 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 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: On October 27, 2021, between 11:50 a.m. and 12:20 p.m., survey staff toured the facility with administrator (A)-C. During the tour, the following observation was made: -The portable fire extinguisher mounted near the fireplace on the main floor of facility was date stamped 2017 on the bottom. The fire extinguisher did not have a label or tag attached indicating when maintenance was performed. During the exit interview with A-C on October 27, 2021, at approximately 12:50 p.m., they did not know annual maintenance was required for portable fire extinguishers. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment	0 810		

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0 810	Continued From page 23 (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, record review and interview, the licensee failed to provide the required training, drills and plans for fire safety and evacuation. This had the potential to affect all residents, staff, and visitors.	0 810		

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0 810	Continued From page 24 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 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: On October 27, 2021, between 11:50 a.m. and 12:20 p.m., survey staff toured the facility with administrator (A)-C. During the facility tour, it was observed that no evacuation maps were posted in the facility. On October 27, 2021, at approximately 12:20 p.m., A-C provided records for review. Records were reviewed by survey staff on October 27, 2021, between 12:20 p.m. and 12:40 p.m. 1. The Fire Emergency plans dated July 2015 failed to include: a. the location and number of resident rooms; b. a plan with accurate instructions on fire protection procedures; i. magnetic door holders and smoke compartment doors were referenced, which the facility does not have. ii. policy stated that an alarm system automatically notifies the fire department upon activation, but the facility does not have this type of alarm system. c. identification of unique or unusual resident needs for movement or evacuation; and d. the required frequency for evacuation drills. i. policy indicated drills were not mandatory in the State of Minnesota but were to be performed 2-3 times per year.	0 810		

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0 810	Continued From page 25 ii. This does not meet the twice per year per shift with at least one evacuation drill every other month frequency requirement. 2. Facility failed to provide annual fire and evacuation training for residents. Documentation was requested by survey staff but not provided. 3. The Training 4.1 Emergency Preparation policy dated July 2015 failed to provide the required staff training frequency. This plan required staff training for fire safety and evacuation during orientation and then annually but did not require training at least twice per year after hire. Staff fire safety and evacuation employee training logs were provided dated 11-1-16 and 5-17-17. On October 27, 2021, at approximately 12:50 p.m., A-C confirmed during interview that the facility failed to provide the required content within the fire safety and evacuation plans. A-C confirmed that evacuation maps were not posted within the facility, and that the training and drill frequency for staff and residents were not met. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 910 SS=F	144G.50 Subd. 2 Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the license number of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable;	0 910		

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0 910	Continued From page 26 (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written assisted living contract with the required content for one of one resident (R1) with record reviewed. 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: R1's service plan signed January 21, 2020, indicated R1 received services which included medication administration, housekeeping, and standby bathing and grooming assistance as needed. R1's record contained a "Housing with Services Contract and Lease Agreement" signed January 21, 2020. The contract lacked the license number of the facility. On October 28, 2021, during a 3:42 p.m. interview, administrator (A)-C acknowledged the current contract for R1 was outdated. A-C stated the contract needed to be updated for all the residents in the facility.	0 910		

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0 910	Continued From page 27 The licensee's policy related to Assisted Living Contract contents was requested but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 910		
0 920 SS=F	144G.50 Subd. 2 Contract information (c) The contract must include: (1) a disclosure of the category of assisted living facility license held by the facility and, if the facility is not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license; (2) a description of all the terms and conditions of the contract, including a description of and any limitations to the housing or assisted living services to be provided for the contracted amount; (3) a delineation of the cost and nature of any other services to be provided for an additional fee; (4) a delineation and description of any additional fees the resident may be required to pay if the resident's condition changes during the term of the contract; (5) a delineation of the grounds under which the resident may be discharged, evicted, or transferred or have services terminated; (6) billing and payment procedures and requirements; and (7) disclosure of the facility's ability to provide specialized diets. This MN Requirement is not met as evidenced by:	0 920		

