Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF REMOVAL OF CONDITIONS ON PROVSIONAL LICENSE - LICENSE GRANTED

Electronic Delivery

January 18, 2024

Licensee
Healing Heart Nursing Care LLC
6937 West Palmer Lake Drive
Brooklyn Center, MN 55429

RE: Initial License Number 408224
Health Facility Identification Number (HFID) 39103
Project Number(s) SL39103015

Dear Licensee:

On December 29, 2023, The Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed September 27, 2023. The follow-up survey found the facility to be in substantial compliance. **Based on these findings, the condition(s) on the license were removed effective January 18, 2024.**

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.

In addition, 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.

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

Sincerely,

Maria King

Maria King, RN
Division Director

Minnesota Department of Health
Health Regulation Division

HHH

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF PROVISIONAL EXTENSION AND CONDITIONAL LICENSE

Electronically Delivered
October 17, 2023

Licensee
Healing Heart Nursing Care LLC
6937 West Palmer Lake Drive
Brooklyn Center, MN 55429

RE: Conditional License Number 408224
Health Facility Identification Number (HFID) 39103
Project Number(s) SL39103015

Dear Licensee:

The Minnesota Department of Health (MDH) completed an initial survey on September 27, 2023, for the purpose of assessing compliance with state licensing statutes and determining issuance of an initial license. Based on the initial survey results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G and Minnesota Food Code, Minnesota Rules Chapter 4626.

As a result, pursuant to Minn. Stat. § 144G.16, Subd. 3(b) is issuing a 90-day conditional provisional license due to expire on **January 15, 2024**.

STATE CORRECTION ORDERS
The enclosed State Form documents the state correction orders. MDH documents state 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 provisional 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.

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.

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

CONDITIONAL LICENSE ISSUED:
MDH will issue Healing Heart Nursing Care LLC a conditional provisional assisted living facility license for 90 calendar days from the date of this notice. At an unannounced point in time, within the 90 calendar days, MDH will conduct a follow-up survey, as defined in Minn. Stat. § 144G.30, Subd. 6. Based on the results of the follow-up survey, MDH will determine if Healing Heart Nursing Care LLC is in substantial compliance.

The following condition applies on the conditional provisional assisted living facility license:

a. **Egress window requirements:** Healing Heart Nursing Care LLC will replace proposed egress windows in occupied resident rooms number 1, number 2 and number 6 with egress windows that meet the minimum size requirements. Egress windows in existing facilities must have a minimum opening dimension of 648 square inches, with opening height and width dimension of no less than 20 inches. Healing Heart Nursing Care LLC will continue to execute fire watch protocols every 30 minutes until such time that the egress windows can be brought into compliance.

RESULTS OF FOLLOW-UP EVALUATION DURING THE CONDITIONAL PROVISIONAL LICENSE PERIOD:
MDH will determine if Healing Heart Nursing Care LLC is in substantial compliance based on the results of the follow up survey. MDH will make this determination within the 90-day conditional provisional license period. If MDH determines Healing Heart Nursing Care LLC is in substantial compliance on the follow up survey, MDH will remove the conditions from Healing Heart Nursing Care LLC's assisted living facility provisional license, and Healing Heart Nursing Care LLC will correct violations identified during the survey to come into substantial compliance. If MDH determines Healing Heart Nursing Care LLC is not in substantial compliance, MDH may take additional enforcement action against Healing Heart Nursing Care LLC, including placement of additional conditions, issuing an extension to the conditional provisional license, or employ any of the enforcement tools

listed in Minn. Stat. § 144G.20 up to and including immediate temporary suspension and revocation.

