Electronically Delivered

January 28, 2025

Licensee
N&V Helpful Heart Care Inc
8159 Mount Curve Boulevard
Brooklyn Park, MN 55445

RE: Project Number(s) SL31111016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on December 13, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E

MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

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

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

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

The correction order documentation should include the following:

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

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

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

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

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

If you have any questions, please contact me.

Sincerely,

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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31111	A. BUILDING: _____ B. WING _____	12/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
N&V HELPFUL HEART CARE INC	8159 MOUNT CURVE BOULEVARD BROOKLYN PARK, MN 55445

(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: SL31111016 On December 9, 2024, through December 13, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 2 residents receiving services under the Assisted Living Facility with Dementia Care 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 and interview, 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 current residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	0 460		

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0 460	Continued From page 2 On December 9, 2024, at 11:02 a.m. during the entrance conference, owner (O)-C stated the licensee did not have a call light or pendant system residents could use to summon staff. O-C stated she had previously purchased a system but had not installed it and was going to return the system to get one that was more appropriate for the licensee's clientele. On December 9, 2024, at 1:04 p.m., during the facility tour, the surveyor observed the facility was a rambler style home with a main floor and basement. No pendants, call light system, or means to request assistance were observed during the facility tour. On December 9, 2024, at 12:18 p.m., O-C stated the licensee did not provide a means for residents to request assistance for health and safety needs 24 hours per day, seven days per week. O-C stated she believed the residents were able to ambulate to an area that staff were located to ask for assistance and therefore they did not need a means for residents to request assistance. 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 (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:	0 480		

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0 480	Continued From page 3 (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food	0 480		

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0 480	Continued From page 4 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 December 9, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 570 SS=C	144G.42 Subdivision 1 Display of license The original current license must be displayed at	0 570		

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0 570	Continued From page 5 the main entrance of each assisted living facility. The facility must provide a copy of the license to any person who requests it. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to display the current assisted living license at the main entrance of the assisted living building. 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: During an observation on December 9, 2024, at 10:15 a.m., the original current assisted living license was not posted at facility entrances, hallways, dining area, or in living areas. On December 9, 2024, at 10:55 a.m., owner (O)-C stated she was not aware the license was not posted at the front entrance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 570		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control	0 660		

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0 660	Continued From page 6 (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 establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included completion of a two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test, for one of one employee (unlicensed personnel (ULP)-B). 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:	0 660		

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0 660	Continued From page 7 The licensee's Facility TB Risk Assessment dated November 13, 2024, indicated the licensee's TB risk level was low. ULP-B was hired on August 18, 2023, to provide direct services to residents. ULP-B's employee record contained the following: -Baseline TB Screening Tool for Healthcare Workers, dated November 5, 2021, which ULP-B answered "yes," to having a positive reaction to a TB skin test; and -a chest x-ray (CXR) dated March 16, 2013, which indicated ULP-B was free of any active communicable disease like TB. ULP-B's employee record lacked documentation of a positive two-step TST or Interferon-Gamma Release Assay (IGRA) test completed prior to the CXR and provider evaluation. On December 9, 2024, at 11:45 a.m., owner (O)-A stated she reviewed the Facility TB Risk Assessment every year but completed a new assessment every two years. O-A was unaware of that requirement and was shown where to find the requirement on the Minnesota Department of Health (MDH) website. On December 9, 2024, at 1:58 p.m., O-A was unable to provide a positive test to accompany the CXR and a provider evaluation for ULP-B. The licensee's 8.16 Tuberculosis Screening policy revised August 30, 2024, indicated the licensee would observe the recommended precautions related to TB prevention as identified by the CDC. The licensee would maintain a current community TB risk assessment and	0 660		

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0 660	Continued From page 8 would be updated annually using data and form provided by MDH. The policy also stated new staff would have an IGRA blood test or a two-step Mantoux conducted. The policy did not provide procedures for a follow up CXR after a positive test. The MDH website Assisted Living Resources & Frequently-Asked Questions (FAQs) dated October 15, 2024, indicated a CXR alone was not acceptable documentation. Staff either need to provide documentation of the following: -a positive two-step TST or IGRA test along with a CXR with provider evaluation after that date; or -documentation of refusal of both the two-step TST and IGRA followed by a new CXR and provider evaluation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment 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 9 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 were interconnected so that the actuation of one alarm caused all alarms in the dwelling unit to actuate, and the licensee failed to comply with the current State Fire Code in Minnesota Rules, chapter 7511. 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). The findings include: On December 12, 2024, from 1:30 p.m. to 2:30 p.m., the surveyor toured the facility with owner (O)-C. The following was observed. SMOKE ALARMS:	0 780		

