Electronically Delivered

June 16, 2025

Licensee
Unity Home Care LLC
2030 Suburban Avenue
Saint Paul, MN 55119

RE: Project Number(s) SL40064015

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 May 1, 2025, 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.

The Department of Health 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. 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.

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,

Renee L. Anderson

Renee Anderson, Supervisor
State Evaluation Team
Email: Renee.L.Anderson@state.mn.us
Telephone: 651-201-5871 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
	40064	A. BUILDING: _____ B. WING _____	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITY HOME CARE LLC	2030 SUBURBAN AVENUE SAINT PAUL, MN 55119

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL40064015-0 On April 29, 2025, through May 1, 2025, the Minnesota Department of Health conducted a full survey at the above provider, and the following orders are issued. At the time of the survey, there were three residents; all receiving services under the Provisional 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.	
0 480 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	0 480		

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

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0 480	Continued From page 2 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated April 30, 2025, 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		

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0 660	Continued From page 3	0 660		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included a completed health history and symptom screening and a two-step tuberculin skin test (TST) or other evidence of TB screening, such as a blood test, for two of two employees (house manager/unlicensed personnel (ULP)-C and clinical nurse supervisor (CNS)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	0 660		

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0 660	Continued From page 4 or has the potential to affect a large portion or all of the residents). The findings include: The Facility TB Risk Assessment, dated August 8, 2024, indicated the facility was at a low risk for TB transmission. ULP-C ULP-C was hired on January 12, 2024, to provide direct care and services to the residents of the facility. Throughout the survey, April 29, 2025, to April 30, 2025, ULP-C was observed providing direct care and services to include assisting with shaving and personal care, assisting with meal preparation, verbal reminders and social interaction, to the residents of the facility. ULP-C's employee record included documentation of a history and symptom screening and TST completed April 16, 2025. ULP-C's record lacked documentation of a second-step TST, and lacked documentation that TB screening was completed upon hire, prior to working with residents. CNS-D CNS-D was hired August 16, 2024, to provide direct care services to residents and supervision of staff. CNS-D's employee record included documentation CNS-D completed a first-step TST September 20, 2024. CNS-D's record lacked documentation of a history and symptom screening completed upon hire, or a second-step TST.	0 660		

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0 660	Continued From page 5 On April 30, 2025, at 12:10 p.m., via telephone conversation, CNS-D stated they were not aware a second-step TST was required, and did not complete a history and symptom screen. CNS-D stated they did not know the TB requirements for assisted living facilities. On April 30, 2025, at 1:08 p.m., ULP-C stated they thought the injection was the first step and the reading was the second step. ULP-C stated he was not directed to complete a second-step TST. On April 30, 2025, at 3:15 p.m., licensed assisted living director (LALD)-A stated it was their responsibility to ensure all employees were screened prior to providing direct care to residents of the facility. LALD-A stated they assumed the clinic would follow up, however, going forward, they would change the process to ensure the residents were at the lowest possible risk for contracting TB. The CDC's document titled Clinical Testing Guidance for Tuberculosis: Health Care Personnel dated December 15, 2023, indicated all health care personnel should be screened for TB upon hire. TB screening includes a baseline individual TB risk assessment, TB symptom evaluation, TB test which included a TB blood Test or TB skin test. The licensee's Tuberculosis Screening /Prevention policy, effective April 15, 2024, indicated the licensee would observe the recommended precautions related to TB prevention as identified by the CDC and the Minnesota Department of Health (MDH). The precautions included a risk assessment, TB	0 660		

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0 660	Continued From page 6 screening and staff education to reduce the risk for exposure to persons who may have had TB disease and would include: -baseline TB screening at the time of hire is required for all healthcare workers in Minnesota -TB screening would consist of three components: assesssing for current symptoms of active TB disease, assessing TB history and TB testing for the presence of infection with Mycobacterium by administering either a two-step TST or single TB blood test. -TB screening of all paid and unpaid health care workers were documented. All reports or copies of TST, blood tests, medical evaluation,TB history and symptom screen, and chest radiograph results were maintained in the health care worker's employee file. Baseline screening included two-step skin testing (unless the TB blood test was used). No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
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;	0 680		

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0 680	Continued From page 7 (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 a written emergency preparedness (EP) plan with all the required content. This had the potential to affect all residents, employees, and visitors to the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On April 30, 2025, at 10:45 a.m., house manager/unlicensed personnel (ULP)-C provided the emergency preparedness binder and explained all documents would be found within this binder. ULP-C stated they developed the program according to what was provided by their	0 680		

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0 680	Continued From page 8 consultants. The licensee's EP plan lacked the following required content: -current, all-hazards approach facility assessment -description of the population served by licensee -process for EP cooperation with state and local EP officials/organizations -subsistence needs for staff and residents during an emergency -procedure for tracking staff and residents -development of all policies/procedures, based on assessment -development of a communication plan, including primary and alternate means for communication -methods for sharing information -EP training and testing program -EP training program for staff (including documentation of training provided) -annual EP testing requirements. - process for cooperation and collaboration with local, tribal, regional, State and Federal EP to maintain integrated response. - process for arrangements with other facilities/providers to receive residents in the event of limitation/cessation of operations to maintain the continuity of services to residents. - process to address the role of the facility under a waiver declared by the secretary in accordance with section 1135 of the act. On April 30, 2025, at 1:45 p.m., licensed assisted living director (LALD)-A stated the licensee developed a disaster program as directed by their consultants. LALD-A stated the consultant company provided the documents that were used to develop the EPP program, and they thought it was a comprehensive EPP but now were uncertain. LALD-A also stated the licensee's education/training, and emergency drills were not	0 680		