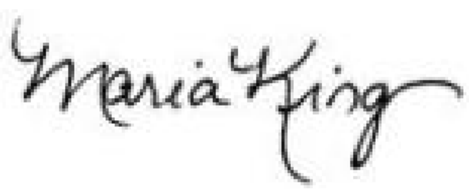
REQUEST FOR RECONSIDERATION:
Pursuant to Minn. Stat. §144G.16, Subd. 4, if a provisional licensee whose assisted living facility license has been denied, or extended with conditions, disagrees with the action taken against the provisional license under this section, the provisional licensee may request a reconsideration no later than 15 calendar days after provisional licensee receives notice of the action. The request for reconsideration should be addressed to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970
Health.HRD.Appeals@state.mn.us

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 Tim Hanna, Interim Assisted Living Engineering Supervisor, directly at: 651-201-4321.

Sincerely,



Maria King, RN
Division Director

Minnesota Department of Health
Health Regulation Division

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39103	A. BUILDING: _____ B. WING _____	09/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALING HEART NURSING CARE LLC	6937 WEST PALMER LAKE DRIVE BROOKLYN CENTER, MN 55429

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL39103015 On September 25, 2023, through September 27, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were four active residents; all whom were receiving services under the Assisted Living license. An immediate correction order was identified on September 27, 2023, issued for SL39103015, tag identification 0820.	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.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480		

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0 480	Continued From page 1 following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated September 26, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	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	0 660		

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0 660	Continued From page 2 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 observation, interview, and record review, the licensee failed to complete a two-step TST (tuberculin skin test) or other evidence of tuberculosis (TB) screening such as a blood test for one of two employees (unlicensed personnel (ULP)-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, 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: The facility's TB risk assessment was completed on June 1, 2023, and was determined to be a low risk level. ULP-D was hired on April 12, 2023, to provide direct care services to residents at the assisted living facility. On September 25, 2023, at 2:22 p.m., the surveyor observed ULP-D administer R1's scheduled medication.	0 660		

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0 660	Continued From page 3 On September 26, 2023, at 7:07 a.m., the surveyor observed ULP-D conduct R3's blood glucose monitoring check. ULP-D's employee record included a TB screening dated May 1, 2023; and a TST that had been completed for another facility on November 1, 2022; however, did not include evidence of a current TST or one which had been completed within 90 days of ULP-D's hire date. On September 26, 2023, at 1:53 p.m., licensed assisted living director/registered nurse (LALD/RN)-A stated ULP-D's TST had not been completed as required. LALD/RN-A stated they were auditing all the employee files to assure they contained all the required information and ULP-D's TST was missed. The licensee's Tuberculosis Screening policy dated January 1, 2023, noted new staff would be screened for active signs of TB using the Baseline TB Screening Tool for healthcare workers (HCWs). New Staff will have a blood test or a two-step Mantoux conducted with results documented on the Baseline TB Screening Tool for HCWs. Staff TB screening results will be kept in each employee medical file. 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 IGRA or TST (first step) dated within 90 days before hire.	0 660		

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0 660	Continued From page 4 The MDH Tuberculosis (TB) Screening and Education Requirements for Assisted Living Facilities and Home Care Providers dated February 3, 2022, indicated a negative TST or IGRA tests can be accepted if dated within 90 days before hire. 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 5 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 plan (EPP) with all the required content. This had the potential to affect all residents, staff, and visitors of 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 of the residents). The findings include: The licensee's EPP dated June 27, 2022, provided to the surveyor included generic instructions for staff to follow in case of a fire, thunderstorm, tornado, pandemic, bomb, winter weather, and utility disruption. The licensee's EPP did not include the following: - a hazard and vulnerability assessment - a quarterly review of the missing resident policy (last reviewed 1/1/23) - a description of the facilities approach to meeting the health/safety/security needs of the staff and residents; - process for EP cooperation with state and local EP officials/organizations; - a description of the population served by the licensee; - development of policies/procedures to address: - procedure for tracking staff and residents; - subsistence needs for staff and residents	0 680		

