Electronically Delivered

March 19, 2025

Licensee
N&v Helpful Heart Care Inc.
7037 Perry Avenue North
Brooklyn Center, MN 55429

RE: Project Number(s) SL32413015

Dear Licensee:

On February 13, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine the correction of orders from the survey completed on August 29, 2024, and the follow-up survey completed on November 26, 2024. This follow-up survey verified that the facility is 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,

Benjamin J. Zwart, P.E., Supervisor
State Engineering Services Section
Health Regulation Division
Email: Benjamin.Zwart@state.mn.us
Telephone: 651-201-3715 Fax: 1-866-890-9290

JMD

Electronically Delivered

January 3, 2025

Licensee
N&V Helpful Heart Care Inc
7037 Perry Avenue North
Brooklyn Center, MN 55429

RE: Project Number(s) SL32413015

Dear Licensee:

On November 26, 2024, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on August 29, 2024. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the August 29, 2024 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on August 29, 2024, found not corrected at the time of the November 26, 2024, follow-up survey and/or subject to penalty assessment are as follows:

0820-Fire Protection And Physical Environment-144g.45 Subd. 2 (g)

The details of the violations noted at the time of this follow-up survey completed on November 26, 2024 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

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 outlined on the state form; however, plans of correction are not required to be submitted for approval.

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

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/HRDAppealsForm

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.

We urge you to review these orders carefully. If you have questions, please contact Benjamin J. Zwart at 651-201-3715.

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

Sincerely,

Benjamin J. Zwart, Supervisor
State Engineering Services Section
Email:Benjamin.Zwart@state.mn.us
Telephone: 651-201-3715 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32413	A. BUILDING: _____ B. WING _____	R 11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
N&V HELPFUL HEART CARE INC	7037 PERRY AVENUE NORTH BROOKLYN CENTER, MN 55429

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL32413015-1 On November 26, 2024, the Minnesota Department of Health conducted a follow-up survey at the above provider on orders issued pursuant to a survey completed on August 29, 2024. At the time of the survey, there were 3 residents; 3 receiving services under the Assisted Living license. As a result of the follow-up survey, the following orders were reissued.	{0 000}		
{0 460} SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit;	{0 460}		

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{0 460}	Continued From page 1 (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by:	{0 460}		
{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	{0 480}	Not reviewed during this survey.	

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{0 480}	Continued From page 2 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; (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:	{0 480}	Not reviewed during this survey.	
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements:	{0 680}		

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{0 680}	Continued From page 3 (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by:	{0 680}	Not reviewed during this survey.	
{0 780} SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate	{0 780}		

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{0 780}	Continued From page 4 sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{0 780}		
{0 790} SS=F	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced	{0 790}		

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{0 790}	Continued From page 5 by: Not reviewed during this survey.	{0 790}		
{0 800} SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{0 800}		
{0 810} SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and 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; (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	{0 810}		

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{0 810}	Continued From page 6 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: Not reviewed during this survey.	{0 810}		
{0 820} SS=F	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction.	{0 820}		

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{0 820}	Continued From page 7 This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide emergency escape and rescue openings in compliance with Minnesota Fire Code, Minnesota Rules 7511. This had the potential to directly affect two residents and all staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The surveyor conducted a follow-up with the above provider to review orders issued pursuant to a survey completed on August 29, 2024. On November 26, 2024, the surveyor emailed the licensee requesting an update on corrections completed for the non-compliant egress windows in bedrooms 1, 2, and 3. The egress windows in resident bedrooms 1, 2, and 3 did not meet the minimum requirements for safe egress. On November 26, 2024, owner (O)-A responded the egress windows had not been replaced and installation of the new windows was scheduled for December 9, 2024. On November 26, 2024, at 1:22 p.m., the surveyor emailed the licensee requesting copies of the following records: 1. Completed fire watch records. 2. A copy of the building permit from the city for the egress window installations.	{0 820}		

