Electronically Delivered

May 1, 2025

Licensee
New Life Health Service
4756 Decatur Avenue North
New Hope, MN 55428

RE: Project Number(s) SL35815016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 8, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

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

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the

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

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

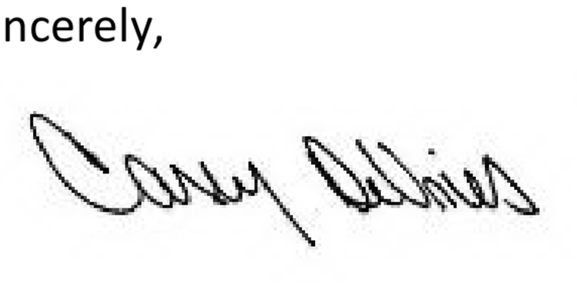
To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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

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

If you have any questions, please contact me.

Sincerely,



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

KKM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35815	A. BUILDING: _____ B. WING _____	04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW LIFE HEALTH SERVICE	4756 DECATUR AVENUE NORTH NEW HOPE, MN 55428

(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 ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL35815016-0 On April 7, 2025, through April 8, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were five residents; five receiving services under the Assisted Living Facility 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 License Providers with Dementia Care. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470		

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0 470	Continued From page 1 determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to evaluate their staffing plan at least twice annually. 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	0 470		

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0 470	Continued From page 2 problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's Staffing Plan dated January 1, 2024, to December 31, 2024, was completed and signed by licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A on January 1, 2024; it lacked evidence it was evaluated at least twice a year for appropriate staffing levels in the facility. On April 7, 2025, at 9:35 a.m., during the entrance conference, LALD/CNS-A stated they last updated their staffing plan at the beginning of the year (2025). On April 8, 2025, at 11:22 a.m., LALD/CNS-A stated they completed a new staffing plan at the beginning of the year but was unable to locate it. LALD/CNS-A stated they updated their staffing plan one time every year unless there was a change in the needs of their residents. On April 8, 2025, at 3:31 p.m., LALD/CNS-A provided a new Staffing Plan updated on April 8, 2025, during survey. The licensee's Staffing Plan and policy dated January 1, 2024, to December 31, 2024, did not address the frequency of which a staffing plan was required to be reviewed or updated. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		

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0 480	Continued From page 3	0 480		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink;	0 480		

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0 480	Continued From page 4 (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated April 7, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee on April 7,	0 480		

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0 480	Continued From page 5 2025. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	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 email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the 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. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post information directing individuals to the Office of Health Facility Complaints (OHFC) at the Minnesota Department of Health (MDH) if they had complaints about the facility or person providing 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	0 550		

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0 550	Continued From page 6 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 April 7, 2025, at 9:56 a.m., during the facility tour with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A, the surveyor observed the licensee's grievance posting lacked information directing individuals to the OHFC if they had complaints about the facility or person providing services. LALD/CNS-A stated they thought they had the required OHFC information on their grievance posting. LALD/CNS-A and house manager (HM)-C searched the facility but were unable to locate an OHFC posting. LALD/CNS-A stated they were aware OHFC information was a required posting. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 650 SS=D	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (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	0 650		

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0 650	Continued From page 7 evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records included annual performance review documentation and job description for one of two employees (unlicensed personnel (ULP)-D). 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: ULP-D was hired on June 29, 2023, to provide direct cares to residents. ULP-D's employee record included a New Lief [sic] Health Service Performance Evaluation form dated July 7, 2023.	0 650		

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0 650	Continued From page 8 ULP-D's employee record lacked an annual performance review for 2024. On April 7, 2025, at 12:20 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated they were looking for ULP-D's annual performance review; they stated they completed it but needed to locate it. On April 8, 2025, at 11:22 a.m., LALD/CNS-A stated they conducted employee annual training on the employee's work anniversary. LALD/CNS-A stated they thought their other nurse had completed ULP-D's 2024 annual performance review before the nurse's employment ended. The licensee's Personnel Records policy, undated, indicated employee records should include, "Annual performance evaluation that identifies areas of improvement needed and training needs." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
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) staff actions to be taken in the event of a fire or similar emergency;	0 810		

