Electronically Delivered

October 6, 2025

Licensee
Pure Heart Health Services Inc.
6213 Lee Avenue North
Brooklyn Center, MN 55429

RE: Project Number(s) SL39189016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 20, 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,

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

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39189	A. BUILDING: _____ B. WING _____	08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PURE HEART HEALTH SERVICES INC	6213 LEE 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: SL39189016-0 On August 18, 2025, through August 20, 2025, the 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 two residents; two receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 485 SS=C	144G.41 Subdivision 1.a (a) Minimum requirements; required food services	0 485		

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0 485	Continued From page 1 (a) All assisted living facilities must offer to provide or make available at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes. The facility must not require a resident to include and pay for meals in the resident's contract. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not require any resident to include and pay for meals as a part of their assisted living monthly base fee for two of two residents (R1, R2). This practice resulted in a level one violation (a violation that will cause only 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:	0 485		

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0 485	Continued From page 2 R1 R1 was admitted to licensee on January 27, 2025. R1's Resident Contract for Assisted Living dated January 27, 2025, indicated all services listed on Attachment A were included in the monthly base fee. Attachment A included at least three meals daily with snacks available seven days per week. On August 20, 2025, at 10:59 a.m., R1 stated they only have coffee and toast in the mornings; and they skip breakfast. R2 R2 was admitted to licensee on February 7, 2025. R2's Resident Contract for Assisted Living dated February 7, 2025, indicated all services listed on Attachment A were included in the monthly base fee. Attachment A included at least three meals daily with snacks available seven days per week. On August 20, 2025, at 10:05 a.m., clinical nurse supervisor (CNS)-D stated the licensee provided their residents with whatever meals or snacks they wanted. CNS-D stated they would have to review the licensee's policy. On August 20, 2025, at 10:15 a.m., agent (A)-C stated the licensee was required to give the residents three meals and two snacks a day. A-C stated some residents get more than two snacks a day. A-C stated they read the regulation as the licensee was required to provide the meals and snacks no matter if the resident paid for the meal. A-C stated they did not want residents in the facility who choose not to eat as some residents	0 485		

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0 485	Continued From page 3 required a snack or food with their medications. A-C stated the licensee tries to provide exceptional care and if the residents don't get food, then the residents would struggle. The licensee's Food Service & Menu Planning policy dated January 3, 2025, indicated the licensee would offer to provide or make available at least three nutritious meals daily with snacks however the policy did not indicate the three meals daily with snacks could not be included in the base monthly fee per statue. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
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 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;	0 650		

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0 650	Continued From page 4 (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the employee record contained the required content for one of two unlicensed personnel ((ULP)-A). 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-A was hired on August 19, 2022, to provide direct care to the licensee's residents. ULP-A's personnel record lacked documentation of Tuberculosis (TB) test either by two-step TB skin test (TST) or TB blood test. On August 19, 2025, at 11:38 p.m., the surveyor had requested documentation of ULP-A's TB testing. Clinical nurse supervisor (CNS)-D asked the surveyor if they had seen ULP-A's chest x-ray, which the surveyor informed CNS-D, a TB test was still needed for the personnel record.	0 650		

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0 650	Continued From page 5 On August 20, 2025, at 10:02 a.m., CNS-D stated they had ULP-A's TB test when the licensee was surveyed in 2023 however, currently the licensee was not able to locate ULP-A's TB test. The licensee's undated Employee Records policy indicated employee records must include the required health screening for TB prevention and control. The licensee's undated Tuberculosis Screening policy indicated each employee who had direct contact with residents must have evidence of baseline TB screening that consisted of an assessment for current symptoms of active TB disease and testing for the presence of TB infection by TST or TB blood test. 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; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar	0 810		

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0 810	Continued From page 6 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 and provide the required training. 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, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when	0 810		

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0 810	Continued From page 7 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 20, 2025, agent (A)-C provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP 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. A-C stated they did not have a policy in place at this time. On August 20, 2025, A-C stated they understood the area of the policy that was incomplete and would work on bringing the FSEP into compliance. TRAINING: The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. A-C stated that staff training was done in Educare and not on the facilities written FSEP. No other training documentation was provided. On August 20, 2025, A-C stated they understood the requirements for training staff and would implement a training program that was compliant	0 810		

