



*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically Delivered

February 7, 2024

Licensee  
Heritage House  
870 9th Avenue Northwest  
New Brighton, MN 55112

RE: Project Number(s) SL36942015

Dear Licensee:

On January 19, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the December 1, 2023, survey were corrected. This follow-up survey verified that the facility is back in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

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

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

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>36942</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>01/19/2024</b>
--------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER  <b>HERITAGE HOUSE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>870 9TH AVENUE NW NEW BRIGHTON, MN 55112</b>
-----------------------------------------------------------	----------------------------------------------------------------------------------------------

(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}	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER</p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, this correction order(s) has been issued pursuant to a survey.</p> <p>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.</p> <p>INITIAL COMMENTS: Project # SL36842015-1</p> <p>On January 19, 2024, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed between November 27, 2023, and November 30, 2023. At the time of the survey, there were 3 residents receiving services under the assisted living license. As a result of the revisit, the licensee is in substantial compliance.</p>	{0 000}		
{0 480} SS=F	<p>144G.41 Subd 1 (13) (i) (B) Minimum requirements</p> <p>(13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and</p>	{0 480}		

Minnesota Department of Health  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>36942</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>01/19/2024</b>
--------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER  <b>HERITAGE HOUSE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>870 9TH AVENUE NW NEW BRIGHTON, MN 55112</b>
-----------------------------------------------------------	----------------------------------------------------------------------------------------------

(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
{0 480}	Continued From page 1  This MN Requirement is not met as evidenced by: No futher action needed.	{0 480}		
{0 650} SS=D	<p><b>144G.42 Subd. 8 Employee records</b></p> <p>(a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information:                      (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules;                      (2) records of orientation, required annual training and infection control training, and competency evaluations;                      (3) current job description, including 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.</p> <p>This MN Requirement is not met as evidenced by: No futher action needed.</p>	{0 650}		
{0 660} SS=D	<p><b>144G.42 Subd. 9 Tuberculosis prevention and control</b></p> <p>(a) The facility must establish and maintain a</p>	{0 660}		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>36942</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>01/19/2024</b>
--------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER  <b>HERITAGE HOUSE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>870 9TH AVENUE NW NEW BRIGHTON, MN 55112</b>
-----------------------------------------------------------	----------------------------------------------------------------------------------------------

(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
{0 660}	<p>Continued From page 2</p> <p>comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines.</p> <p>(b) The facility must maintain written evidence of compliance with this subdivision.</p> <p>This MN Requirement is not met as evidenced by: No futher action needed.</p>	{0 660}		
{0 680} SS=F	<p>144G.42 Subd. 10 Disaster planning and emergency preparedness</p> <p>(a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents.</p> <p>(b) The facility must provide emergency and</p>	{0 680}		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>36942</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>01/19/2024</b>
--------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER  <b>HERITAGE HOUSE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>870 9TH AVENUE NW NEW BRIGHTON, MN 55112</b>
-----------------------------------------------------------	----------------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 680}	Continued From page 3  disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule.  This MN Requirement is not met as evidenced by: No futher action needed.	{0 680}		
{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment  (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the	{0 810}		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>36942</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>01/19/2024</b>
--------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER  <b>HERITAGE HOUSE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>870 9TH AVENUE NW NEW BRIGHTON, MN 55112</b>
-----------------------------------------------------------	----------------------------------------------------------------------------------------------

(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
{0 810}	Continued From page 4  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: No futher action needed.	{0 810}		
{01500} SS=F	144G.63 Subd. 5 Required annual training  (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and	{01500}		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>36942</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>01/19/2024</b>
--------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER  <b>HERITAGE HOUSE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>870 9TH AVENUE NW NEW BRIGHTON, MN 55112</b>
-----------------------------------------------------------	----------------------------------------------------------------------------------------------

(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}	<p>Continued From page 5</p> <p>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: (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.</p> <p>This MN Requirement is not met as evidenced by: No futher action needed.</p>	{01500}		



*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically Delivered

December 27, 2023

Licensee  
Heritage House  
870 9th Avenue Northwest  
New Brighton, MN 55112

RE: Project Number(s) SL36942015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on December 1, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

#### **STATE CORRECTION ORDERS**

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

#### **IMPOSITION OF FINES**

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

Level 1: no fines or enforcement.