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0 680	Continued From page 6 during an emergency to include (food, water, medical supplies, pharmacy supplies, sewer and waste disposal, emergency lighting, fire detection, extinguishing and alarm systems); - evacuation plan which included staff responsibilities during an evacuation and transporting services for residents being evacuated; - a medical record documentation system to preserve resident information, security, and availability; - emergency staffing strategies to include volunteers; - the development of arrangements with other facilities and providers to receive residents if needed; and - the facilities role in providing care and treatment at alternative sites under a 1135 waiver; - a communication plan that included: - names and contact information for staff, entities providing services under arrangement, resident physicians, other facilities, volunteers; - arrangement with other facilities; - contact information for federal, state, tribal, local EP staff, ombudsman, state licensing and certification agencies; - primary and alternative means for communicating with facility staff, federal, state, regional and local emergency management agencies; - a method of sharing information and medical documentation for residents; and - a means to provide information regarding the facility's needs, and its ability to provide assistance to include information about their occupancy On September 26, 2023, at 2:28 p.m., after a brief review of the components required in an EPP by the surveyor, licensed assisted living	0 680		

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0 680	Continued From page 7 director/registered nurse (LALD/RN)-A stated they have been working on developing the EPP and are aware the EPP was incomplete. LALD/RN-A stated she felt comfortable of what needed to be included in the facility's EPP, but just hadn't had the time to fully develop the EPP. The licensee's Disaster Planning and Emergency Preparedness policy dated June 27, 2022, noted the licensee would have in place a general EPP, that was in alignment with facility's requirement to also comply with the Centers for Medicare and Medicaid Services (CMS) Appendix Z. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so	0 780		

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0 780	Continued From page 8 that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that are interconnected throughout the facility so that actuation of one alarm will cause all alarms in the dwelling to actuate. This deficient condition had the ability to affect all staff and 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). Findings include: On a facility tour on September 27, 2023, between approximately 10:06 a.m. and 10:53 a.m. with Licensed Assisted Living Director/Registered Nurse (LALD/RN-A) and Certified Nurse Supervisor (CNS-B), observed that smoke alarms throughout the facility were not interconnected so that actuation of one alarm will cause all alarms in the dwelling to actuate. This was discovered when the LALD/RN-A tested the smoke alarms.	0 780		

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0 780	Continued From page 9 LALD/RN-A verbally confirmed survey staff observations during the facility tour. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide proper door locking arrangements that did not constitute a distinct hazard to life. This had the potential to directly affect all residents and staff. It was also observed the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition had the ability to affect a limited number of staff and 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	0 800		

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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
0 800	Continued From page 10 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). Findings include: On September 27, 2023, approximately from 10:06 a.m. to 10:53 a.m., survey staff toured the facility with Licensed Assisted Living Director/Registered Nurse (LALD/RN-A) and Clinical Nurse Supervisor (CNS-B). During the facility tour, survey staff observed and verified the front and side emergency exit doors, had dead bolts that required more than one operation to release and open. Exit door latch hardware is required to release, unlock, and open for the purpose of exiting in one operation. LALD/RN-A stated that the front (dining room) and side (kitchen) doors will stay on the emergency exit plan and have one of the door locks removed. The following maintenance items was observed: It was observed that there was an area around the fan on the Main floor bathroom ceiling that had all of the paint and texture peeled off. It was also observed in this same bathroom that the door had a hole in it. These deficient conditions were visually verified by LALD/RN-A accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39103	A. BUILDING: _____ B. WING _____	09/27/2023

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0 810	Continued From page 11 (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 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 a record review and interview, the licensee failed to develop a fire safety and evacuation plan with required elements and failed	0 810		

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0 810	Continued From page 12 to conduct required evacuation drills. This had the potential to affect all staff, residents, 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). Findings include: A record review and interview were conducted on September 27, 2023, approximately between 10:45 a.m. and 11:00 a.m. with Licensed Assisted Living Director/Registered Nurse (LALD/RN-A) and Certified Nurse Supervisor (CNS-B), on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review of the available documentation indicated that the licensee did not have all the employee actions to be taken in the event of a fire or similar emergency. Record review of the available documentation indicated that the licensee did not have all the fire protection procedures necessary for residents included in the fire safety and evacuation plan. Record review of the available documentation indicated that the evacuation plan did not include 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.	0 810		