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0 810	Continued From page 9 (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) Staff 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 staff 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 interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	0 810		

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0 810	Continued From page 10 or has potential to affect a large portion or all of the residents). The findings include: On April 8, 2025, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP, titled "New Life Health Service Emergency/Disaster Plan:", undated, failed to include the following: 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. The plan included instructions to evacuate residents but did not include the identification of any residents that needed assistance, any resident-specific procedures to staff for assisting residents during evacuation, nor did it include instructions for staff to follow in case of relocation. On April 8, 2025, at 1:30 p.m., LALD/CNS-A stated they had identified the residents who have evacuation assistance needs, but have not written the procedures for the staff on what kind of assistance the residents need or how to provide the needed assistance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		

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0 910	Continued From page 11	0 910		
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification 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; (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 contract with the required health facility identification number (HFID) for one of one resident (R2). 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 the potential to affect a large portion or all the residents). The findings include: R2 was admitted to the licensee on August 5, 2022. R2's Service Plan signed on June 1, 2024, indicated R2 received services for medication	0 910		

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(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
0 910	Continued From page 12 management, meals, bathing assistance, dressing, grooming and housekeeping. R2's Assisted Living Contract signed on August 5, 2022, lacked the licensee's HFID 35815. On April 8, 2025, at 11:22 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated they did not know the HFID was required to be in their contract. LALD/CNS-A stated they had a new contract but all five of their residents only had the old one signed which did not include their HFID. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 910		
01290 SS=D	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits.	01290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35815	A. BUILDING: _____ B. WING _____	04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW LIFE HEALTH SERVICE	4756 DECATUR AVENUE NORTH NEW HOPE, MN 55428

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01290	Continued From page 13 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure they received a background study (BGS) clearance from NETStudy 2.0 (web-based system use to submit BGS requests to the Department of Human Services (DHS)) in affiliation with the assisted living licensee's health facility identification number (HFID) 35815 for two of six employees (unlicensed personnel (ULP)-B, ULP-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: The licensee's HFID was 35815. The licensee was the owner of a second license HFID 37989. The licensee's current Employee List form dated April 7, 2025, indicated ULP-B and ULP-D were currently employed under HFID 35815. ULP-B ULP-B was hired on March 4, 2024, to provide direct cares to residents. ULP-B's employee record included a Background Study Notice clearance letter which indicated ULP-B had a completed BGS under HFID 37989 on March 4, 2024.	01290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35815	A. BUILDING: _____ B. WING _____	04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW LIFE HEALTH SERVICE	4756 DECATUR AVENUE NORTH NEW HOPE, MN 55428

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01290	Continued From page 14 On April 8, 2025, at 9:04 a.m., the surveyor observed ULP-B administer medication for R2. ULP-D ULP-D was hired on June 29, 2023, to provide direct cares to residents. ULP-D's employee record included a Background Study Notice clearance letter which indicated ULP-D had a completed BGS under HFID 37989 on June 29, 2023. The licensee's NETStudy 2.0 roster dated April 7, 2025, for HFID 35815, indicated ULP-B and ULP-D did not have a BGS completed under the HFID. On April 7, 2025, at 10:28 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated ULP-B was not on their NETStudy 2.0 roster for HFID 35815. LALD/CNS-A stated ULP-B also worked at one of their other facilities and should have a BGS but may have been completed under one of their other licensee's HFID. On April 7, 2025, at 10:46 a.m., LALD/CNS-A stated ULP-B and ULP-D worked at one of their other facilities and should have a BGS completed under one of their other facilities HFID where they both were originally hired. On April 7, 2025, at 10:49 a.m., LALD/CNS-A provided the above-mentioned Background Study Notice for ULP-B and ULP-D and stated both BGS's were completed under one of their other licensee's HFID 37989. LALD/CNS-A stated they were aware a BGS needed to be completed for each HFID an employee worked for.	01290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35815	A. BUILDING: _____ B. WING _____	04/08/2025

