Electronically Delivered

February 27, 2024

Licensee
Hope Homes, LLC
8035 Stevens Avenue South
Bloomington, MN 55420

RE: Project Number(s) SL38736015

Dear Licensee:

This is your **official notice** that you have been **granted your assisted living facility license.** Your license effective and expiration dates remain the same as on your provisional license. Your updated status will be listed on the license certificate at renewal and **this letter serves as proof** in the meantime. If you have not received a letter from us with information regarding renewing your license within 60 days prior to your expiration date, please contact us at (651) 201-5273 or by email at Health.assistedliving@state.mn.us.

The Minnesota Department of Health completed an initial survey on February 7, 2024, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

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

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
Per 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 residents/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

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

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

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.

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If you have any questions, please contact me.

Sincerely,

Kelly Thorson

Kelly Thorson, Supervisor
State Evaluation Team
Email: kelly.thorson@state.mn.us
Telephone: 320-223-7336 Fax: 1-866-890-9290

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38736	A. BUILDING: _____ B. WING _____	02/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPE HOMES LLC	8035 STEVENS AVENUE SOUTH BLOOMINGTON, MN 55420

(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: SL38736015 On February 5, 2024, through February 7, 2024, 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 was one resident receiving services under the Assisted Living 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 License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 460 SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request assistance for health and safety needs 24 hours	0 460		

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0 460	Continued From page 1 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; (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, interview, and record review, 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 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 February 5, 2024, at 10:55 a.m., during the	0 460		

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0 460	Continued From page 2 entrance conference, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated they do not currently have a call pendant system because they only have one resident and the staff were always with the resident. On February 5, 2023, at 11:15 a.m., during a facility tour, the surveyor observed resident (R1) in the living room sitting alone on the couch watching television. R1 did not have a call pendant to summon for staff assistance. The licensee's 24-Hour Emergency Response policy dated August 1, 2023, indicated residents have access to 24-hour emergency response by staff. All residents are given instructions on the use of emergency response system upon move in and ongoing, as need. Pressing the button on the emergency response button or pulling an emergency response cord will activate the response system which will notify a designated staff person. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 460		
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;	0 680		

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0 680	Continued From page 3 (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: Based on interview and record review the licensee failed to develop an all-hazards risk assessment emergency preparedness program and plan to include Appendix Z required elements. This 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, 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 the residents). The findings include: The licensee's undated emergency preparedness	0 680		

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0 680	Continued From page 4 plan (EPP), lacked the required content: - a process for emergency preparedness (EP) collaboration with state and local EP officials/organizations; - the development of policies/procedures to address: - subsistence needs for staff and patients; - procedures for tracking staff and residents; - evacuation plan; - sheltering; - the medical record documentation system to preserve resident information; - use of volunteers; and - roles under a wavier declared by secretary. - method for sharing information from the emergency plan with residents and their families/representatives; and - a quarterly review of missing resident policy. On February 6, 2024, at 1:15 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A agreed their emergency preparedness plan was missing some of the required content. LALD/CNS-A stated they had not been aware of all the exact requirements and policies required for the emergency plan. The licensee's Emergency Preparedness Plan -Appendix Z Compliance policy, dated August 1, 2023, indicated the licensee's emergency preparedness plan will include all required elements of appendix Z. The plan will be in writing and reviewed annually. The plan is based on our assisted living-based and community-based risk assessments, utilizing an all-hazards approach. Key elements of the plan include four primary components: 1.Risk assessment and planning 2.Policies and procedures 3.A communication plan	0 680		

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0 680	Continued From page 5 4.Staff training and exercises/drills Per Assisted Living Facilities: Minnesota Rules Chapter 4659, 4659.0110, Subp. 4. Review missing resident plan. The assisted living director and clinical nurse supervisor must review the missing person plan at least quarterly and document any changes to the plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the	0 810		

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0 810	Continued From page 6 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, interview and record review, the licensee failed to develop the fire safety and evacuation plan with required content, make the plan readily available, 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 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 February 7, 2024, at 10:15 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A, provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN	0 810		