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0 810	Continued From page 8 with statute requirements. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01290 SS=E	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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a background study was affiliated with the licensee's health facility identification number (HFID) for two of nine employees (unlicensed personnel (ULP)-B, ULP-E). 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	01290		

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01290	Continued From page 9 cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-B On August 19, 2025, at 8:29 a.m., the surveyor observed ULP-B assist resident (R1) and R2 with medication administration. ULP-B was hired on May 7, 2025, to provide direct care to residents. ULP-B's Background Study Clearance dated May 5, 2025, indicated it was affiliated to a different HFID 36280. ULP-B's personnel record lacked a background study clearance for HFID 39189. ULP-E ULP-E was hired on July 16, 2025, to provide direct care to residents. ULP-E's Background Study Clearance dated July 1, 2025, indicated it was affiliated to a different HFID 36280. ULP-E's personnel record lacked a background study clearance for HFID 39189. On August 19, 2025, at 12:44 p.m., ULP-E confirmed they worked for the licensee at the facility (HFID 39189) every Friday, Saturday, and Sunday from 7:00 p.m. to 7 a.m. ULP-E stated	01290		

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01290	Continued From page 10 their job duties included medication administration, housekeeping, and assisting residents with their activities of daily living. On August 19, 2025, at 10:34 a.m., agent (A)-C acknowledged ULP-B and ULP-E were not listed on the licensee's Netstudy (web-based system for submitting and managing background studies) roster under HFID 39189. A-C stated ULP-B and ULP-E had a cleared background study for a different licensee under HFID 36280, which was owned by the same company. A-C stated they did not know they had to associate all employees who worked for the company to the licensee's HFID. The licensee's undated Background Studies policy indicated the facility required background screening to be completed on all employees. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01530 SS=D	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of	01530		

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01530	Continued From page 11 training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure all employees received two (2) hours of initial training on topics related to mental illness and de-escalation for direct care staff as required for one of two unlicensed personnel ((ULP)-B).	01530		

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01530	Continued From page 12 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: On August 19, 2025, at 8:29 a.m., the surveyor observed ULP-B assist resident (R1) and R2 with medication administration. ULP-B was hired on May 7, 2025, to provide direct care to residents. ULP-B's undated transcript included training on Mental Illness (0.75 hours) and Behavioral Health (0.75 hours), however the training did not include the required topic on mental illness de-escalation. Also, ULP-B had only completed a total of 1.5 hours and not the required 2 hours of initial mental health training. On August 20, 2025, at 10:34 a.m., clinical nurse supervisor (CNS)-D stated they trained staff on mental health illness and how to de-escalate. CNS-D stated agent (A)-C would assign the training through Educare (common online training program) but did not know the required number of hours. On August 20, 2025, at 10:36 a.m., A-C stated the training was complete as frequently or as needed, based on the residents' needs. A-C	01530		

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	39189	A. BUILDING: _____ B. WING _____	08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PURE HEART HEALTH SERVICES INC	6213 LEE AVENUE NORTH BROOKLYN CENTER, MN 55429

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01530	Continued From page 13 stated they were aware of the required training on mental illness per Statute but did not know the required number of hours needed. A-C stated they thought the training should be four or six hours; and they planned to step up their mental health training. The licensee's Mental Health Training policy dated January 3, 2025, indicated all staff would complete the mental health training requirements under 144G Statue within 30 days of hire. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must	01620		

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01620	Continued From page 14 be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure reassessment and monitoring were completed no more than fourteen calendar days after initiation of services and not to exceed ninety calendar days from previous assessment for two of two	01620		

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01620	Continued From page 15 residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On August 19, 2025, at 8:29 a.m., the surveyor observed ULP-B assist R1 and R2 with medication administration. R1 R1 was admitted to the licensee on January 27, 2025, with diagnoses including traumatic compartment syndrome of left upper extremities, spinal cord injury, and generalized anxiety. R1's Service Plan dated February 10, 2025, indicated R1 received assistance with medication administration. R1's record included a fourteen-day nursing assessment completed on February 12, 2025, and a ninety-day nursing assessment completed on May 8, 2025. The fourteen-day assessment completed on February 12, 2025, indicated the fourteen-day assessment was completed sixteen days after the initiation of services. The ninety-day assessment completed on May 8, 2025, indicated a reassessment should have been completed on or before August 6, 2025. The record lacked another assessment after May	01620		