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{0 820}	Continued From page 8 3. Verification that a plan review application had been submitted to the Minnesota Department of Health Engineering Services for the egress window installations. On November 27, 2024, at 3:59 p.m., O-A emailed the surveyor copies of fire watch records and the building permit for the new egress window installations. During an interview on November 27, 2024, at 4:05 p.m., (O)-A stated resident bedrooms 1 and 3 were occupied and bedroom 2 was unoccupied. O-A stated the licensee had been completing a fire watch, a permit for the new egress window installation had been obtained, and the windows were scheduled for installation in December. Verification that a plan review application had been submitted to the Minnesota Department of Health Engineering Services for the egress window installations was not provided. One window in each resident bedroom must meet the minimum window opening size of at least 20 inches in width and, a minimum height of 20 inches, with a total open area of at least 648 square inches (4.5 square feet). Smoking material disposal was not reviewed during this survey.	{0 820}		
{01640} SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must	{01640}		

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{01640}	Continued From page 9 include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by:	{01640}	Not reviewed during this survey.	
{01940} SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions	{01940}		

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{01940}	Continued From page 10 relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by:	{01940}	Not reviewed during this survey.	
{01950} SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and	{01950}		

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{01950}	Continued From page 11 the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by:	{01950}	Not reviewed during this survey.	
{01960} SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by:	{01960}	Not reviewed during this survey.	

Electronically Delivered

October 3, 2024

Licensee
N&V Helpful Heart Care Inc.
7037 Perry Avenue North
Brooklyn Center, MN 55429

RE: Project Number(s) SL32413015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 29, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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 . . ."

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.

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

0110 - 144g.10 Subdivision 1a - Assisted Living Director License Required - $500.00
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 $3,500.00**. 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 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

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/HRDAppealsForm

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.

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,

Jodi Johnson, Supervisor
State Evaluation Team
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32413	A. BUILDING: _____ B. WING _____	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
N&V HELPFUL HEART CARE INC	7037 PERRY AVENUE NORTH BROOKLYN CENTER, MN 55429

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL32413015-0 On August 26, 2024, through August 29, 2024, Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were three residents; all of whom received services under the provider's Assisted Living Facility license. 0820: An immediate oder was issued on August 29, 2024, at a level 3/Widespread (I). The licensee was asked to provide documentation of actions taken to comply with the immediate correction order. No documentation was received as of September 4, 2024. 2310: An immediate order was issued on August 27, 2024, at a level 3/Widespread (I).	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	

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0 110	Continued From page 1	0 110		
0 110 SS=F	144G.10 Subdivision 1a Assisted living director license required Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employment of a licensed assisted living director (LALD). This had the potential to affect all current residents receiving assisted living services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The license and registration document on file with the Minnesota Department of Health (MDH) for application of assisted living facility licensure was signed by owner (O)-A on January 5, 2024. The application named an assisted living director with responsibility of administration, management, supervision, and general administrative charge of the facility. That person was O-A. On August 26, 2024, at 12:02 p.m. during the entrance conference, O-A had been the licensed assisted living director in residency (LALDIR) for	0 110		

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0 110	Continued From page 2 the facility until it expired on November 24, 2022. At that time, LALD-D took over the director scope of responsibility. On August 26, 2024, the Minnesota Board of Executives for Long-Term Services and Support (BELTSS) website was reviewed for verification of the licensed assisted living director's licensure. O-A was listed as having a residency permit for the licensee that expired on November 23, 2022. On August 28, 2024, an email was sent to LALD-D by a representative from BELTSS to inquire if LALD-D was currently working as the LALD. LALD-D responded to the email that he "pulled" that license with licensee late 2023 and was no longer the licensee's LALD. On August 27, 2024, at 9:19 p.m. O-A stated the facility did not have a current LALD and was currently working on getting her LALD. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
0 460 SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a	0 460		

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0 460	Continued From page 3 roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide a means for residents to request assistance for health and safety needs 24 hours a day, seven days a week. This had the potential to affect all current residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On August 26, 2024, at 12:02 p.m. during the entrance conference, owner (O)-A stated the licensee did not have a call light or pendant system residents could use to summon staff. On August 26, 2024, at 1:04 p.m. during the facility tour, the surveyor observed the facility was a rambler style home with a main floor and basement. One resident's room was in the	0 460		