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0 680	Continued From page 9 completed; the only drills that were completed were fire drills. The licensee's Emergency Preparedness policy, effective April 15, 2024, indicated the licensee would have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services. The plan would consider the organization's commitment to provide services while ensuring the safety of its employees and residents. The licensee would implement the Emergency Management program as soon as the agency became aware of the existence of an emergency. 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) 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	0 810		

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0 810	Continued From page 10 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 observation, 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On April 29, 2025, from 10:30 a.m. to 1:00 p.m., house manager/unlicensed professional (ULP)-C	0 810		

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0 810	Continued From page 11 provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP, titled "Fire Safety", undated, failed to include the following: STAFF ACTIONS: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate). The provided FSEP was from a third-party provider and had not been updated to the specific facility. RESIDENT ACTIONS: The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. UNIQUE AND UNUSUAL RESIDENT NEEDS: The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation nor did it include instructions for staff to follow in case of relocation. On April 29, 2025, at 11:30 a.m., ULP-C stated	0 810		

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0 810	Continued From page 12 they understood the areas of their policy that were incomplete and would work on bringing them into compliance. The policy reviewed was an unedited policy purchased from a third-party provider that was not specific to the facility. TRAINING: The licensee failed to provide evacuation training to residents at least once per year. ULP-C lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan. The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. Staff does web-based training at the time of hire, ULP-C stated they were using evacuation drills as training. No other training documentation was provided. On April 29, 2025, at 11:30 a.m., ULP-C stated they understood the requirements for training residents and staff and would implement a training program that was compliant with statute requirements. DRILLS The licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. Record review of licensee's evacuation drill log, titled "Fire Drill Log", undated, indicated evacuation drills were conducted on December 20, 2024, and March 2, 2025. No other documentation was provided. On April 29, 2025, at 11:30 a.m., ULP-C stated there were no residents in the facility until November 2024. ULP-C understood the fire drill requirements and will make adjustments going	0 810		

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	40064	A. BUILDING: _____ B. WING _____	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITY HOME CARE LLC	2030 SUBURBAN AVENUE SAINT PAUL, MN 55119

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0 810	Continued From page 13 forward. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01060 SS=D	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and	01060		

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01060	Continued From page 14 community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content after an emergency relocation, 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 history of stroke, transient ischemic attack, acute and chronic right sided weakness, dysarthria. R1's Service Plan Agreement dated November 19, 2024, indicated R1 received services including assistance with dressing, grooming, mobility, transfers, housekeeping, laundry and medication reminders.	01060		

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01060	Continued From page 15 R1's record included a caregiver progress note dated January 31, 2025, that indicated R1 was sent to the hospital. A subsequent progress note dated February 2, 2025, indicated R1 returned to the facility. R1's record included a hospital discharge report, dated February 2, 2025, that indicated R1 was admitted to the hospital January 31, 2025, and discharged to home February 2, 2025. R1's record lacked evidence of a written notice provided to the resident, the resident's legal representative, and designated representative that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident had been relocated and any new service provider; - contact information for the Office of Ombudsman for Long-Term Care (OOLTC); - if known and applicable, the approximate date or range of dates within which the resident was expected to return to the facility, or a statement that a return date was not currently known; and - a statement that, if the facility refused to provide housing or services after a relocation, the resident had the right to appeal and the contact information for the agency to which the resident may submit an appeal. On April 30, 2025, at 12:38 p.m., clinical nurse supervisor (CNS-D) stated she did not recall being notified of R1's admission to the hospital on January 31, 2025. On April 30, 2025, at 1:15 p.m., house manager/unlicensed personnel (ULP)-C stated they notified CNS-D via phone on January 31, 2025, that R1 was being sent to the hospital.	01060		

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01060	Continued From page 16 On April 30, 2025, at 2:10 p.m., licensed assisted living director (LALD)-A stated the licensee was not aware of the requirement of the written notification process related to emergency relocation of a resident into the hospital or another facility. LALD-A stated they would look into it and implement this process. The licensee's Discharge and Transfer of Residents policy, dated April 15, 2024, indicated: -residents discharged or transferred from the facility would have a coordinated process for discharge or transition to another provider/setting -notice to the ombudsman would be provided as soon as possible or practical, but at least within two (2) business days after providing notice to the resident and shall include the phone number for the resident or, if the resident does not have a phone number, the number for the resident's representative or case manager. -a written copy of the relocation evaluation would be provided to the resident, the resident's representative and case manager as soon as possible or practical, but not later than the planning conference. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted	01620		

