Electronically Delivered

June 2, 2026

Licensee
Restart Inc
4525 Aldrich Avenue South
Minneapolis, MN 55419

RE: Project Number(s) SL25372016

Dear Licensee:

On June 17, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on March 19, 2025. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Stephanie Jones de Palma, Supervisor
State Engineering Services Section
Email: stephanie.jones.de.palma@state.mn.us
Telephone: 651-201-4320 Fax: 1-866-890-9290

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Electronically Delivered

April 21, 2025

Licensee
Restart Inc
4525 Aldrich Avenue South
Minneapolis, MN 55419

RE: Project Number(s) SL25372016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on March 19, 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.

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

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

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

The correction order documentation should include the following:

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

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

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

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

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

If you have any questions, please contact me.

Sincerely,

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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25372	A. BUILDING: _____ B. WING _____	03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RESTART INC	4525 ALDRICH AVENUE SOUTH MINNEAPOLIS, MN 55419

(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: SL25372016-0 On March 17, 2025, through March 19, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 10 residents; 10 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.	
0 460 SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request	0 460		

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0 460	Continued From page 1 assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (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 harm a resident's health or safety, though not likely to cause serious injury, impairment, or death). The violation was issued at a widespread scope (problems are pervasive or represent a systemic failure affecting a large portion or all residents). The findings include: On March 17, 2025, at 10:22 a.m., during the	0 460		

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0 460	Continued From page 2 entrance conference, licensed assisted living director (LALD)-A stated the facility did nota means for residents to request assistance. On March 17, 2025, from 10:55 a.m. to 11:28 a.m., during a facility tour, the surveyor did not observe call lights, call pendants, bells, or any other means for residents to request assistance located in the rooms of the residents or in the common areas. The facility was a three-story building with ten bedrooms. The licensee's census was ten residents, distributed as follows: five rooms on the top floor, four rooms on the main floor, and one room in the basement. On March 17, 2025, at 11:28 a.m., LALD-A further stated that the licensee was working with case managers to order personal emergency response systems (PERS) for residents, which would function both within and outside the facility. However, no PERS devices had been provided to residents at the time of the survey. R2 R2 was admitted on October 1, 2003, and began receiving assisted living services on August 1, 2021. R2's diagnosis included cardiovascular accident (CVA) (primary), gastroesophageal reflux disorder (GERD), implantable cardioverter defibrillator (ICD), peripheral vascular disease (PVD), coronary artery disease, diabetes IDDM, hypertension, chronic obstructive pulmonary disease (COPD), anxiety, hemiparesis (right), Hyperlipidemia, TBI (due to CVA), congestive heart failure (CHF) - EF 15-20%, orchiectomy (right), urethral stricture-anterior urethroplasty, aneurysm of left ventricular, benign prostate hyperplasia (BPH), depression, atrial fibrillation,	0 460		

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0 460	Continued From page 3 chronic kidney disease (CKD), stage III, subluxation, ischemic cardiomyopathy - ejection fraction (EF) 15-20%, and expressive aphasia. R2's Service Plan (Waiver) - addendum to contract dated March 14, 2025, indicated R2 received assistance with ambulation, bathing reminders, continuous blood glucose monitoring, room cleaning, dressing, mobility assistance, behavior management, meal assistance, medication administration, oral care, vital signs, safety checks five times per day, shopping assistance, and assistance with transportation. R2's 90-day assessment, dated February 29, 2024, indicated that R2 was unable to activate an emergency call system and required assistance in emergencies, including phone use. R2's master care plan dated February 28, 2025, indicated R2 had difficulty using the phone and required staff assistance with dialing the phone for calls. R11 R11 was admitted on February 29, 2012, and began receiving assisted living services on August 1, 2021. R11's diagnosis included hypertension (primary), blindness, asthma, periodontal disease, excessive cerumen in ear canal, and diabetes NIDDM. R11's service recap summary for March 2025 indicated R11 received assistance with housekeeping, behavior management, meal assistance, orientation, vital signs, safety checks five times per day, laundry, room cleaning, oral care, bathing assistance, and medication	0 460		

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0 460	Continued From page 4 administration. R11's 90-assessment dated February 28, 2025, indicated R11 required staff assistance with verbal cues during emergencies and was unable to evacuate without help. R11's ability to independently seek assistance, including phone use, was not documented. R11's master care plan dated February 28, 2025, indicated R11 required cueing to participate in activities and staff assistance with verbal cues during emergencies. On March 19, 2025, at 10:34 a.m., clinical nurse supervisor (CNS)-B stated all residents were assessed as independent and capable of making phone calls without assistance, and resident phones would be relied upon for obtaining assistance from staff on a 24/7 basis. CNS-B stated the licensee did not ensure residents had their phones fully charged or on their person, as they were considered independent in managing their phones. However, CNS-B acknowledged R11 required additional support in emergencies, and R2 did not own a personal cell phone. CNS-B stated R2's cell phone referenced in their master care plan and assessment was only used for monitoring of R2's ICD. CNS-B stated this phone could not be used for phone calls. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 460		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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0 480	Continued From page 5 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are	0 480		