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0 810	Continued From page 13 Record review of the available documentation indicated that the licensee did not conduct evacuation drills twice per year per shift and every other month as required by statute. Provided documentation indicated that drills were not being conducted every other month. During interview, LALD/RN-A and CNS-B, verified that the fire safety and evacuation plan for the facility lacked these provisions. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 820 SS=E	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide properly sized egress windows for resident rooms that did not create a distinct hazard for residents. This had the potential to	0 820		

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0 820	Continued From page 14 directly affect a portion of the residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On September 27, 2023, between the hours of 10:10 a.m. and 10:46 a.m., survey staff conducted a facility tour with Licensed Assisted Living Director/Registered Nurse (LALD/RN-A) and Clinical Nurse Supervisor (CNS-B). During facility tour, survey staff observed the following: LALD/RN-A fully opened the proposed egress window in occupied resident room #1 and survey staff verified the measurement of the openable area of the window to be 13" high x 30.5" wide for a total of 396.5 square inches. Egress windows in existing facilities must have a minimum opening dimension of 648 square inches with an opening height and width dimension of no less than 20". LALD/RN-A visually verified the deficient condition. LALD/RN-A fully opened the proposed egress window in occupied resident room #2 and survey staff verified the measurement of the openable area of the window to be 13" high x 30.5" wide for a total of 396.5 square inches. Egress windows in existing facilities must have a minimum opening	0 820		

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0 820	Continued From page 15 dimension of 648 square inches with an opening height and width dimension of no less than 20". LALD/RN-A visually verified the deficient condition. LALD/RN-A fully opened the proposed egress window in occupied resident room #6 which was identified on the fire safety evacuation map and submitted floorplan as "living room". Survey staff verified the measurement of the openable area of the window to be 38.25" high x 14.25" wide for a total of 545 square inches. Egress windows in existing facilities must have a minimum opening dimension of 648 square inches with an opening height and width dimension of no less than 20". LALD/RN-A visually verified the deficient condition. During interview, LALD/RN-A indicated that the licensee has been conducting a fire watch and provided documentation of the fire watch logs. Record review of the fire watch logs indicated that staff were conducting fire watch protocols every 30 minutes of their shift in accordance with the facility fire watch policy. LALD/RN-A verbally verified that all staff would continue to execute the fire watch procedure as indicated on their previous plan of correction until such time that the egress windows can be brought into compliance. No further information provided. TIME PERIOD FOR CORRECTION: Immediate	0 820		
0 930 SS=C	144G.50 Subd. 2 (d-e; 1-4) Contract information (d) The contract must include a description of the facility's complaint resolution process available to residents, including the name and contact	0 930		

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0 930	Continued From page 16 information of the person representing the facility who is designated to handle and resolve complaints. (e) The contract must include a clear and conspicuous notice of: (1) the right under section 144G.54 to appeal the termination of an assisted living contract; (2) the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer; (3) contact information for the Office of Ombudsman for Long-Term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints; (4) the resident's right to obtain services from an unaffiliated service provider; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the assisted living contract included all required content for one of one resident (R1). This had the potential to affect all four residents who received assisted living services. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	0 930		