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0 460	Continued From page 4 basement while the other resident rooms were on the main floor. No pendants or call light system was observed during the facility tour. On August 27, 2024, at 12:18 p.m. O-A stated the licensee did not provide a means for residents to request assistance for health and safety needs 24 hours per day, seven days per week. O-A stated she thought she had one, but it was not being used currently. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 460		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all	0 480		

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0 480	Continued From page 5 the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated August 26, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also	0 680		

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0 680	Continued From page 6 working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have a written emergency preparedness (EP) plan with all of the required content and failed to post an emergency preparedness plan prominently. This had the potential to affect all residents receiving services under the assisted living license, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the initial tour on August 26, 2024, at 1:04 p.m., the licensee lacked evidence of signage posted or information regarding the licensee's emergency plan. The licensee's emergency disaster preparedness plan lacked evidence of the following required content: - a comprehensive program to include infectious diseases and pandemics; - a description of the population served by the licensee; - process for emergency preparedness (EP)	0 680		

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0 680	Continued From page 7 cooperation with state and local EP officials/organizations; - procedure for tracking staff and residents; - subsistence needs for staff and residents during emergency situation; - development of policies/procedures to address: - evacuation plan (not customized for the facility); - fire (not customized for the facility) - shelter in place; - a tracking system used to document locations or residents and staff - the medical record documentation system to preserve resident information - emergency staff strategies - the facilities role in providing care and treatment at alternative sites - a communication plan that included: - arrangement with other facilities - names and contact information for staff, resident physicians, other facilities - contact information for federal, state, tribal, local EP staff, ombudsman - primary and alternative means for communicating with facility staff, federal, state, regional and local emergency management agencies - a method of sharing information and medical documentation for residents - a means to provide information regarding the facility's needs, and its ability to provide assistance to include information about their occupancy - a method of sharing information from the emergency plan with residents and their families - EP training and testing program - EP training program for staff (including documentation of training provided) - EP testing/annual testing requirements	0 680		

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0 680	Continued From page 8 On August 26, 2024, at 2:08 p.m. owner (O)-A confirmed staff were not familiar with Appendix Z (a section of the Centers for Medicare and Medicaid Services [CMS] State Operations Manual which includes the emergency preparedness guidelines). O-A also verified the licensee had not fully developed and implemented the facility's emergency preparedness plan/program, and the last update was October 2021. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and	0 780		

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0 780	Continued From page 9 (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that complied with fire protection requirements. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On August 29, 2024, at 2:00 p.m., survey staff toured the facility with unlicensed personnel (ULP)-C. During the tour, the surveyor observed the following: 1. When ULP-C tested the smoke alarms in resident bedrooms none of the other smoke alarms in the dwelling unit were actuated. The dwelling unit smoke alarms were not interconnected as required by statute. 2. A smoke alarm was not installed outside basement bedroom 4 in the immediate vicinity of this bedroom. During the facility tour interview on August 29, 2024, ULP-C verified the above listed smoke	0 780		

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0 780	Continued From page 10 alarm observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to install and maintain the portable fire extinguishers as required by statute. This deficient condition had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all	0 790		

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0 790	Continued From page 11 of the residents). The findings include: On August 29, 2024, at 2:00 p.m., survey staff toured the facility with unlicensed personnel (ULP)-C. During the tour, the surveyor observed the following: 1. Tags or labels were not attached to the portable fire extinguishers showing annual maintenance had been performed by certified service personnel. 2. Tags or labels were not attached to the portable fire extinguishers showing monthly inspections had been completed. Fire extinguisher inspections must be conducted every month to ensure that each extinguisher is in its designated place, that it has not been tampered with, and that there is no obvious physical damage or condition that would interfere with its use or operation. 3. The fire extinguisher installed in the basement was rated 1-A:10BC. During the facility tour interview on August 29, 2024, ULP-C verified the fire extinguishers had not been properly maintained and the basement fire extinguisher did not meet the minimum rating required by statute. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds,	0 800		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
N&V HELPFUL HEART CARE INC	7037 PERRY AVENUE NORTH BROOKLYN CENTER, MN 55429