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0 810	Continued From page 7 The licensee FSEP undated, failed to include the following: The FSEP did not identify specific fire protection actions evident by not including written procedures specific for residents during a fire or similar emergency. The FSEP included standard resident evacuation procedures, but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan failed to include written evacuation status and unique and unusual needs for each individual resident. This documentation is used to communicate the needs of each individual resident during an evacuation. During an interview on February 7, 2024, at 10:30 a.m., LALD/CNS-A, stated the resident procedures during a fire or similar emergency and resident evacuation status/ unique and unusual needs were not included in writing in the FSEP. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person;	01470		

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01470	Continued From page 8 (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased	01470		

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01470	Continued From page 9 incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employees received orientation to assisted living facility licensing requirements before providing services for two of two employees (unlicensed personnel (ULP)-B, ULP-C), 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: ULP-B ULP-B began employement on September 15, 2023, to provide direct care services. On February 6, 2024, at 12:15 p.m., the surveyor observed ULP-B administer medications to R1. ULP-B's employee record included an Orientation Checklist which included classes needed for assisted living Minnesota and a transcript that documented the classes ULP-B had competed.	01470		

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01470	Continued From page 10 ULP-C ULP-C began employment on September 15, 2023, to provide direct care services. ULP-C's employee record included an Orientation Checklist which included classes needed for assisted living Minnesota and a transcript that documented the classes ULP-C had competed. ULP-B and ULP-C's employee records lacked orientation in the following Assisted Living topics: - Overview of Assisted Living statutes; - Reporting maltreatment of vulnerable adults or minors; - Handling of resident complaints, reporting of complaints, where to report; - Consumer advocacy services; and - Principles of person-centered planning/service delivery. On February 6, 2024, at 2:20 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated they had missed assigning the correct classes to include all required topics for the staff orientation. The licensee's Orientation of Staff and Supervisors & Content policy, dated August 1, 2023, indicated orientation must contain the following topics: - An overview of the appropriate Assisted Living statutes and rules; - An introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; - Handling of emergencies and use of emergency services - Compliance with and reporting of the	01470		

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01470	Continued From page 11 maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); - The Assisted Living Bill of Rights and staff responsibilities related to ensuring the exercise and protection of those rights; - Principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; - Handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; - Consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; - A review of the types of assisted living services the employee will be providing and the facility's category of licensure - The facility's organization chart and the roles of staff within the facility, and the services offered by the facility as identified in the uniform checklist disclosure of services; and - The identification of incidents of maltreatment as defined under Minnesota Statutes, section 626.5572, subdivision 15, including abuse, financial exploitation, and neglect, and an explanation that any act that constitutes maltreatment is prohibited. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		

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01530	Continued From page 12	01530		
01530 SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure all direct care staff received at least eight hours of initial dementia care training within the first 160 working hours of employment for direct care employees as required for two of two employees (unlicensed personnel (ULP)-B, ULP-C).	01530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38736	A. BUILDING: _____ B. WING _____	02/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPE HOMES LLC	8035 STEVENS AVENUE SOUTH BLOOMINGTON, MN 55420

(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
01530	Continued From page 13 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: ULP-B ULP-B began employment on September 15, 2023, to provide direct care services. On February 6, 2024, at 12:15 p.m., the surveyor observed ULP-B administer medications to R1. ULP-B's employee record indicated ULP-B completed 6.75 hours of dementia training, thus did not contain documentation ULP-B completed the initial eight hours of training required related to dementia care, within 160 working hours of ULP-B's employment start date. ULP-C ULP-C began employment on September 15, 2023. ULP-C's employee record indicated ULP-C completed 7.50 hours of dementia training, thus did not contain documentation ULP-C completed the initial eight hours of training required related to dementia care, within 160 working hours of ULP-C's employment start date. On February 7, 2024, at 11:00 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A, stated the 8 hours had been missed due to being unaware of this requirement.	01530		

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01530	Continued From page 14 The licensee's Dementia Training policy, dated August 1, 2023, indicated direct care employees will complete eight (8) hours of initial training within 160 working hours of the employment start date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01530		
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered	01730		

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	38736	A. BUILDING: _____ B. WING _____	02/07/2024