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01290	Continued From page 15 LALD/CNS-A was able to demonstrate they had access to HFID 37989 on NETStudy 2.0 and the sensitive information person for 35815 would receive notifications if ULP-B and ULP-D's eligibility were to change. The DHS website for Background Studies updated February 18, 2025, indicated, "The Minnesota Department of Human Services (DHS) requires background studies for people who work in certain health and human services programs, and in childcare settings if they provide care or have direct contact with vulnerable populations. DHS also completes background studies on others, such as people planning to provide foster care or adopt. Minnesota statutes direct the background study process for entities required to initiate background studies." The licensee's Background Studies policy, undated, indicated: "1. Each facility employee/volunteer or contractor who will provide direct care to residents must have a background study completed. The forms will be completed at the time of hire. If the person fails to provide the information necessary to complete the background study, their application for direct care employment will not be completed. 2. Employees may not work until the results of the background study have been received. (The law allows an individual to provide direct contact services while a study is pending IF that person is under continuous direct supervision of the employer)." No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35815	A. BUILDING: _____ B. WING _____	04/08/2025

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02040	Continued From page 16	02040		
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 assessment or safety risk assessment of the physical environment with mitigation factors on and around the property for the facility. This deficient practice had the ability to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On April 8, 2025, house manager (HM)-C	02040		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35815	A. BUILDING: _____ B. WING _____	04/08/2025

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02040	Continued From page 17 provided documents on the hazard vulnerability assessment (HVA). The licensee's HVA, undated, failed to include the following: The HVA included the identification of global risk factors like severe weather, wild fires, epidemics, systems failures, and civil disturbances but failed to identify any potential hazards or risks that were specific to the facility's neighborhood, grounds, building, or population. The HVA did not include a section that identified specific mitigation factors to be in place for any hazards or risks that were identified in the HVA. On April 8, 2025, at 1:30 p.m. HM-C stated they had not performed a hazard vulnerability assessment with mitigation factors on and around the property. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		

Minnesota Department of Health
Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975
6512014500

Type: Full
Date: *04/07/25*
Time: 10:30:00
Report: 1047251086

Food and Beverage Establishment Inspection Report

Location:
New Life Health Service
4756 Decatur Avenue North
New Hope, MN55428
Hennepin County, 27

Establishment Info:
ID #: 0037805
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6122000112
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.

4-600 Cleaning Equipment and Utensils

4-601.11C

MN Rule 4626.0840C Clean non-food contact surfaces of equipment and maintain free of accumulations of dust, dirt, food residue, and other debris.

BOTTOM OF STOVE HAD BUILD UP OF BURNED FOOD DEBRIS

Comply By: 04/21/25

Surface and Equipment Sanitizers

Hot Water: = at 160 Degrees Fahrenheit
Location: Dishwasher
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: Refrigerator- milk
Violation Issued: No

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: Refrigerator- cheese
Violation Issued: No

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

Inspection conducted with operator and MDH Nurse Evaluator J. Keen.

Establishment has a residential kitchen with laminate flooring, a texured painted ceiling, painted walls, laminate countertop, and wood/composite cabinetry. Discussed continued maintenance (paint touch ups,

resealing drawers, etc.) to keep all surfaces smooth, durable, and easily cleanable.

A two basin sink is located in the kitchen. One basin is designated for hand washing. A residential dish machine is located in the kitchen.

Discussed hand washing, ware washing, staff illness policy, temperature control, final cook temperatures, cleaning/sanitizing, serving highly susceptible populations, and food handling procedures.

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 1047251086 of 04/07/25.

Certified Food Protection Manager: Rodney N. Cline

Certification Number: FM108192 Expires: 10/25/27

Inspection report reviewed with person in charge and emailed.

Signed: _____

Rodney Cline
Operator

Signed: _____

Holly Sievers
Public Health Sanitarian 2
Metro Office
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Holly.Sievers@state.mn.us