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0 480	Continued From page 6 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated March 17, 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	0 480		

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0 480	Continued From page 7 to the FBEIR for any compliance dates.	0 480		
0 660 SS=D	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 two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test for one of two employees (unlicensed personnel (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 cause serious injury, impairment, or death), and	0 660		

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0 660	Continued From page 8 was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The licensee's TB risk assessment dated July 5, 2024, indicated the facility was a low risk. ULP-E was hired October 13, 2023, to provide assisted living services. ULP-E's employee record lacked documentation of TB screening. On March 18, 2025, at 12:06 p.m., director of residential services (DRS)-C stated ULP-E's employee record lacked proper documentation of a completed TB test. DRS-C stated there was documentation that a TB test had been requested, but there was no documentation showing a completed test. DRS-C stated when ULP-E started, the licensee was using a different human resource provider and could not verify a TB test as having been completed. The licensee's Personnel Records policy dated August 1, 2021, indicated personnel records for each person will include TB screening results and other documentation related to communicable diseases. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines, indicated an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative	0 660		

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0 660	Continued From page 9 IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record." 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; (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	0 680		

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0 680	Continued From page 10 requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z and failed to post the emergency plan prominently. 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 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 March 17, 2025, at 12:05 p.m., the surveyor retrieved a copy of the licensee's EPP, which was pinned to the wall of the licensee's nursing office. Copies of this EPP were also found in the kitchen area of the facility, as well as near entrances. The licensee's EPP was incomplete in its content and did not contain the appendices listed in the table of contents. The licensee's Emergency Plan dated August 1, 2021, lacked evidence of the following required content: - documentation of an annual review of the EPP; - documentation of quarterly review of the licensee's missing resident plan; - documentation of an annual review of the	0 680		

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0 680	Continued From page 11 licensee's all hazards risk assessment; - policies and procedures regarding at risk population needs like maintaining independence, communication, transportation, supervision and medical care; - development of policies and procedures based on the risk assessment; - development of policies and procedures for subsistence needs for staff and patients; - development of policies and procedures for tracking staff and patients. - development of policies and procedures that address the safe evacuation from the facility, including consideration of care/tx needs of evacuees; staff responsibilities; transportation; primary/alternate communication means with external sources of assistance; - development of policies and procedures to address a system of medical documentation that preserves resident information, protects confidentiality, and secures/maintains availability of records; - development of policies and procedures to address the use of volunteers, including the process/role for integration; - development of policies and procedures to address providing care/tx at alternate are sites under 1135 waiver; - documentation of the annual review of the communication plan; - contact information for federal, state, tribal, regional & local EP staff, state licensing and certification agency, MN Office of Ombudsman for LTC and other sources of assistance; - methods for sharing information and medical documentation for residents under the facility's care, as necessary, with other HCPs to maintain continuity of care, and; - means to providing information about the facility's occupancy, needs, and its ability to	0 680		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 680	Continued From page 12 provide assistance. On March 18, 2025, at 9:12 a.m., during a discussion about the required contents of the EPP, licensed assisted living director (LALD)-A stated they were responsible for the development of the licensee's EPP and thought their EPP contained all required contents. After further discussion, LALD-A stated the licensees EPP did not contain all required contents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the Minnesota State Fire Code in Minnesota Rules, chapter 7511. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large	0 775		

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	25372	A. BUILDING: _____ B. WING _____	03/19/2025

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0 775	Continued From page 13 portion or all of the residents). The findings include: On March 18, 2025, from approximately 1:05 p.m. to 1:35 p.m., survey staff toured the facility with house manager (HM)-D. During the tour, survey staff asked HM-D to open the windows in the resident bedrooms for measurement. The noncompliant measurements were as follows: OCCUPIED SLEEPING ROOMS: Bedroom 1: Window measured 22 inches clear width, 27.5 inches clear height, and 605 square inches total open area for each window. Bedroom 2: Window measured 22 inches clear width, 27.5 inches clear height, and 605 square inches total open area for each window. Bedroom 3: Window measured 22 inches clear width, 28.5 inches clear height, and 627 square inches total open area for each window Bedroom 4: Window measured 22 inches clear width, 27.5 inches clear height, and 605 square inches total open area for each window. Bedroom 7: Window measured 22 inches clear width, 27.5 inches clear height, and 605 square inches total open area for each window. Bedroom 8: Window measured 22 inches clear width, 27.5 inches clear height, and 605 square inches total open area for each window. Bedroom 9: Window measured 24 inches clear width, 13.5 inches clear height, and 324 square inches total open area for each window.	0 775		