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0 920	Continued From page 28 Based on interview and record review, the licensee failed to execute a written assisted living contract with the required content for one of one resident (R1) with record reviewed. 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: R1's service plan signed January 21, 2020, indicated R1 received services which included medication administration, housekeeping, and standby bathing and grooming assistance as needed. R1's record contained a "Housing with Services Contract and Lease Agreement" signed January 21, 2020. The contract lacked a disclosure of the category of assisted living facility license held by the facility and, if the facility is not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license. On October 28, 2021, during a 3:42 p.m. interview, administrator (A)-C acknowledged the current contract for R1 was outdated. A-C stated the contract needed to be updated for all the residents in the facility. The licensee's policy related to Assisted Living Contract contents was requested but not provided.	0 920		

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0 920	Continued From page 29 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 920		
0 930 SS=F	144G.50 Subd. 2 Contract information (d) The contract must include a description of the facility's complaint resolution process available to residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints. (e) The contract must include a clear and conspicuous notice of: (1) the right under section 144G.54 to appeal the termination of an assisted living contract; (2) the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer; (3) contact information for the Office of Ombudsman for Long-Term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints; (4) the resident's right to obtain services from an unaffiliated service provider; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written assisted living contract with the required content for one of one resident (R1) with record reviewed. This practice resulted in a level two violation (a	0 930		

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0 930	Continued From page 30 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: R1's service plan signed January 21, 2020, indicated R1 received services which included medication administration, housekeeping, and standby bathing and grooming assistance as needed. R1's record contained a "Housing with Services Contract and Lease Agreement" signed January 21, 2020. The contract lacked: - the right under section 144G.54 to appeal the termination of an assisted living contract; - the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer. On October 28, 2021, during a 3:42 p.m. interview, administrator (A)-C acknowledged the current contract for R1 was outdated. A-C stated the contract needed to be updated for all the residents in the facility. The licensee's policy related to Assisted Living Contract contents was requested but not provided. No further information was provided. TIME PERIOD FOR CORRECTION:	0 930		

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0 930	Continued From page 31 Twenty-One (21) days	0 930		
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure a registered nurse (RN) conducted direct supervision of staff performing a delegated task within 30 days of providing services for one of one employee (unlicensed personnel (ULP)-B) with employee record reviewed.	01440		

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01440	Continued From page 32 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-B was hired September 10, 2013, and provided direct cares for the residents of the facility. ULP-B's record indicated ULP-B was trained and evaluated for competency on January 30, 2017, in medication administration and treatments, including catheter care and blood glucose testing. ULP-B's record did not include documentation of direct supervision by an RN within 30 days of ULP-B performing delegated nursing tasks, including medication administration. On October 28, 2021, at 9:39 a.m., ULP-B was observed administering medications to R1. On October 28, 2021, at 2:34 p.m., administrator (A)-C verified ULP-B's record does not include 30-day supervision of medication administration or other delegated tasks. A policy regarding supervision of unlicensed staff providing delegated tasks was requested, but not provided. The licensee's Comprehensive Home Care Resource Manual Service Plan Addendum, indicated, " Staff will be supervised within the first	01440		

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01440	Continued From page 33 30 days of service delivery and periodically thereafter." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human	01470		

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01470	Continued From page 34 Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this 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 the challenges it poses to communication; (2) 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 employees received orientation to include all required content for one of two employees (unlicensed personnel (ULP)-B) with records reviewed. 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	01470		

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N&V HELPFUL HEART CARE INC	8159 MOUNT CURVE BOULEVARD BROOKLYN PARK, MN 55445

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01470	Continued From page 35 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: ULP-B was hired September 10, 2013, and provided direct cares for the residents of the facility. ULP-B's employee record lacked documentation the following orientation topics were completed: -An overview of assisted living laws 144G. On October 28, 2021, at 11:38 a.m., administrator (A)-C stated employees have not had updated orientation to the assisted living laws. The licensee's Orientation for Home Care Staff policy dated August 12, 2021, indicated, "All staff of [licensee] providing and supervising direct home care services must complete an orientation to home care licensing requirements and regulations before providing home care services to clients." The policy further indicated the orientation must contain an overview of "the appropriate home care rules." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01500 SS=D	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	01500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31111	A. BUILDING: _____ B. WING _____	10/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
N&V HELPFUL HEART CARE INC	8159 MOUNT CURVE BOULEVARD BROOKLYN PARK, MN 55445