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0 780	Continued From page 10 The smoke alarms in the facility were not interconnected. Where more than one smoke alarm is required in an individual dwelling unit, all smoke alarms are required to be interconnected so activation of one alarm activates all alarms throughout the facility. The hardwired smoke alarms were missing from the existing wired connections in multiple locations. There were wires provided from the building electrical system for hardwired smoke alarms (alarms receiving power from the building electrical system) at the missing smoke alarms in the hallway and one other room. Existing hardwired smoke alarms are required to be maintained as installed at the time of construction and interconnected to additional battery-operated alarms so activation of one alarm activates all alarms throughout the facility. Existing hardwired smoke alarms are required to continue as hardwired when replaced. SMOKING AREA: There was used cigarette butts disposed on the ground and next to the building. All used smoking materials are required to be discarded in appropriate containers in accordance with Minnesota State Fire Code. DRYER VENT: The dryer vent was disconnected from the dryer in the basement with an excessive amount of lint collection between the dryer and the wall. Lint collection is a fire hazard and shall routinely be cleaned. Dryer vents shall be connected when the dryer is in use. On December 13, 2024, at 11:30 a.m. O-C stated they did not realize the smoke alarms were not interconnected and the dryer vent was	0 780		

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0 780	Continued From page 11 disconnected. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
0 800 SS=E	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 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 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 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).	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 12 The findings include: On December 12, 2024, from 1:30 p.m. to 2:30 p.m., the surveyor toured the facility with owner (O)-C. The following was observed. The window pane in occupied bedroom 2 was broken. The lower right corner of the window had four large cracks arching from the right frame edge to the bottom frame. The window in bedroom 1 was frozen shut. O-C did not have a way to get the window open in case of fire or similar emergency. Egress windows must be provided, have a clear path of access, and be properly maintained to allow for the proper function in buildings not equipped with an automatic sprinkler system. On December 13, 2024, at 11:30 a.m. O-C stated they didn't realize the windows were broken and didn't function correctly. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and	0 810		

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	31111	A. BUILDING: _____ B. WING _____	12/13/2024

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N&V HELPFUL HEART CARE INC	8159 MOUNT CURVE BOULEVARD BROOKLYN PARK, MN 55445

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0 810	Continued From page 13 (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. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 810		

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0 810	Continued From page 14 The findings include: On December 10, 2024, owner (O)-C provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee's FSEP, titled "Fire Safety and Evacuation", August 29, 2024, failed to include the following: The FSEP did not identify specific fire protection actions for residents. The section of the FSEP titled "Responsibilities of Clients" indicated that clients should respond to alarms and promptly evacuate, but did not include instructions to residents on how to evacuate the building in a fire or similar emergency. The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included language for persons with disabilities to shelter-in-place in a building stairwell, fire-rated exit corridor, or an enclosed room with a fire resistant door in a building that did not have any fire resistant construction or life safety systems. The plan failed to be appropriate for the building type. The plan included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation nor did it include instructions for staff to follow in case of relocation. On December 13, 2024, at 11:30 a.m., O-C	0 810		

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0 810	Continued From page 15 stated they were working on evolving their FSEP after completing surveys at their other facilities and hadn't finished all the required sections yet. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plan was revised to include all services being provided for one of one resident (R1).	01640		

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01640	Continued From page 16 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: During an observation on December 9, 2024, at approximately 10:30 a.m., registered nurse (RN)-A performed a blood glucose test for R1. R1's Service Agreement dated September 26, 2022, indicated R1 received the following services: medication management, bathing assistance, laundry, housekeeping, and meal set up. R1's service agreement plan did not include all services provided by the licensee's staff to include: blood glucose monitoring. On December 9, 2024, at approximately 1:00 p.m., owner (O)-C acknowledged the service of blood glucose monitoring was missing from R1's service plan. O-A also stated she will ensure RN-A added the missing service to R1's service plan. The licensee's Service Plan policy dated September 29, 2024, indicated a service plan would include: a. A description of the services that are to be provided based on the most recent assessment and resident preferences. b. Fees for services to be provided. c. The frequency of each service to be provided	01640		