(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
0 800	Continued From page 12 systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On August 29, 2024, at 2:00 p.m., survey staff toured the facility with unlicensed personnel (ULP)-C. During the tour, the surveyor observed the following: Resident bedrooms: 1. Occupied bedroom 1: a. A space heater was plugged into a power strip. The improper use of power strips creates a fire hazard. b. The knob on the closet door was loose. c. The window blind slats were damaged. 2. The closet was off the track in occupied	0 800		

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0 800	Continued From page 13 bedroom 2. Building physical environment: 1. The door knob was loose on the side door leading from the kitchen/dining area to the exterior of the building. This door was labeled as an exit on the posted emergency floor plan. 2. Main floor resident bathroom: a. One drawer was missing from the sink vanity with nails exposed in this opening, creating a safety risk to residents. b. Knobs were missing from a sink vanity drawer and cabinet door. Exterior physical environment: 1. The landing was not flat at the top of the ramp installed at the front door. 2. The exterior light fixtures were loose at the front and side doors. 3. A cover was not installed on one exterior electrical outlet. During the facility tour interview on August 29, 2024, ULP-C verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and 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	0 810		

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0 810	Continued From page 14 a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to develop the fire safety and evacuation plan with required content, make the plan readily available, and provide required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 810		

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0 810	Continued From page 15 resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On August 29, 2024, at 2:00 p.m., survey staff toured the facility with unlicensed personnel (ULP)-C. During the tour, the surveyor observed resident sleeping rooms were identified by numbers posted at the bedroom doors. The posted FSEP floor plans did not identify resident sleeping rooms by number. Resident sleeping room numbers are required to be included on the fire safety and evacuation floor plan to provide efficient communication for exiting in the event of a fire or similar emergency. During the facility tour interview, ULP-C verified the resident sleeping rooms were not identified. On August 29, 2024, at 3:00 p.m., survey staff requested the FSEP, training, and drill records. ULP-C explained the owner would need to provide this information and it would be emailed to the surveyor. The FSEP was not readily available within the facility. ULP-C called the owner (O)-A on the phone. O-A stated drill records were posted on the wall. On August 29, 2024, at 5:08 p.m., O-A emailed documents on the fire safety and evacuation plan (FSEP). FIRE SAFETY AND EVACUATION PLAN The posted emergency floor plan dated December 17, 2021, failed to include the number of resident sleeping rooms.	0 810		

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0 810	Continued From page 16 Record review of the available documentation indicated the licensee had not developed and maintained a facility FSEP. 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 employee actions were limited to the RACE (Remove, Alarm, Confine, Extinguish/Evacuate) and PASS (Pull, Aim, Squeeze, Sweep) acronyms. Record review of the available documentation indicated the licensee had not developed and maintained a facility FSEP with specific fire protection procedures necessary for residents evident by no procedures in the plan. Record review of the available documentation indicated the licensee had not developed and maintained a facility FSEP with specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents evident by no procedures in the plan. The FSEP Appendix G Fire Emergency procedures inappropriately instructed employees to wait to evacuate residents from the facility during a large scale fire until directed by the local fire department. The FSEP inaccurately referenced pull fire alarms, which were not installed at this facility. TRAINING Record review of the available documentation indicated the licensee failed to provide training to employees on the FSEP upon hire and/or at least twice per year evident by the lack of training	0 810		

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0 810	Continued From page 17 documentation. No training records were provided to support employee training on the facility FSEP had been completed. Record review of the available documentation indicated the licensee failed to provide fire safety and evacuation training to residents at least once per year evident by the lack of training documentation. No resident training records were provided for review. DRILLS Record review of the available documentation indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month evident by a review of completed fire drill logs lacking the required frequency. Three fire drills were recorded in 2021. No drill records were provided for 2022, 2023, or 2024. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 820 SS=I	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to	0 820		