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0 775	Continued From page 14 Bedroom 10: Window measured 22 inches clear width, 29 inches clear height, and 638 square inches total open area for each window. The window in bedroom 9 did not meet the minimum requirements for opening height. The window in bedrooms 1, 2, 3, 4, 7, 8 and 9 did not meet the minimum requirements for total openable area. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. Survey staff explained to HM-D that at least one window in each bedroom in a state-licensed facility must meet the minimum state fire code standard for an egress window to be a complying bedroom for resident occupancy. On March 18, 2025, survey staff explained to HM-D that an immediate correction order was issued for the above findings. TIME PERIOD FOR CORRECTION: Immediate	0 775		
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	0 810		

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0 810	Continued From page 15 or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans 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 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	0 810		

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0 810	Continued From page 16 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 March 18, 2025, at 2:37 p.m., housing manager HM-D 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 FSEP (fire safety and evacuation plan) 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) and was very basic. The provided FSEP was a general guidance for fire response including responding to a fire alarm, activating the RACE and Pass systems but did not provide specific employee and resident actions to take in the event of a fire or similar emergency geared to this facility. HM-D stated that recently there had been a change in supervisors and was not aware that this plan was not up to date and in need of these requirements. TRAINING: The licensee failed to provide evacuation training to residents at least once per year. HM-D stated residents were provided the training once per year but lacked documentation showing any	0 810		

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0 810	Continued From page 17 training was offered 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. HM-D stated that they were doing training upon hire and twice per year but was unable to provide the documentation for this. 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 indicated evacuation drill was conducted on March 16, 2025, February 16, 2025, September 12, 2024, February 26,2024, May 21, 2024 and June 30, 2024. No other documentation was provided. HM-D stated that they were doing the evacuation drills every month and she understood the requirements for employees twice per year, per shift with at least one evacuation drill every other month. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01470 SS=D	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; (3) handling of emergencies and use of	01470		

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01470	Continued From page 18 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 staff member 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 incidence of dementia, falls, hospitalizations,	01470		

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01470	Continued From page 19 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 interview and record review, the licensee failed to ensure employees completed required orientation before providing services for one of two employees (director of residential services (DRS)-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 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: DRS-C was hired January 27, 2025, to provide administrative oversite and support to assisted living residents. DRS-C was an unlicensed personnel. DRS-C's employee record lacked documentation of the following required orientation topics: - overview of Assisted Living Statutes; - handing of resident complaints, reporting of complaints, where to report; and	01470		

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01470	Continued From page 20 - consumer advocacy services. On March 18, 2025, at 11:52 a.m., DRS-C stated they did not complete the missing trainings. DRS-C stated they believed they may have accidently removed the trainings from their assigned training list when they assigned trainings for other staff. The licensee's Assisted Living Orientation - ULP Staff policy dated July 12, 2021, indicated newly hired unlicensed personnel will receive orientation and training on topics required by Minnesota statutes and rules for assisted living organizations. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01620 SS=F	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 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	01620		

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01620	Continued From page 21 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) completed an ongoing resident reassessment that did not exceed 90 days as required for two of two residents (R2, R3). 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: R2 R2 was admitted on October 1, 2003, and began receiving assisted living services August 1, 2021. R2's signed service plan (waiver) - Addendum to Contract, dated March 14, 2025, indicated R2 received assistance with ambulation, bathing reminders, continuous blood glucose monitoring, deep room cleans, dressing assistance, drinking assistance, escort, housekeeping, laundry, linen	01620		

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01620	Continued From page 22 changes, behavior management, meal assistance, medication administration, oral care, vital signs, respiratory equipment care, safety checks, shopping assistance, and transportation. R2's record contained assessments dated May 24, 2024, and August 29, 2024, which indicated 97 days had lapsed between assessment dates. R2 next assessment was dated December 2, 2024, which indicated 95 days had lapsed between assessment dates. R3 R3 was admitted on November 6, 2024, to receive assisted living services. R3's signed service plan (waiver) - Addendum to Contract, dated November 6, 2024, indicated R3 received assistance with appointment reminders, deep room cleans, housekeeping, laundry, linen changes, behavior management, meal assistance and reminders, medication administration, vital signs, safety checks, and socialization. R3's record contained an admission assessment dated November 6, 2024, and a 14-day assessment dated November 21, 2024, which indicated 15 days had lapsed between assessment dates. Additionally, R3's next assessment was dated February 26, 2025, which indicated 97 days had lapsed between assessment dates. On March 17, 2025, at approximately 10:30 a.m., clinical nurse supervisor (CNS)-B stated assessments were completed upon admission, 14-days after admission, and then every 90-days or with a change in condition. On March 18, 2025, at 1:44 p.m., CNS-B stated they believed the timing mistake of the	01620		