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01620	Continued From page 17 as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) 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. (e) 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 interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident monitoring and reassessments not to exceed 90 calendar days from the last date of the assessment or complete a comprehensive change of condition assessment following hospitalization 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 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 resident are affected or one or a limited number of staff are involved or the	01620		

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01620	Continued From page 18 situation has occurred only occasionally). The findings include: R1 was admitted November 19, 2024, with diagnoses of history of stroke and hypertension. R1's Service Plan Agreement dated, November 19, 2024, indicated the resident received services including assistance with dressing, grooming, mobility, transfers, housekeeping, laundry, and medication reminders. R1's hospital discharge report dated, February 2, 2025, indicated R1 was admitted to the hospital January 31, 2025, by ambulance with symptoms of worsening right-sided weakness and difficulty speaking, and was discharged February 2, 2025. R1's record included a 90-day nurse reassessment, dated February 19, 2025. The assessment indicated R1 had been sent to the hospital January 31, 2025, and returned to the facility February 2, 2025. R1's record lacked evidence of change of condition assessment completed by a RN when R1 returned from the hospital. During a phone conversation April 30, 2025, at 1:38 p.m., clinical nurse supervisor (CNS)-D explained this was their first experience employed with an assisted living facility and was not aware an RN was responsible to complete a change of condition assessment upon R1's hospital return. CNS-D stated in the future they would ensure this process was complete. During an interview on April 30, 2025, at 2:10 p.m. licensed assisted living director (LALD)-A	01620		

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01620	Continued From page 19 stated the licensee's practice was to complete a change of condition assessment upon hospital return or any other significant change in a resident's condition. The licensee's Assessment and Reassessment policy, dated April 15, 2024, indicated: -an individualized initial evaluation of all new residents receiving assisted living services would be completed by a registered nurse to develop a personalized service plan. The assessment would be revised regularly and as appropriate -RN would provide a reassessment visit to update the evaluation of the resident and services no more than 14 days after initiation of services. -ongoing resident reassessments must be conducted by an RN and cannot exceed 90 days from the last date of assessment. -ongoing resident monitoring must be conducted as needed based on changes in the needs of the resident and would be completed by other licensed nurses acting within their scope of license. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

Unity Home Care LLC
2030 Suburban Ave
St Paul, MN 55119
Ramsey County
Parcel:

Phone:

License Info

License: HFID 40064

Risk:
License:
Expires on:
CFPM: LARRY A. HUTCHINSON
CFPM #: FM16590; Exp: 04/27/2026

Inspection Info

Report Number: F1005251006
Inspection Type: Full - Single
Date: 4/30/2025 Time: 10:00 AM
Duration: 30 minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 1
Total Priority 3 Orders: 0
Delivery: Emailed

New Order: 4-300 Equipment Numbers and Capacities
4-302.13B *Priority Level: Priority 2 CFP#: 48*
MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.
COMMENT: THERE WAS NO IRREVERSIBLE REGISTERING TEMPERATURE INDICATOR AVAILABLE FOR THE DISHWASHER. OPERATOR ORDERED ONE SAME DAY AND SENT A PICTURE TO INSPECTOR ON 5/1/25 THAT THEY HAVE RECEIVED IT.
Comply By: Complied On Site Originally Issued On: 4/30/2025

Food & Beverage General Comment

INSPECTION COMPLETED WITH FOOD MANAGER AND EMAILED TO HRD NURSING EVALUATOR MARY BRUESS.

DISCUSSED DATE MARKING, GLOVE USE, COOKING TEMPERATURES, CROSS-CONTAMINATION, AND EMPLOYEE ILLNESS.

OPERATOR ORDERED A MAXIMUM REGISTERING THERMOMETER AND LATER SENT INSPECTOR A PICTURE AFTER RUNNING IT THROUGH THE DISHWASHER, WHICH SHOWED THAT THE DISHWASHER PROVIDED A UTENSIL SURFACE TEMPERATURE OF 160 DEGREES F.

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

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

NOTE: 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 Metro District Office inspection report number F1005251006 from 4/30/2025

LARRY HUTCHINSON

Jessica Davis, REHS
Public Health Sanitarian 3
651-201-3961
jessica.davis@state.mn.us

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

Temperature Observations/Recordings

Establishment Info

Unity Home Care LLC
St Paul
County/Group: Ramsey County

Inspection Info

Report Number: F1005251006
Inspection Type: Full
Date: 4/30/2025
Time: 10:00 AM

Food Temperature: Product/Item/Unit: MILK**; Temperature Process:** Cold-Holding
Location: REFRIGERATOR at 38 Degrees F.
Comment:
Violation Issued?: No

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

Food Temperature: Product/Item/Unit: TACO MEAT**; Temperature Process:** Cold-Holding
Location: REFRIGERATOR at 40 Degrees F.
Comment:
Violation Issued?: No

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

Sanitizer Observations/Recordings

Establishment Info

Unity Home Care LLC
St Paul
County/Group: Ramsey County

Inspection Info

Report Number: F1005251006
Inspection Type: Full
Date: 4/30/2025
Time: 10:00 AM

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** High Temp Dishwasher
Location: DISHWASHER **Equal To** 160 Degrees F.
Comment:
Violation Issued?: No