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0 820	Continued From page 18 correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide facilities that were not a distinct hazard to life. This had the potential to directly affect two residents and all staff. 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 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 August 29, 2024, at 2:00 p.m., survey staff toured the facility with unlicensed personnel (ULP)-C. During the tour, survey staff observed the following: Egress windows: The egress windows in resident bedrooms were opened by ULP-C and measured by the surveyor. The egress windows in resident bedrooms 1, 2, and 3 did not meet the minimum requirements for safe egress. Egress window measurements: Resident occupied bedroom 1 - the clear open area of the window measured 31 inches width, 16 1/2 inches height, with a total clear area of 511 square inches.	0 820		

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0 820	Continued From page 19 Resident occupied bedroom 2 - the clear open area of the window measured 35 inches width, 16 1/2 inches height, with a total clear area of 577 square inches. Unoccupied bedroom 3 - the clear open area of the window measured 34 3/4 inches width, 16 1/2 inches height, with a total clear area of 573 square inches. One window in each resident bedroom must meet the minimum window opening size of at least 20 inches in width and, a minimum height of 20 inches, with a total clear area of at least 648 square inches (4.5 square feet). During the facility tour interview, ULP-C verified the egress window measurements. Smoking material disposal: Side of home - burnt cigarettes were disposed of inside a wooden box on the attached wood deck. Front of home - burnt cigarettes were disposed of on the ground and in the window well. Dried leaves were observed in the window well where the burnt cigarettes had been disposed of. Improper disposal of smoking materials creates a fire hazard. During an interview on August 29, 2024, at the end of the facility tour, the owner (O)-A verified the improper disposal of smoking materials by residents. TIME PERIOD FOR CORRECTION: Immediate	0 820		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to	01640		

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01640	Continued From page 20 (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the current service plan included a signature or other authentication by the resident to document agreement on the services to be provided for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or	01640		

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01640	Continued From page 21 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's Service Plan dated December 20, 2022, lacked a signature or other authentication by the resident documenting agreement on the services to be provided. On August 27, 2024, at 9:24 a.m. unlicensed personnel (ULP)-C was observed to administer R2's morning medications. On August 27, 2024, at 2:26 p.m. owner (O)-A stated the service plan had been developed on December 15, 2022, and stated it lacked a signature by the resident as required. No further information was provided. TIME PERIOD TO CORRECT: Twenty-one (21) days	01640		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided;	01940		

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01940	Continued From page 22 (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an individual treatment management record to include all required content and failed to include the treatment record services on the service plan for one of one resident (R2) who had an ordered treatment. 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:	01940		

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01940	Continued From page 23 R2 was admitted December 15, 2022, with a diagnosis to include hypertension and diabetes. On August 27, 2024, at 9:24 a.m. unlicensed personnel (ULP)-C was observed to administer R2's morning medications. R2 normally received treatment services of blood glucose check and compression stockings; however, R2 refused. R2's Service Plan dated December 15, 2022, failed to include a written statement of the treatment services R2 was to receive. In addition, R2's record failed to include an individual treatment management record to include all required content. R3's physician's orders dated December 12, 2022, and renewed October 3, 2023, included an order for blood glucose checks twice daily and compression stockings on in the a.m. and off at bed time. On August 27, 2024, at 3:35 p.m. owner (O)-A stated blood glucose checks and compression stockings were not included on the service plan dated December 15, 2022, and R2's record lacked an individualized treatment plan to include blood glucose checks and compression stockings. The licensee's Treatment and Therapy Management Plan policy dated February 17, 2024, indicated the facility will prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. 1. The licensee would develop and maintain a current individualized treatment and therapy management record for each resident which must	01940		

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01940	Continued From page 24 contain at least the following: a. A statement of the type of services that will be provided. b. Documentation of specific resident instructions relating to the treatments or therapy administration. c. Identification of treatment or therapy tasks that will be delegated to unlicensed personnel. d. Procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services. e. Any resident-specific requirements relating to documentation of treatment and therapy received. f. Verification that all treatment and therapy was administered as prescribed. g. Monitoring of treatment or therapy to prevent possible complications or adverse reactions. 2. The treatment or therapy management record must be current and updated when there are any changes. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01950 SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or	01950		