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

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

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

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5), the MDH may impose fine amounts of either \$1,000 or \$5,000 to licensees who are found to be responsible for maltreatment. The MDH may impose a fine of \$1,000 for each substantiated maltreatment violation that consists of

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

In accordance with Minn. Stat. § 144G.31, Subd. 4 (b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this survey:

**St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services = \$3,000.00**

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$3,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

#### **DOCUMENTATION OF ACTION TO COMPLY**

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

The correction order documentation should include the following:

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

#### **CORRECTION ORDER RECONSIDERATION PROCESS**

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

To submit a reconsideration request, please visit:

**<https://forms.web.health.state.mn.us/form/HRD-Appeals-Form>**

#### **REQUESTING A HEARING**

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this

section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. to submit a hearing request, please visit <https://forms.web.health.state.mn.us/form/HRD-Appeals-Form>.

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

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

If you have any questions, please contact me.

Sincerely,



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

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>36942</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/01/2023</b>
--------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER  <b>HERITAGE HOUSE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>870 9TH AVENUE NW NEW BRIGHTON, MN 55112</b>
-----------------------------------------------------------	----------------------------------------------------------------------------------------------

(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	<p><b>Initial Comments</b></p> <p>*****ATTENTION*****</p> <p><b>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)</b></p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.</p> <p>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.</p> <p><b>INITIAL COMMENTS:</b> SL36942015</p> <p>On November 27, 2023, through November 30, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were three (3) active resident received services under the Assisted Living license.</p> <p>On November 27, 2023, at approximately 5:04 p.m. an immediate order was issued for 2310.</p> <p>On November 30, 2023, the immediacy of order 2310 was removed, but the scope and level remain unchanged.</p>	0 000	<p>Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Provider. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction.</p> <p><b>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.</b></p> <p><b>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</b></p> <p>The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.</p>	
0 480 SS=F	<p><b>144G.41 Subd 1 (13) (i) (B) Minimum requirements</b></p> <p>(13) offer to provide or make available at least the</p>	0 480		

Minnesota Department of Health  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>36942</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/01/2023</b>
--------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER  <b>HERITAGE HOUSE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>870 9TH AVENUE NW NEW BRIGHTON, MN 55112</b>
-----------------------------------------------------------	----------------------------------------------------------------------------------------------

(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
0 480	<p>Continued From page 1</p> <p>following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and</p> <p>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.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).</p> <p>The findings include:</p> <p>Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated November 29, 2023, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.</p> <p>TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.</p>	0 480		
0 650 SS=D	<p>144G.42 Subd. 8 Employee records</p> <p>(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</p>	0 650		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>36942</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/01/2023</b>
--------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER  <b>HERITAGE HOUSE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>870 9TH AVENUE NW NEW BRIGHTON, MN 55112</b>
-----------------------------------------------------------	----------------------------------------------------------------------------------------------

(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
0 650	<p>Continued From page 2</p> <p>include the following information:</p> <p>(1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules;</p> <p>(2) records of orientation, required annual training and infection control training, and competency evaluations;</p> <p>(3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision;</p> <p>(4) documentation of annual performance reviews that identify areas of improvement needed and training needs;</p> <p>(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</p> <p>(6) documentation of the background study as required under section 144.057.</p> <p>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 for one of two employees (unlicensed personnel (ULP)-B).</p> <p>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).</p> <p>The findings include:</p>	0 650		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>36942</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/01/2023</b>
--------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER  <b>HERITAGE HOUSE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>870 9TH AVENUE NW NEW BRIGHTON, MN 55112</b>
-----------------------------------------------------------	----------------------------------------------------------------------------------------------

(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
0 650	<p>Continued From page 3</p> <p>ULP-B was hired on December 10, 2021, and began providing assisted living cares to licensee's residents.</p> <p>ULP-B's record lacked evidence of annual performance reviews to identify areas of improvement needed and training needs.</p> <p>On November 29, at 1:30 p.m., licensed assisted living director (LALD)-C verified the above content was missing from the employee's records.</p> <p>The licensee's Employee Evaluation policy dated August 01, 2021, indicated the [Licensee] will be given an employee evaluation at least annually.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-One (21) days</p>	0 650		
0 660 SS=D	<p>144G.42 Subd. 9 Tuberculosis prevention and control</p> <p>(a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines.</p>	0 660		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>36942</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/01/2023</b>
--------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER  <b>HERITAGE HOUSE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>870 9TH AVENUE NW NEW BRIGHTON, MN 55112</b>
-----------------------------------------------------------	----------------------------------------------------------------------------------------------