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01620	Continued From page 16 8, 2025. R2 R2 was admitted to the licensee on February 7, 2025, with diagnosis of diabetes. R2's Service Plan dated February 18, 2025, indicated R2 received assistance with medication administration. R2's record included a ninety-day nursing assessment dated May 11, 2025. The ninety-day assessment completed on May 11, 2025, indicated a reassessment should have been completed on or before August 9, 2025. The record lacked another assessment after May 11, 2025. On August 20, 2025, at 10:02 a.m., clinical nurse supervisor (CNS)-D stated they do an initial assessment, 14-day assessment, and then annually unless the resident had a change in condition. CNS-D stated they performed the 90-day assessment based on the day they moved in but was not sure if they were doing it correctly. After the surveyor explained the statute, CNS-D stated they did not know an assessment was required every 90 days. The licensee's undated Nursing Assessment and Reassessment of Residents policy indicated a comprehensive assessment would be complete by the RN within 14 days after start of services, with change in condition, and at least every 90 days. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	01620		

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01620	Continued From page 17 days	01620		
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 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 service plan was revised to include all services being provided for one of two residents (R1). 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	01640		

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01640	Continued From page 18 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: R1 was admitted to the licensee on January 27, 2025, with diagnoses including traumatic compartment syndrome of left upper extremities, spinal cord injury, and generalized anxiety. R1's Service Plan dated February 10, 2025, indicated R1 received assistance with medication set up, wound care, and supervision of wound care. On August 19, 2025, at 8:29 a.m., the surveyor observed ULP-B assist R1 with medication administration. The surveyor observed R1's medications were preset up by an outside company through R1's pharmacy. On August 19, 2025, at 3:38 p.m., clinical nurse supervisor (CNS)-D confirmed R1's wound was healed. On August 20, 2025, at 10:59 a.m., R1 stated in the past, they were going to a wound clinic when they had a problem with a diaper rash in their perineal area due to being allergic to the pads, however, R1 confirmed the wound had been healed. On August 20, 2025, at 12:15 p.m., clinical nurse supervisor (CNS)-D stated R1 had received medication set up by the licensee however R1's	01640		

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01640	Continued From page 19 pharmacy had begun setting up medications for R1 in June 2025. CNS-D stated the licensee currently did not provide any wound care to R1 other than peri care (cleaning of genital and anal areas to maintain skin health). CNS-D stated they would have to update R1's service plan. The licensee's undated Service Plan policy indicated the service plan must be revised as needed based on resident assessment; any revisions must include a signature by the assisted living provider and by the resident or resident's representative; and any revised service plan would be entered into the resident record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to monitor refrigeration temperatures to ensure temperatures were maintained according to the manufacturer's instructions for one of one resident (R2) with medications stored in the refrigerator. This practice resulted in a level two violation (a violation that did not harm a resident's health or	01880		

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01880	Continued From page 20 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 the potential to affect a large portion or all of the residents). The findings include: On August 18, 2025, at 11:26 a.m., during a facility tour, the surveyor observed the inside of the licensee's refrigerator used to store resident medications that required refrigeration. Upon opening the refrigerator, the surveyor observed the refrigerator temperature was at 30 degrees (°) Fahrenheit (F). The surveyor observed the following medications being stored in the refrigerator: - R2's eight boxes of Toujeo Max Solostar; - R2's one box of Humalog Kwikpen; - R2's one box of Latanoprost eye drops; and - R2's one box of dorzolamide/timolol eye drops. On August 18, 2025, at 1:29 p.m., the surveyor observed the inside of the licensee's refrigerator used to store resident medications that required refrigeration. Upon opening the refrigerator, the surveyor observed the refrigerator temperature was at 31° F. On August 19, 2025, at 9:04 a.m., the surveyor observed the inside of the licensee's refrigerator used to store resident medications that required refrigeration. Upon opening the refrigerator, the surveyor observed the refrigerator temperature was at 35° F.	01880		