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0 930	Continued From page 17 R1's service plan dated February 15, 2023, indicated services included medication management, blood glucose monitoring, laundry, housekeeping, and assistance with transferring, toileting, dressing, bathing, and grooming. On September 26, 2023, at 11:57 a.m., the surveyor observed unlicensed personnel (ULP)-D conduct R1's blood glucose monitoring check. At 12:58 p.m., the surveyor observed ULP-D administer R1's scheduled medications. R1's Assisted Living Contract dated February 1, 2023, did not include the facility's policy regarding transfer of residents within the facility, under which circumstances a transfer may occur, and the circumstances under which resident consent was required to transfer. On September 26, 2023, at 10:27 a.m., licensed assisted living director/registered nurse (LALD/RN)-A stated the contract was a template contract that was developed by a consulting company contracted by the licensee and provided to all residents. LALD/RN-A stated the Assisted Living Contract did not include the above noted content. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 930		
0 950 SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the	0 950		

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0 950	Continued From page 18 contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of one resident's (R1) assisted living contract included a notice with the required verbiage for the residents to identify a designated representative. This had the potential to affect all four residents who received services at the facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not	0 950		

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0 950	Continued From page 19 affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1's service plan dated February 15, 2023, indicated services included medication management, blood glucose monitoring, laundry, housekeeping, and assistance with transferring, toileting, dressing, bathing, and grooming. R1's service plan included the name and contact information of R1's designated representative. R1's record did not include evidence of a notice with required statutory language for the resident to have the opportunity to identify or to decline to name a designated representative. On September 26, 2023, at 9:14 a.m., licensed assisted living director/registered nurse (LALD/RN)-A stated she thought the required statutory language regarding the designated representative was a part of each resident's service plan and now after review she can see it is not. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not	0 970		

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0 970	Continued From page 20 include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property of a resident. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: The Assisted Living Contract provided included clauses that indicated the resident would waive the facility's liability for health, safety, or personal property of the resident. Section 7. Security/Valuables/Keys subdivision C indicated if you (the resident) choose not to lock your valuables, you assume liability for them. Section Indemnification: Liability, indicated the resident agrees to be liable and responsible for all obligations herein referenced, monetary and otherwise, of the resident and where this Contract as been executed by a party designated below.	0 970		

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0 970	Continued From page 21 On September 26, 2023, at 10:30 a.m., licensed assisted living director/registered nurse (LALD/RN)-A stated the contract was a template contract that was developed by a consulting company contracted by the licensee and provided to all residents. LALD/RN-A stated she was aware the facility could not waive their liability and after reviewing the above noted sections of the Assisted Living Contract could see how these statements could be interpreted as the facility waiving their liability. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		
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	01060		

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01060	Continued From page 22 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 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 to the resident, legal representative, and designated representative who had an emergency relocation out of the facility, and failed to provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC) when the resident did not return from the emergency relocation within four days 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 an	01060		

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01060	Continued From page 23 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, chronic kidney disease, diabetes, hypertension (high blood pressure), and congested heart failure (CHF-a condition in which the heart's function as a pump is inadequate to meet the body's needs). R1's service plan dated February 15, 2023, indicated R1 received the following services: medication management, blood glucose monitoring, laundry, housekeeping, and assistance with transferring, toileting, dressing, bathing, and grooming. R1's Notes included the following: - September 22, 2023, at 7:21 p.m., R1 arrived back from dialysis at 12:15 p.m., and had Tylenol and ear drops for ear pain. At about 6:00 p.m., R1 had a bleed in her right arm and staff called the ambulance and R1 was transported to the hospital. - September 28, 2023, at 2:25 p.m., R1 just returned at 2:30 p.m., and was currently sitting on the side of the bed and seemed to be in good spirits. - September 28, 2023, at 6:17 p.m., R1 came home from the hospital today. R1's incident report dated June 28, 2023, indicated on June 22, 2023, staff had called 911 due to R1 removing her dressing over her fistula after dialysis. After removing the dressing R1 was noted to have excessive bleeding which was not controlled by pressure. 911 was called and	01060		