(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
0 660	<p>Continued From page 4</p> <p>(b) The facility must maintain written evidence of compliance with this subdivision.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee tuberculosis (TB) symptom and history screenings were completed and documented for one of two employees (unlicensed personnel (ULP)-B).</p> <p>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).</p> <p>The findings include:</p> <p>The licensee's Facility TB risk assessment dated August 1, 2023, indicated the facility was low risk.</p> <p>ULP-B was hired on December 10, 2021, and began providing assisted living cares to licensee's residents.</p> <p>ULP-B's employee record included blood test (QuantiFERON -TB Gold Plus) dated December 16, 2021, with positive result and chest x-ray dated December 22, 2021, indicated negative for active TB. ULP-B's record lacked evidence of TB history and symptom screening.</p> <p>On November 28, 2023, at 12:30 p.m., ULP-B was observed to set-up, then administer</p>	0 660		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>36942</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/01/2023</b>
--------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER  <b>HERITAGE HOUSE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>870 9TH AVENUE NW NEW BRIGHTON, MN 55112</b>
-----------------------------------------------------------	----------------------------------------------------------------------------------------------

(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
0 660	<p>Continued From page 5</p> <p>medications for R1.</p> <p>On November 29, at 1:30 p.m., licensed assisted living director (LALD)-C confirmed ULP-B's TB history and symptom screening was not completed. LALD-C stated they are aware of the required TB screening for all staff.</p> <p>The licensee's Infection Control policy dated August 1, 2021, indicated the licensee would establish and maintain a comprehensive TB infection control program according to the most current TB infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC).</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	0 660		
0 680 SS=F	<p>144G.42 Subd. 10 Disaster planning and emergency preparedness</p> <p>(a) The facility must meet the following requirements:</p> <p>(1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency;</p> <p>(2) post an emergency disaster plan prominently;</p> <p>(3) provide building emergency exit diagrams to all residents;</p> <p>(4) post emergency exit diagrams on each floor; and</p> <p>(5) have a written policy and procedure regarding missing residents.</p>	0 680		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>36942</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/01/2023</b>
--------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER  <b>HERITAGE HOUSE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>870 9TH AVENUE NW NEW BRIGHTON, MN 55112</b>
-----------------------------------------------------------	----------------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 680	<p>Continued From page 6</p> <p>(b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site.</p> <p>(c) The facility must meet any additional requirements adopted in rule.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness (EP) plan with all the required content. This had the potential to affect all current residents, staff, and visitors.</p> <p>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).</p> <p>The findings include:</p> <p>The licensee's plan consisted of a number of documents and policies contained in a red three-ringed binder titled "Emergency Preparedness". The binder included a risk assessment, a communication plan, various policies/procedures, and after-action reviews.</p> <p>The licensee's undated plan lacked the following required content:</p>	0 680		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>36942</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/01/2023</b>
--------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER  <b>HERITAGE HOUSE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>870 9TH AVENUE NW NEW BRIGHTON, MN 55112</b>
-----------------------------------------------------------	----------------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 680	<p>Continued From page 7</p> <ul style="list-style-type: none"> <li>- description of the population served by licensee;</li> <li>- review EP annually and update made to the plan based on the review;</li> <li>- arrangement with other facilities;</li> <li>- names resident physicians, and other facilities;</li> <li>- system to track the location of on-duty staff and sheltered residents</li> <li>- process for emergency preparedness (EP) cooperation with local, tribal, regional, State and Federal EP to maintain integrated response; and</li> <li>- development of policies/procedures to address medical documentation</li> </ul> <p>On November 29, at 1:45 p.m., licensed assisted living director (LALD)-C verified the provided EP plan was missing customizations for the licensee. LALD-C stated a more complete EP was kept in a locked cabinet in the office and staff have no access. LALD-C acknowledged they should have the info accessible to staff during an emergency.</p> <p>The licensee's 9.01 Emergency Preparedness Plan - Appendix Z policy dated August 1, 2021, noted the licensee would have in place a general emergency preparedness plan, that was in alignment with licensee's requirement to also comply with CMS Appendix Z.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-One (21) days</p>	0 680		
0 810 SS=F	<p>144G.45 Subd. 2 (b)-(f) Fire protection and physical environment</p> <p>(b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:</p>	0 810		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>36942</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/01/2023</b>
--------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER  <b>HERITAGE HOUSE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>870 9TH AVENUE NW NEW BRIGHTON, MN 55112</b>
-----------------------------------------------------------	----------------------------------------------------------------------------------------------