(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 36 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 subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics:	01500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31111	A. BUILDING: _____ B. WING _____	10/29/2021

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N&V HELPFUL HEART CARE INC	8159 MOUNT CURVE BOULEVARD BROOKLYN PARK, MN 55445

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01500	Continued From page 37 (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 employees received at least eight (8) hours of annual training for each 12 months of employment for one of two employees (registered nurse (RN)-A) with training records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: RN-A's employee record lacked evidence of eight hours of annual training. RN-A had a hire date of August 18, 2013, and provided direct and supervisory cares for	01500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31111	A. BUILDING: _____ B. WING _____	10/29/2021

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01500	Continued From page 38 residents of the facility. RN-A's employee file included documentation of annual training completed April 29, 2020. During an interview on October 28, 2021, at 11:57 a.m., administrator (A)-C verified last annual training for RN-A was April 29, 2020. The licensee's Required Annual Staff Training policy dated January 20, 2021, indicated, "All staff of [licensee], that performs direct home care services will complete a minimum of 8 hours of annual training for each 12 months of employment." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		
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 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	01530		

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01530	Continued From page 39 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 direct care staff received the required amount of dementia care training in the required time frame for two of two employees (unlicensed personnel (ULP)-B and registered nurse (RN)-A) with records reviewed. 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: RN-A and ULP-B's records lacked documentation of the required two (2) hours of annual dementia care training. RN-A had a hire date of August 18, 2013, and provided direct and supervisory cares for	01530		

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01530	Continued From page 40 residents of the facility. RN-A's record included annual dementia care training completed April 29, 2020. During an interview on October 28, 2021, at 11:57 a.m., administrator (A)-C verbalized employees get 8 hours of dementia care training annually. A-C verified the last annual dementia training for RN-A was April 29, 2020. ULP-B was hired September 10, 2013, and provided direct cares for residents of the facility. ULP-B's record included annual dementia care training last completed November 1, 2016. ULP-B's record included annual training completed October 27, 2021, which included annual orientation topics, but did not include the required two hours of annual dementia care training. During an interview on October 28, 2021, at 2:34 p.m., administrator (A)-C verified ULP-B had no further training/orientation other than the annual training completed October 27, 2021. The licensee's Alzheimer's Disease and Related Disorders - Training and Notification policy, dated "1/21/201(sic)" indicated "[licensee] provides services to clients with Alzheimer's disease or related disorders. As a result, [licensee], will provide relevant training to caregivers and share such training information with those who request it." No further information provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days	01530		

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01650 SS=D	144G.70 Subd. 4 Service plan, implementation, and revisions t (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the resident service plan included the required content for one of one resident (R1) with records reviewed. This practice resulted in a level two violation (a	01650		

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01650	Continued From page 42	01650		

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's service plan signed January 21, 2020, indicated R1 received services which included medication administration, housekeeping, and standby bathing and grooming assistance as needed.

On October 28, 2021, at 9:39 a.m., unlicensed personnel (ULP)-B was observed administering medications to R1.

R1's service plan lacked the following:
-information indicating if resident had a health care directive and the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters.

On October 28, 2021, at approximately 11:00 a.m., registered nurse (RN)-A verified the contingency plan section of R1's service plan was not complete and did not include the circumstances in which emergency medical services are not to be summoned.