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01730	Continued From page 15 nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an individual medication management plan to include all required content for one of one resident (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 resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On February 5, 2024, at 10:30 a.m., during the entrance conference the licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated they provide medication services for the	01730		

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	38736	A. BUILDING: _____ B. WING _____	02/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01730	Continued From page 16 resident in the facility. On February 6, 2024, at 12:10 p.m., the surveyor observed unlicensed staff (ULP)-B administer R1's medications. R1 was admitted on September 18, 2023. R1's diagnoses included hypertension (high blood pressure) and chronic obstructive pulmonary disease (COPD). R1's Service Plan dated September 18, 2023, indicated R1 received services for medication administration, manage behavior, dressing, bathing assistance, housekeeping, and laundry. R1 record lacked an individual medication management plan with the following content: - a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; and - identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis. On February 6, 2024, at 10:00 a.m., LALD/CNS-A stated being unaware the medication management plan was missing the storge of medications. The licensee's Medication Management Individualized Plan policy, dated August 1, 2023, indicated the licensee will develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: a. A statement describing the medication management services that will be provided.	01730		

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	38736	A. BUILDING: _____ B. WING _____	02/07/2024

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01730	Continued From page 17 b. A description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions. c. Documentation of specific resident instructions relating to the administration of medications. d. Identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis. e. Identification of medication management tasks that may be delegated to unlicensed person. f. Procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services, and g. Any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01730		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not	01760		

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	38736	A. BUILDING: _____ B. WING _____	02/07/2024

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01760	Continued From page 18 completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were transcribed as prescribed for one of one resident (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 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's diagnoses included hypertension, chronic obstructive pulmonary disease, and mild intermittent asthma. R1's service plan dated September 18, 2023, indicated R1 received medication administration daily. R1's standing orders dated and signed by the provider on September 19, 2023, included an order for acetaminophen 650 mg(milligrams) every 4 hours PRN. On February 6, 2024, at 12:15 p.m., the surveyor observed unlicensed personnel (ULP)-B	01760		

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01760	Continued From page 19 administer R1's scheduled medications. R1's February 2024 medication administration record (MAR) included an order for acetaminophen 500 mg every 6 hours PRN. On February 6, 2024, at 9:00 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated R1's acetaminophen order was not transcribed correctly onto R1's MAR by LALD/CNS-A and was unsure why. The licensee's Medication and Treatment Orders policy, dated August 1, 2023, indicated the registered nurse is responsible for assuring that a residents MAR will be audited regularly by licensed nurse or designee for documentation compliance. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		

Minnesota Department of Health
Environmental Health, FPLS
P.O Box 64975
Saint Paul
651-201-4500

Type: Full
Date: *02/05/24*
Time: 15:35:32
Report: 1018241021

Food and Beverage Establishment Inspection Report

Location:
Hope Homes
8035 Stevens Ave S
Minneapolis, MN55420
Hennepin County, 27

Establishment Info:
ID #: 0042412
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/24

Operator:

Phone #:
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.

No NEW orders were issued during this inspection.

Food and Equipment Temperatures

Process/Item: Cold Holding/ BUTTER
Temperature: 40 Degrees Fahrenheit - Location: FRIDGE
Violation Issued: No

Process/Item: Cold Holding/ MILK
Temperature: 40 Degrees Fahrenheit - Location: FRIDGE
Violation Issued: No

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

ESTABLISHMENT DOES ALL SAME DAY SERVICE OF FOOD.

KITCHEN HAS A TWO BASIN SINK FOR DISH WASHING AND HAND WASHING.

DISHWASHER HAS SANITIZE FUNCTION.

FLOORS, WALLS, CEILINGS AND EQUIPMENT OBSERVED TO BE IN GOOD CONDITION.

DISCUSSED PEST CONTROL AND ILLNESS REPORTING.

VIEWED ILLNESS LOG

Type: Full
Date: *02/05/24*
Time: 15:35:32
Report: 1018241021
Hope Homes

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 1018241021 of 02/05/24.

Certified Food Protection Manager: ALI E EGAL

Certification Number: FM81953 Expires: 12/04/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
ALI E EGAL

Signed: _____
Rebecca Prestwood
Sanitarian 3
6512013777
rebecca.prestwood@state.mn.us