(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
0 810	<p>Continued From page 8</p> <p>(1) location and number of resident sleeping rooms;</p> <p>(2) employee actions to be taken in the event of a fire or similar emergency;</p> <p>(3) fire protection procedures necessary for residents; and</p> <p>(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.</p> <p>(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.</p> <p>(d) Fire safety and evacuation plans shall be readily available at all times within the facility.</p> <p>(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.</p> <p>(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.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training. This had the potential to directly affect all residents, staff, and visitors.</p>	0 810		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>36942</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/01/2023</b>
--------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER  <b>HERITAGE HOUSE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>870 9TH AVENUE NW NEW BRIGHTON, MN 55112</b>
-----------------------------------------------------------	----------------------------------------------------------------------------------------------

(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
0 810	<p>Continued From page 9</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>On November 28, 2023, licensed assisted living director (LALD)-C provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility.</p> <p><b>FIRE SAFETY AND EVACUATION PLAN</b> The licensee FSEP dated August 01, 2021, failed to include the following:</p> <p>The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan inappropriately stated the facility would follow a shelter-in-place strategy unless told to evacuate by the Fire Department. In another portion of the FSEP, titled "9.06 Fire Policy", undated, the facility plan indicated to use RACE (Remove, Alarm, Confine and Extinguish or Evacuate) acronym but the plan was designed for a building with life safety systems such as fire doors and smoke compartments. The policy had not been updated to provide complete actions for employees to take in the event of a fire or similar emergency at the licensed facility which did not have life safety systems or a fire-resistant construction type.</p>	0 810		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>36942</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/01/2023</b>
--------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER  <b>HERITAGE HOUSE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>870 9TH AVENUE NW NEW BRIGHTON, MN 55112</b>
-----------------------------------------------------------	----------------------------------------------------------------------------------------------

(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
0 810	<p>Continued From page 10</p> <p>The FSEP did not identify specific fire protection actions for residents evidenced by the policy titled "Resident Evaluation [sic] Plan", undated, which included incomplete resident procedures that were not specific to the facility's building layout. The facility plan indicated "clients will be encouraged to have fire extinguishers in the home and reminded to call 911 for emergencies." Survey staff asked LALD-C if that was an accurate expectation of the residents living in the assisted living facility and LALD-C stated the assisted living residents were not expected to own and operate a fire extinguisher, nor were they expected to call 911 in an emergency. LALD-C stated those actions should be part of the staff procedures.</p> <p>The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents.</p> <p>During an interview on November 29, 2023, at 9:30 a.m., LALD-C stated she understood the areas of her policy that were incomplete and would work on bringing them into compliance.</p> <p><b>TRAINING</b> Record review indicated the licensee failed to provide evacuation training to residents at least once per year. LALD-C was unable to provide documentation showing any training offered to residents on the fire safety and evacuation plan.</p> <p>Record review indicated the licensee failed to provide training to employees on the FSEP upon hire and/or at least twice per year as evidenced</p>	0 810		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>36942</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/01/2023</b>
--------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER  <b>HERITAGE HOUSE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>870 9TH AVENUE NW NEW BRIGHTON, MN 55112</b>
-----------------------------------------------------------	----------------------------------------------------------------------------------------------