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01620	Continued From page 23 assessments occurred due to an oversite on their part. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide documentation in the resident's record regarding the disposition of medication to include the date of disposition and names of staff and other individuals involved in	01910		

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01910	Continued From page 24 the disposition for two of two discharged residents (R1, R10). 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: R1 discharged from the licensee on August 30, 2024. R10 discharged from the licensee on June 27, 2024. R1 and R10's records lacked documentation of the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. On March 18, 2025, at 1:44 p.m., clinical nurse supervisor (CNS)-B stated R1 was discharged after hours. CNS-B stated they had sent information to be signed by R1's family, but never received the documentation back. CNS-B stated R10 self-discharged to home and their form was not completed accurately. The licensee's Disposition or Disposal of Medication policy dated July 12, 2021, indicated staff will document in the resident's record the	01910		

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01910	Continued From page 25 name of the person to whom the medications were given, the time and date, the name of each medication and the amount of medication remaining. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		

Minnesota Department Of Health
Food, Pools, and Lodging Services
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *03/17/25*
Time: 13:30:06
Report: 1050251055

Food and Beverage Establishment Inspection Report

Location:
Restart Inc
4525 Aldrich Avenue South
Minneapolis, MN55419
Hennepin County, 27

Establishment Info:
ID #: 0037709
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6127013645
ID #:

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

The following orders were issued during this inspection.

4-300 Equipment Numbers and Capacities

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

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

ESTABLISHMENT MISSING THIN PROBE THERMOMETER AT TIME OF INSPECTION. DISCUSSED MN REQUIREMENTS AND REPLACING FOR USE WHEN COOKING. COMPLY WITH RULE ABOVE.

Comply By: 03/17/25

4-600 Cleaning Equipment and Utensils

4-601.11B

MN Rule 4626.0840B Maintain the food contact surfaces of cooking equipment and pans free of encrusted grease deposits and other soil accumulations.

OBSERVED FOOD DEBRIS AND LEFTOVER MEATBALLS WITH MOLD GROWTH LEFT INSIDE OF AIR FRYER IN KITCHEN. REMOVE MOLDED ITEMS AND PROPERLY CLEAN/SANITIZE BEFORE USE. COMPLY WITH RULE ABOVE.

Comply By: 03/17/25

Food and Equipment Temperatures

Process/Item: Cold Holding/Cheese
Temperature: 39F Degrees Fahrenheit - Location: Reach-In Cooler
Violation Issued: No

Process/Item: Cold Holding/Strawberrys
Temperature: 40F Degrees Fahrenheit - Location: Reach-In Cooler
Violation Issued: No

Process/Item: Cold Holding/Peppers
Temperature: 39F Degrees Fahrenheit - Location: Reach-In Cooler
Violation Issued: No

Process/Item: Cold Holding/Milk
Temperature: 38F Degrees Fahrenheit - Location: Reach-In Cooler
Violation Issued: No

Process/Item: Cold Holding/Cabbage
Temperature: 38F Degrees Fahrenheit - Location: Reach-In Cooler
Violation Issued: No

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

Announced inspection completed by MDH Andrew Spaulding and Maria Medina on 3/17/25.

Current pest management contract with Plunketts with service every 6 months. No pest issues seen on site during time of inspection.

2nd floor kitchen is not in use reach-in cooler is for staff meals only.

Facility had ten residents on site at time of inspection. Meals are prepared on site no leftovers are kept after meals are served.

This establishment has a residential kitchen. Food must be prepared for same day service only. The kitchen has wood cabinets with a hollow base and wooden flooring. All found to be in good condition.

Discussed the following:
-Employee illness policy and logging requirements
-Hand washing
-Glove-use and bare hand contact
-Food storage and preventing cross contamination
-Date marking
-Vomit clean up procedures/ Kit purchase
-Restrictions concerning serving a highly susceptible population.

Type: Full
Date: *03/17/25*
Time: 13:30:06
Report: 1050251055
Restart Inc

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department Of Health inspection report number 1050251055 of 03/17/25.

Certified Food Protection Manager: Maria D. Medina

Certification Number: FM25320 Expires: 04/05/26

Inspection report reviewed with person in charge and emailed.

Signed:_____

Maria D. Medina
Operator

Signed:_____

Andrew Spaulding
Public Health Sanitarian 2
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