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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
01060	Continued From page 24 R1 was transported to a nearby hospital. R1's record lacked a written notice that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the OOLTC and the Office of Ombudsman for Mental Health and Developmental Disabilities; - 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 - 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. In addition, R1's record lacked notification to the OOLTC that the resident had been relocated and had not returned to the facility within four days. On September 26, 2023, at 10:43 a.m., licensed assisted living director/registered nurse (LALD/RN)-A stated she was aware of the requirement to provide a written notice for an emergency relocation and to notify the ombudsman if the resident does not return within four days. LALD/RN-A stated R1's emergency contact had been called regarding the transfer however, the written emergency relocation notice had not been completed for R1, nor had the OOLTC been notified when R1 had not returned to the facility within four days. The licensee's Emergency Relocation policy	01060		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39103	A. BUILDING: _____ B. WING _____	09/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALING HEART NURSING CARE LLC	6937 WEST PALMER LAKE DRIVE BROOKLYN CENTER, MN 55429

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01060	Continued From page 25 dated July 22, 2022, noted in the event of an emergency relocation, the licensee would provide a written notice that contained, at a minimum: a. the reason for the relocation; b. the name and contact information for the location to which the resident has been relocated and any new service provider; c. contact information for the OOLTC d. 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 e. a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal. The notice required would be delivered as soon as practicable to: a. The resident, legal representative, and designated representative b. For residents who received home and community-based waiver services, the resident's care manager, and c. The OOLTC if the resident has been relocated and has not returned to the facility within four days. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01060		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access.	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39103	A. BUILDING: _____ B. WING _____	09/27/2023

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01880	Continued From page 26 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of one medication refrigerator maintained an acceptable temperature to ensure the medications were stored according to manufacturer's recommendations. 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 September 25, 2023, at 1:35 p.m., the surveyor toured the facility with licensed assisted living director/registered nurse (LALD/RN)-A, including a review of a drawer in the kitchen refrigerator where medications were being stored. LALD/RN-A stated the current temperature of the refrigerator was 35 degrees Fahrenheit (F) as indicated on the digital temperature reading monitor on the door of the refrigerator. LALD/RN-A stated the temperature of the refrigerator was checked daily on the night shift and recorded electronically. The medication refrigerator contained the following medications: - five unopened Lantus 100 units/milliliter (ml) insulin pens (a multiple dose pen shaped injector device for insulin administration) for R1 - four unopened Lantus 100 units/ml insulin pens for R3 LALD/RN-A stated she thought the acceptable	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39103	A. BUILDING: _____ B. WING _____	09/27/2023

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HEALING HEART NURSING CARE LLC	6937 WEST PALMER LAKE DRIVE BROOKLYN CENTER, MN 55429

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01880	Continued From page 27 temperature range for storing medications was 32-41 degrees F. On September 26, 2023, at 7:55 a.m., the Temp-Kitchen Refrigerator electronic log dated September 1, 2023, through September 24, 2023, was reviewed with LALD/RN-A. The temperature of the refrigerator had been documented daily. Of the 24 recorded daily temperature readings; 22 were below 36 degrees F. LALD/RN-A stated the recorded refrigerator temperature was consistently below 36 degrees F. LALD/RN-A stated the incorrect acceptable temperature range had been entered into the electronic documentation log. The manufacturer's instructions for Lantus insulin pens dated May 2019, indicated unopened insulin pens should be stored in the refrigerator 36 to 46 degrees F. The licensee's Medication Storage policy dated June 27, 2022, noted medications would be stored consistent with manufacturer's recommendations (refrigerated, room temperature, or frozen). No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39103	A. BUILDING: _____ B. WING _____	09/27/2023

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01890	Continued From page 28 expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to monitor for expired medications for one of four residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: On September 25, 2023, at 1:25 p.m., the surveyor toured the facility with licensed assisted living director/registered nurse (LALD/RN)-A, including a review of the locked medication cabinets. LALD/RN-A observed and confirmed R2's opened bottle of olanzapine (antipsychotic) 5 milligrams (mg) tablets expired August 2023. LALD/RN-A stated the nurses were to check for expired medications weekly. LALD/RN-A stated she thought this bottle of medication had been removed from the medication cabinet. The licensee's Medication Disposal policy dated June 27, 2022, noted expired medications managed by the licensee would be disposed of according to the accepted practices of the Minnesota board of Pharmacy. No further information was provided.	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39103	A. BUILDING: _____ B. WING _____	09/27/2023