(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
0 810	<p>Continued From page 11</p> <p>by the provided record, titled "Staff Fire/ Emergency/ Safety Training Log". The record indicated staff were trained yearly, but did not include specific dates of training to show that the licensee was compliant with the twice-per-year requirement for training on fire safety and evacuation.</p> <p>During an interview on November 29, 2023, at 9:30 a.m., LALD-C stated residents review fire safety and evacuation procedures when they are admitted to the facility, but she had not offered any additional training each year for residents. LALD-C also stated staff receive training on the FSEP twice per year, but she would have to pull the documentation out of each staff file and email it to the surveyor. Survey staff agreed to review any additional documentation on staff training, but none was provided after the interview was completed.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days.</p>	0 810		
01500 SS=F	<p>144G.63 Subd. 5 Required annual training</p> <p>(a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include:</p> <p>(1) training on reporting of maltreatment of vulnerable adults under section 626.557;</p> <p>(2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;</p> <p>(3) review of infection control techniques used in</p>	01500		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>36942</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/01/2023</b>
--------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER  <b>HERITAGE HOUSE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>870 9TH AVENUE NW NEW BRIGHTON, MN 55112</b>
-----------------------------------------------------------	----------------------------------------------------------------------------------------------

(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	<p>Continued From page 12</p> <p>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;</p> <p>(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;</p> <p>(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</p> <p>(6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person.</p> <p>(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:</p> <p>(1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication;</p> <p>(2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or</p> <p>(3) information about strategies and technology that may enhance communication and involvement, including communication strategies,</p>	01500		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>36942</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/01/2023</b>
--------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER  <b>HERITAGE HOUSE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>870 9TH AVENUE NW NEW BRIGHTON, MN 55112</b>
-----------------------------------------------------------	----------------------------------------------------------------------------------------------

(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	<p>Continued From page 13</p> <p>assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions.</p> <p>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 hours of annual training for each 12 months of employment for one of two employees (unlicensed personnel (ULP)-B, registered nurse (RN)-A).</p> <p>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).</p> <p>The findings include:</p> <p>ULP-B ULP-B was hired on December 10, 2021, and began providing assisted living cares to licensee's residents.</p> <p>RN-A RN-A was hired on March 4, 2022, and began providing assisted living cares to licensee's residents.</p> <p>ULP-B and RN-A's employee training records lacked evidence ULP-B and RN-A had successfully completed annual training as required in the following areas: -training on reporting of maltreatment of</p>	01500		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>36942</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/01/2023</b>
--------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER  <b>HERITAGE HOUSE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>870 9TH AVENUE NW NEW BRIGHTON, MN 55112</b>
-----------------------------------------------------------	----------------------------------------------------------------------------------------------

(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	<p>Continued From page 14</p> <p>vulnerable adults under section 626.557; -review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; -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; -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; -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 -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person.</p> <p>During interview on November 29, 2023, at 1:45 p.m., licensed assisted living director (LALD)-C acknowledged RN-A and ULP-B's employee records were missing the required annual training. LALD-C stated they are of aware of required annual training for the topics above. LALD-C provided an annual checklist completed in 2022 and LALD-C stated all staff have assigned annual training through the online program EduCare for 2023, and they will ensure the trainings are completed as required.</p> <p>The licensee's 4.05 Employee Records policy</p>	01500		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>36942</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/01/2023</b>
--------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER  <b>HERITAGE HOUSE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>870 9TH AVENUE NW NEW BRIGHTON, MN 55112</b>
-----------------------------------------------------------	----------------------------------------------------------------------------------------------

(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 15  dated August 1, 2021, indicated employee records for each person will include verification of completed orientation, annual training, and competency.  No further information was provided.  TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		
02310 SS=G	144G.91 Subd. 4 (a) Appropriate care and services  (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards.  This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care standards, medical or nursing standards for one of three residents (R1) who utilized consumer portable bed rails. This practice resulted in an immediate correction order.  This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).	02310		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>36942</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/01/2023</b>
--------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER  <b>HERITAGE HOUSE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>870 9TH AVENUE NW NEW BRIGHTON, MN 55112</b>
-----------------------------------------------------------	----------------------------------------------------------------------------------------------