The licensee's Service Plans policy, revised October 28, 2021, indicated the service plan must include a contingency plan that includes the circumstances in which emergency medical services are not to be summoned consistent with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01650	Continued From page 43 chapters 145B and 145C, and declarations made by the client under those chapters. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01650		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment 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 hazard vulnerability or safety risk assessment for the facility. This had the potential to affect all dementia care 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), 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).	02040		

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02040	Continued From page 44 The findings include: On October 27, 2021, at approximately 12:20 p.m., administrator (A)-C provided records for review. Records were reviewed by survey staff on October 27, 2021, between 12:20 p.m. and 12:40 p.m. A hazard vulnerability or safety risk assessment for the facility was requested by survey staff but not provided. On October 27, 2021, at 12:50 p.m., A-C confirmed during interview that the facility did not complete a hazard vulnerability or safety risk assessment for the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors Subd. 8.Notice to visitors. (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the required notice was posted at the main entry way of the establishment to display	03090		

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03090	Continued From page 45 statutory language to disclose electronic monitoring activity, potentially affecting all current residents in the assisted living facility, staff, and any visitors to the facility. This practice resulted in a level one violation (a violation that has not 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: During a facility tour on October 27, 2021, at 10:00 a.m., no electronic monitoring notice to visitors was observed posted near the entrance to the facility. During an interview on October 27, 2021, at 10:33 a.m., administrator (A)-C verified there was no electronic monitoring notice to visitors posted in the facility. A policy regarding electronic monitoring was requested but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	03090		

Minnesota Department of Health

625 Robert Street North
St Paul
651-201-4500

Type: Full
Date: *10/27/21*
Time: 13:45:20
Report: 7994211128

Food and Beverage Establishment Inspection Report

Location:
N&V Helpful Heart Care Inc
8159 Mount Curve Boulevard
Brooklyn Center, MN55445
Hennepin County, 27

Establishment Info:
ID #: 0038128
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7634420460
ID #:

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

The following orders were issued during this inspection.

4-300 Equipment Numbers and Capacities

4-302.13B ** Priority 2 **

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

THERE IS NO CURRENT TEMPERATURE MEASURING DEVICE TO CHECK THE TEMP OF THE SANITIZING DISHWASHER.

Comply By: 11/01/21

6-300 Physical Facility Numbers and Capacities

6-301.11 ** Priority 2 **

MN Rule 4626.1440 Provide an adequate supply of hand soap at each handwashing sink or group of 2 adjacent handwashing sinks.

NO HAND SOAP DISPENSER FOUND AT HAND SINK. ENSURE HAND SOAP DISPENSER IS AVAILABLE FOR STAFF TO WASH HANDS.

Comply By: 11/01/21

6-300 Physical Facility Numbers and Capacities

6-301.12 ** Priority 2 **

MN Rule 4626.1445 Provide and maintain a supply of individual disposable towels, a continuous towel system, a heated-air hand drying device, or an approved ambient air temperature hand drying device at each handwashing sink or group of adjacent handwashing sinks.

THERE WERE NO PAPER TOWELS AT THE SINKS WHEN FIRST ARRIVING. ENSURE THAT A PAPER TOWEL DISPENSER IS INSTALLED AND STOCKED AT ALL TIMES.

Comply By: 11/01/21

Type: Full
Date: *10/27/21*
Time: 13:45:20
Report: 7994211128
N&V Helpful Heart Care Inc

Food and Beverage Establishment Inspection Report

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.
NO CURRENT CFPM WAS FOUND ON SITE. CFPM SITE INFORMATION INCLUDED WITH REPORT.

Comply By: 11/01/21

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

THIS REPORT WAS COMPLETED AT THE REQUEST OF HRD AS PART OF A ROUTINE SURVEY.

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 7994211128 of 10/27/21.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed:_____
Establishment Representative

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

Report #: 7994211128

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
625 Robert Street North
St Paul

No. of RF/PHI Categories Out	2	**Date**	10/27/21
No. of Repeat RF/PHI Categories Out	0	**Time In**	13:45:20
Legal Authority MN Rules Chapter 4626		**Time Out**	

	Address	**City/State**	**Zip Code**	**Telephone**
N&V Helpful Heart Care Inc	8159 Mount Curve Boulevard	Brooklyn Center, MN	55445	7634420460

License/Permit #	**Permit Holder**	**Purpose of Inspection**	**Est Type**	**Risk Category**
0038128		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		

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		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	X	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:** 11/01/21

Inspector (Signature) Crystal Elva