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HEALING HEART NURSING CARE LLC	6937 WEST PALMER LAKE DRIVE BROOKLYN CENTER, MN 55429

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01890	Continued From page 29 TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

DEPARTMENT OF HEALTH

Type: Full
Date: *09/26/23*
Time: 10:59:31
Report: 1036231249

Food and Beverage Establishment Inspection Report

Location:

Healing Heart Nursing Care LLC
6937 West Palmer Lake Drive
Brooklyn Center, MN55429
Hennepin County, 27

Establishment Info:

ID #: 0041340
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/23

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.

The following orders were issued during this inspection.

3-300B Protection from Contamination: cross-contamination, eggs

3-302.11A(1) ***** Priority 1 *****

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

OBSERVED EGGS BEING STORED OVER RTE FOOD IN THE FRIDGE. ISSUE CORRECTED ON SITE.

Comply By: 09/26/23

2-100 Supervision

2-102.12AMN

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

NO CFPM ON SITE. APPLICATION/INSTRUCTIONS FOR OBTAINING A CFPM EMAILED TO ESTABLISHEMNT.

Comply By: 10/26/23

Surface and Equipment Sanitizers

UTENSIL SURFACE TEMP: = at 170 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Type: Full
Date: *09/26/23*
Time: 10:59:31
Report: 1036231249
Healing Heart Nursing Care LLC

Food and Beverage Establishment Inspection Report

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

Process/Item: Ambient Temp
Temperature: 5 Degrees Fahrenheit - Location: LG FREEZER
Violation Issued: No

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

THIS INSPECTION WAS CONDUCTED IN CONJUNCTION WITH MDH HEALTH REGULATORY DIVISION (HRD) SURVEY. SURVEYOR FROM HRD WAS JANA BROMENSHENKEL. INSPECTION CONDUCTED IN PRESENCE OF KRIS WRIGHT, THE PERSON IN CHARGE. ALL VIOLATIONS WERE DISCUSSED WITH THE PERSON IN CHARGE AND HRD EVALUATOR DURING INSPECTION.

THIS FACILITY DOES NOT HAVE COMMERCIAL GRADE ANSI EQUIPMENT. ALL FOOD MUST BE SERVED THE SAME DAY IT IS PREPARED, AND LEFTOVERS CAN NEVER BE SAVED.

DISCUSSED ALL ORDERS ON SITE IN ADDITION TO THE FOLLOWING WITH THE PERSON IN CHARGE:

- EMPLOYEE ILLNESS LOG AND EXCLUSION POLICY.
- HAND WASHING POLICY AND REVIEW.
- GLOVE USAGE.
- THERMOMETER USE AND CALIBRATION.
- DATE MARKING.
- PEST CONTROL.
- FULLY COOKING FOOD FOR HIGH RISK POPULATIONS.
- ANSI 184 STANDARD FOR RESIDENTIAL DISH WASHER.

FOR CORRECT BY DATES REFER TO COMPLETE REPORT ISSUED BY HRD.

**IF ANY RESIDENT COMPLAINS OF ILLNESS, CONTACT THE MINNESOTA DEPARTMENT OF HEALTH AND PROVIDE THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER TO THE CUSTOMER. THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER IS 1-877-366-3455.

Type: Full
Date: *09/26/23*
Time: 10:59:31
Report: 1036231249
Healing Heart Nursing Care LLC

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 inspection report number 1036231249 of 09/26/23.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Inspection report reviewed with person in charge and emailed.

Signed:_____
KRIS WRIGHT
PERSON IN CHARGE

Signed:_____
Jeff Johanson