(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
02310	<p>Continued From page 16</p> <p>The findings include:</p> <p>On November 27, 2023, at 11:30 a.m., the surveyor observed R1's bed had a bedrail on the right side, which was not attached to the bed. The bedrail was in the up position proceeding between the mattress and box spring. Registered nurse (RN)-A grasped the bedrail and noted the bedrail was secured to the bed and did move when pulled and pushed on with force.</p> <p>R1 admitted on February 21, 2023, with diagnoses including high risk for falls, cerebral palsy, opioid use disorder, and chronic pain.</p> <p>R1's Service Plan dated February 21, 2023, indicated R1 received services including medication management, assistance with shower, incontinent care, and managing behaviors.</p> <p>R1's Bed Safety Assessment dated September 5, 2023, indicated R1 used bedrail to assist with sitting up.</p> <p>R1's Clinical Update Assessment dated September 5, 2023, indicated R1's father installed the bedrail per R1's preference only to help her sit up while in a nonhospital queen size bed.</p> <p>R1's record lacked documentation of education of the risks and benefits associated with the use of bedrail, and evidence the bedrail was installed, maintained, and used per manufacturer's instructions.</p> <p>On November 27, 2023, at 2:37 p.m., RN-A stated R1's family installed the consumer bedrail. RN-A stated she is not sure if they followed the</p>	02310		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>36942</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/01/2023</b>
--------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER  <b>HERITAGE HOUSE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>870 9TH AVENUE NW NEW BRIGHTON, MN 55112</b>
-----------------------------------------------------------	----------------------------------------------------------------------------------------------

(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
02310	<p>Continued From page 17</p> <p>manufacturer's guidelines for appropriate installation, because R1's family installed the bedrail. RN-A stated she has discussed risks and benefits with R1, but did not document the discussion.</p> <p>The licensee's Side Rails policy dated August 1, 2021, indicated "The licensee will assess the use, educate the resident, and when appropriate, the responsible person, regarding the risks and benefits of side rails, and verify that the side rail in use is of a safe design and utilized consistent with the manufacturer's directions. This policy shall be followed regardless of who owns or is supplying the side rail."</p> <p>The Minnesota Department of Health's (MDH) Resources and Frequently Asked Questions (FAQ) website dated August 7, 2023, indicated the following documentation should be included in a resident's record for consumer bedrails:</p> <ul style="list-style-type: none"> <li>- Purpose and intention of the bedrail;</li> <li>- Condition and description (i.e., an area large enough for a resident to become entrapped) of the bedrail;</li> <li>- The resident's bedrail use/need assessment;</li> <li>- Risk vs. benefits discussion (individualized to each resident's risks);</li> <li>- The resident's preferences;</li> <li>- Installation and use according to manufacturer's guidelines;</li> <li>- Physical inspection of bedrail and mattress for areas of entrapment, stability, and correct installation; and</li> <li>- Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements.</li> </ul> <p>TIME PERIOD FOR CORRECTION: Immediate</p>	02310		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>36942</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/01/2023</b>
--------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER  <b>HERITAGE HOUSE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>870 9TH AVENUE NW NEW BRIGHTON, MN 55112</b>
-----------------------------------------------------------	----------------------------------------------------------------------------------------------

(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
02310	<p>Continued From page 18</p> <p>On November 27, 2023, at approximately 5:04 p.m. an immediate order was issued for 2310.</p> <p>On November 30, 2023, the immediacy of order 2310 was removed, but the scope and level remain unchanged.</p>	02310		

Type: Full  
Date: 11/29/23  
Time: 11:00:00  
Report: 1005231276

## Food and Beverage Establishment Inspection Report

Page 1

**Location:**

Heritage House  
870 9th Avenue NW  
New Brighton, MN55112  
Ramsey County, 62

**Establishment Info:**

ID #: 0042113  
Risk:  
Announced Inspection: No

**License Categories:**

Expires on: 12/31/23

**Operator:**

Phone #: 6128650532  
ID #:

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

The following orders were issued during this inspection.

### **3-500D Microbial Control: disposition of food**

#### **3-501.18A \*\* Priority 1 \*\***

MN Rule 4626.0405A Discard all TCS food prepared in the establishment or opened commercially packaged food when the time exceeds 7 days from the preparation or opening date or if the container or package is not marked.

HOT DOGS AND TURKEY DELI MEAT HAD BEEN OPENED MORE THAN 3 WEEKS AGO. FOOD WAS DISCARDED. FACT SHEET EMAILED WITH REPORT.