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01950	Continued From page 25 assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record for one of one resident (R2) who had an ordered treatment. 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: R2 was admitted December 15, 2022, with a diagnosis to include hypertension and diabetes. On August 27, 2024, at 9:24 a.m. unlicensed personnel (ULP)-C was observed to administer	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32413	A. BUILDING: _____ B. WING _____	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
N&V HELPFUL HEART CARE INC	7037 PERRY AVENUE NORTH BROOKLYN CENTER, MN 55429

(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
01950	Continued From page 26 R2's morning medications. R2 normally received a blood glucose check and compression stockings; however, R2 refused. R2's Service Plan dated December 15, 2022, failed to include a written statement of the treatment services R2 was to receive. R2's physician's orders dated October 3, 2023, included an order blood glucose checks twice daily, and compression stockings on in the a.m. and off at bedtime. R2's record lacked documentation of specific instructions for R2's blood glucose checks and compression stockings. On August 27, 2024, at 3:35 p.m. owner (O)-A stated R2's record lacked specific instructions for blood glucose and compression stockings. The licensee's Treatment and Therapy Management Plan policy dated February 17, 2024, indicated the licensee would develop and maintain a current individualized treatment and therapy management record for each resident which must contain documentation of specific resident instructions relating to the treatments or therapy administration. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an	01960		

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01960	Continued From page 27 assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure documentation that treatments were completed as instructed for one of one resident (R2) who had an ordered treatment. 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: R2 was admitted December 15, 2022, with a diagnosis to include hypertension and diabetes. On August 27, 2024, at 9:24 a.m. unlicensed personnel (ULP)-C was observed to administer R2's morning medications. R2 normally received the treatment services of a blood glucose check and compression stockings; however, R2 refused.	01960		

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01960	Continued From page 28 R2's Service Plan dated December 15, 2022, failed to include a written statement of the treatment services R2 was to receive. R2's physician's orders dated December 12, 2022, and renewed October 3, 2023, included an order for blood glucose checks twice daily and compression stockings on in the a.m. and off at bedtime. R2's record lacked evidence of completing blood glucose checks and application of the compression stockings. On August 27, 2024, at 3:35 p.m. owner (O)-A stated R2's record lacked documentation for blood glucose checks and application of compression stockings. The licensee's Treatment and Therapy Management Plan policy dated February 17, 2024, indicated the licensee would develop and maintain a current individualized treatment and therapy management record for each resident which must contain verification that all treatment and therapy was administered as prescribed. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		
02310 SS=I	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	02310		

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02310	Continued From page 29 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 ensure the care and services were provided according to acceptable health care, medical, or nursing standards for one of one resident (R2) with hospital bed rails. This resulted in an immediate correction order on August 27, 2024. 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 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 August 26, 2024, at 1:04 p.m. during facility tour, R2 was observed laying on a hospital bed with a half upper side rail, in the up position, on the right and left side of the bed. R2's diagnoses included history of stroke, diabetes, and hypertension. R2's Service Plan dated December 15, 2022, indicated R2 received assistance with dressing, oral care, hair care, grooming, toileting, bathing, medication administration, transfers, laundry and housekeeping. R2's uniform assessment tool dated August 5,	02310		

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	32413	A. BUILDING: _____ B. WING _____	08/29/2024

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02310	Continued From page 30 2024, indicated R2 had bed rails. R2's medical record lacked: -a side rail assessment; -documentation of measurements of zones of entrapment; and -documentation of discussion of the risk and benefits with R2 and/or R2's responsible party. On August 26, 2024, at 2:10 p.m. clinical nurse supervisor (CNS)-B stated she was aware of the bedrail assessment requirement and stated the facility recently changed forms that did not include the required bed rail requirements. On August 27, 2024, at 11:03 a.m. owner (O)-A and CNS-B stated R2's record did not include the information missing above and would CNS-B would do it right away. The FDA's A Guide to Bed Safety, revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." On page 21, Table 3 Summary of FDA Hospital Bed Dimensional Limit Recommendations indicated specific measurement limits for each entrapment zone. The Minnesota Department of Health (MDH) website, Assisted Living Resources &	02310		