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01880	Continued From page 21 The licensee's Temperature Check for Medication dated August 2025, July 2025, and June 2025, indicated the refrigerator temperatures documented were between 30 ° F and 31 ° F. The surveyor received this temperature log on August 18, 2025, at 1:17 p.m. The licensee's Facility Temperatures - by Type dated July 1, 2025, to August 18, 2025, indicated the refrigerator temperatures documented were between 46 ° F and 30 ° F. The surveyor received this temperature log on August 18, 2026, at 6:58 p.m. The licensee stated they may have given the surveyor the wrong temperature log, but the correct version was from Rtask (electronic documentation system). The temperatures documented on July 8, 2025, July 22, 2025, and August 5, 2025, were outside of the recommended refrigerator temperature recommendations for R2's Toujeo Max Solostar; R2's Humalog Kwikpen; and R2's Latanoprost eye drops that were being stored in the refrigerator. R2's dorzolamide/timolol eye drops should not have been stored in the refrigerator per the manufacturer's instructions. On August 18, 2025, at 1:29 p.m., clinical nurse supervisor (CNS)-D stated they were not aware of the manufacturer's recommendations on temperature range when storing medications in the refrigerator. CNS-D stated they were usually very particular with making sure refrigerated medications were put in the refrigerator right away upon the delivery of medications. CNS-D confirmed they had never been notified by staff when the medication refrigerator temperature was outside of range. CNS-D stated they planned to change the instructions for staff to notify the nurse when outside of the	01880		

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01880	Continued From page 22 recommended temperature parameters. The licensee's Medication Storage policy dated May 15, 2025, indicated the licensee would store all medications in accordance with the manufacturer's instructions. The manufacturer's instructions for Toujeo Max Solostar revised May 2025, indicated to store unopened pens in the refrigerator at 36° F to 46° F and not to use if the pen had been frozen. The manufacturer's instructions for Humalog Kwikpen revised August 2023, indicated to store unused pens in the refrigerator at 36° F to 46° F and not to use if the pen had been frozen. The manufacturer's instructions for latanoprost ophthalmic solution revised July 2022, indicated to store unopened bottle in the refrigerator at 36° F to 46° F. The manufacturer's instructions for dorzolamide hydrochloride and timolol maleate ophthalmic solution revised June 2023, indicated to store at 68 ° F to 77 ° F and to protect from light. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		

St Cloud District Office
Minnesota Department of Health
4140 Thielman Lane, Suite 101
St Cloud, MN 56301
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

PURE HEART HEALTH SERVICES INC
6213 LEE AVENUE NORTH
Brooklyn Center, MN 55429
Hennepin County
Parcel:

Phone:

License Info

License: HFID 39189

Risk:
License:
Expires on:
CFPM: Emmanuel N. Benson
CFPM #: 112920; Exp: 09/22/2025

Inspection Info

Report Number: F1051251084
Inspection Type: Full - Single
Date: 8/18/2025 Time: 11:00:00 AM
Duration: 30 minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

No orders were issued for this inspection report.

Food & Beverage General Comment

MET WITH THE NURSE EVALUATOR, RHAWNIE QUINEHAN.

DISCUSSED THE FOLLOWING WITH EMMANUEL:

EMPLOYEE ILLNESS LOG
VOMIT CLEAN-UP PROCEDURES
HANDWASHING & GLOVE USE/DISPOSAL
CERTIFIED FOOD PROTECTION MANAGER CERTIFICATE RENEWAL

THE KITCHEN HAS A SMOOTH TEXTURE CEILING, LAMINATE COUNTERTOPS WITH HOLLOW BASES, LAMINATE CABINETS, TILE FLOORS, AND A NSF 184 DISHWASHER.

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the St Cloud District Office inspection report number F1051251084 from 8/18/2025

Kai Yang

Emmanuel N. Benson

Kai Yang,
Public Health Sanitarian 1
320-640-3532
kai.yang@state.mn.us

St Cloud District Office
Minnesota Department of Health
4140 Thielman Lane, Suite 101
St Cloud, MN 56301

Temperature Observations/Recordings

Establishment Info

PURE HEART HEALTH SERVICES INC
Brooklyn Center
County/Group: Hennepin County

Inspection Info

Report Number: F1051251084
Inspection Type: Full
Date: 8/18/2025
Time: 11:00:00 AM

Food Temperature: Product/Item/Unit: MILK**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 41 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: LETTUCE**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 32 Degrees F.
Comment:
Violation Issued?: No