Comply By: 11/29/23

### **7-200 Toxic Supplies and Applications**

#### **7-204.11 \*\* Priority 1 \*\***

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

SANITIZER IN THE SPRAY BOTTLE WAS OVER 200 PPM CHLORINE (BLEACHED OUT TEST STRIP). DISCUSSED USE OF TEST STRIPS TO ENSURE CHLORINE STAYS BETWEEN 50 AND 200 PPM. SANITIZER WILL BE DILUTED.

Comply By: 11/29/23

### **Surface and Equipment Sanitizers**

Chlorine: = 200+PPM at Degrees Fahrenheit  
Location: SPRAY BOTTLE  
Violation Issued: Yes

### **Food and Equipment Temperatures**

Type: Full  
Date: 11/29/23  
Time: 11:00:00  
Report: 1005231276  
Heritage House

# Food and Beverage Establishment Inspection Report

---

Process/Item: Cold Hold/HOT DOG  
Temperature: 36 Degrees Fahrenheit - Location: KITCHEN REFRIGERATOR  
Violation Issued: No

---

Process/Item: Cold Hold/TURKEY  
Temperature: 39 Degrees Fahrenheit - Location: KITCHEN REFRIGERATOR  
Violation Issued: No

---

Process/Item: Cold Hold/MILK  
Temperature: 35 Degrees Fahrenheit - Location: KITCHEN REFRIGERATOR  
Violation Issued: No

---

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

INSPECTION COMPLETED WITH FACILITY DIRECTOR AND REVIEWED WITH HRD NURSE EVALUATOR SAFIA HASSAN.

DISCUSSED ORDERS ON REPORT AS WELL AS GLOVE USE, EMPLOYEE ILLNESS, DATE MARKING, AND COOKING TEMPERATURES.

A MAXIMUM TEMPERATURE REGISTERING THERMOMETER WAS ON SITE FOR THE DISHWASHER AND DIRECTOR STATES IT PROVIDES A UTENSIL SURFACE TEMPERATURE OF OVER 170 DEGREES F.

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

FLOORING IS LAMINATE, CABINETS ARE WOOD WITH HOLLOW BASE, COUNTERS ARE LAMINATE, AND THE CEILING HAS A POPCORN FINISH. ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT SUCH A TIME THEY ARE FOUND TO BE A CONCERN OR RISK OF CONTAMINATION, THEY WILL BE ORDERED TO BE REPLACED AND BROUGHT UP TO CODE.

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

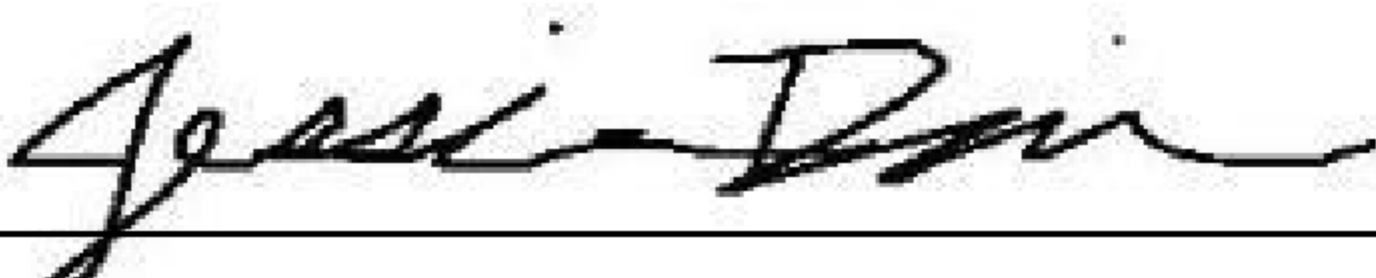
I acknowledge receipt of the Minnesota Department of Health inspection report number 1005231276 of 11/29/23.

Certified Food Protection Manager: AMAL MOHAMED

Certification Number: FM108413 Expires: 09/26/24

**Inspection report reviewed with person in charge and emailed.**

Signed: \_\_\_\_\_  
AMAL A. MOHAMED  
DIRECTOR

Signed:  \_\_\_\_\_  
Jessica Davis  
Public Health Sanitarian III  
651-201-3961  
jessica.davis@state.mn.us