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02310	Continued From page 31 Frequently-Asked Questions (FAQs) last updated April 3, 2024, indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Installation and use according to manufacturer's guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". Additionally, the MDH website indicated for hospital-style bed rails, the licensee must include in their documentation, the bed rail measurements and that the bed rail has not shifted and is securely attached to the bed frame per manufacturer recommendations. The licensee's Side Rail policy, dated February 15, 2023, indicated the licensee would educate	02310		

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02310	Continued From page 32 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. The side rails are installed securely and maintained in good operating condition. Be aware of "wobbly" side rails. The side rail design is consistent with the FDA's 2006 recommended dimensional measurements to reduce entrapment. This means side rail zones 1,2, and 3 must not exceed 4.75". The resident and, when appropriate, the resident's representative, shall be informed of the risks and benefits regarding the use of side rails. Education provided will be documented in the resident record. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	02310		

Minnesota Department of Health

3333 Division St #212
St. Cloud
320 223-7300

Type: Full
Date: *08/26/24*
Time: 12:40:00
Report: 1051241095

Food and Beverage Establishment Inspection Report

Location:

N&V Helpful Heart Care Inc
7037 Perry Avenue North
Brooklyn Center, MN55429
Hennepin County, 27

Establishment Info:

ID #: 0037547
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7634420460
ID #:

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

The following orders were issued during this inspection.

3-500C Microbial Control: date marking

3-501.17A ***** Priority 2 *****

MN Rule 4626.0400A Mark the refrigerated, ready-to-eat, TCS food prepared and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded.

DATE MARK THE RESIDENT'S FOOD. FACT SHEET WILL BE SENT WITH THE REPORT.

Comply By: 08/26/24

4-300 Equipment Numbers and Capacities

4-302.12B ***** Priority 2 *****

MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.

AT TIME OF INSPECTION, THERE WAS NO THIN-TIPPED THERMOMETER.

Comply By: 09/02/24

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.111C ***** Priority 2 *****

MN Rule 4626.1565C Use approved trapping devices or other means of pest control when pests are found.

AT TIME OF INSPECTION, FLY STRIP TRAPS WERE ABOVE THE KITCHEN HANDSINK. DISCONTINUE USING FLY STRIP TRAPS. HAD STAFF DISCARD FLY STRIP TRAP. CORRECTED ON SITE.

Corrected on Site

2-100 Supervision

2-102.12AMN

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

AT TIME OF INSPECTION, THERE IS NO CFPM. MAIMAH PASSED THE COURSE ON 8/11/24 AND STILL NEEDS TO SEND IN THE RESULTS WITH THE STATE APPLICATION. APPLICATION WILL BE ATTACHED TO THE EMAIL.

Comply By: 09/09/24

6-300 Physical Facility Numbers and Capacities

6-301.14A

MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands

BOTH THE UPSTAIRS AND DOWNSTAIRS RESTROOM NEED A HANDWASH SIGN.

Comply By: 08/26/24

Food and Equipment Temperatures

Process/Item: Upright Cooler
Temperature: 41 Degrees Fahrenheit - Location: MEATBALL
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 38 Degrees Fahrenheit - Location: MIXED VEGETABLES
Violation Issued: No

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

MET WITH NURSE EVALUATOR, JENN PANITZKE

DISCUSSED THE FOLLOWING WITH THE PERSON IN CHARGE, VERA:

EMPLOYEE ILLNESS LOG
VOMIT CLEAN-UP PROCEDURE
CERTIFIED FOOD PROTECTION MANAGER
APPROVED INSECT TRAPPING DEVICES
DATE MARKING AND DISPOSITION OF FOOD
HIGHLY SUSCEPTIBLE POPULATION

THE KITCHEN HAS A HIGH TEMP DISHWASHER, MDF WOODEN CABINETS, VINYL TILE FLOORS, SMOOTH TEXTURE CEILING, AND LAMINATE COUNTERTOPS WITH HOLLOW BASES.

Type: Full
Date: *08/26/24*
Time: 12:40:00
Report: 1051241095
N&V Helpful Heart Care Inc

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1051241095 of 08/26/24.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed:_____
Vera Dixon

Signed:_____
Kai Yang
Public Health Sanitarian 1
St. Cloud
320 640-3532
Kai.Yang@state.mn.us