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01640	Continued From page 17 based on the most recent assessment and resident preferences. d. An identification of staff or categories of staff who will be providing services (RN, LPN, unlicensed personnel, etc.). No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and	01940		

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01940	Continued From page 18 monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an individual treatment management plan to include all required content and failed to include the treatment record services on the service plan for one of one resident (R1) who had an ordered treatment. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted October 5, 2022, with diagnoses to include anxiety and diabetes. On December 9, 2024, at 10:24 a.m., registered nurse (RN)-A was observed to administer services of blood glucose monitoring to R1. R1's Service Agreement dated September 26, 2022, indicated R1 received the following services: medication management, bathing assistance, laundry, housekeeping, and meal set up. R1's service agreement plan did not include	01940		

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01940	Continued From page 19 R1's treatment of blood glucose monitoring. R1's record failed to include an individual treatment management plan to include all required content. On December 9, 2024, at 1:35 p.m. owner (O)-A stated blood glucose checks were not included on the service plan dated September 26, 2022, and R1's record lacked an individualized treatment plan to include blood glucose checks. The licensee's Treatment and Therapy Management Plan policy dated February 17, 2024, indicated the facility will prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. 1. The licensee would develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: a. A statement of the type of services that will be provided. b. Documentation of specific resident instructions relating to the treatments or therapy administration. c. Identification of treatment or therapy tasks that will be delegated to unlicensed personnel. d. Procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services. e. Any resident-specific requirements relating to documentation of treatment and therapy received. f. Verification that all treatment and therapy was administered as prescribed. g. Monitoring of treatment or therapy to prevent possible complications or adverse	01940		

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01940	Continued From page 20 reactions. 2. The treatment or therapy management record must be current and updated when there are any changes. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide a hazard vulnerability assessment or safety risk assessment of the physical environment with mitigation factors on and around the property for the facility. This deficient practice had the ability 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	02040		

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02040	Continued From page 21 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 December 12, 2024, owner (O)-C provided documents on the hazard vulnerability assessment (HVA). The licensee's HVA, titled "7.02 Hazard Vulnerability Analysis", undated, failed to include the following: The HVA included the identification of global risk factors like severe weather, wild fires, epidemics, systems failures, and civil disturbances but failed to identify any potential hazards or risks that were specific to the facility's neighborhood, grounds, building, or population. The HVA did not include a section that identified specific mitigation factors to be in place for any hazards or risks that were identified in the HVA. On December 13, 2024, at 11:30 a.m. O-C stated they had not performed a hazard vulnerability assessment with mitigation factors on and around the property. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	02040		
02260 SS=C	144G.90 Subd. 3 Notice of dementia training An assisted living facility with dementia care shall	02260		

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02260	Continued From page 22 make available in written or electronic form, to residents and families or other persons who request it, a description of the training program and related training it provides, including the categories of employees trained, the frequency of training, and the basic topics covered. A hard copy of this notice must be provided upon request. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide in written or electronic form to residents, families, or other persons who request it, a description of the dementia care training program, the categories of employees trained, the frequency of training, and the basic topics covered. The deficient practice 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: On August 1, 2021, the licensee started providing services as an assisted living facility with dementia care. On December 9, 2024, at 1:10 p.m., during the entrance conference, the surveyor requested the description of the dementia training program and related training the licensee provided.	02260		

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02260	Continued From page 23 On December 9, 2024, at 1:15 p.m., owner (O)-A acknowledged the licensee lacked a description of the dementia care training program, the categories of employees trained, the frequency of training, and the basic topics covered. O-A stated all the licensee's dementia training was done in Educare software. The licensee's March 3, 2024, 5.03 Dementia Training policy indicated the licensee will provide consumers a written or electronic description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02260		

Environmental Health
Food, Pools, and Lodging
625 Robert St. N
St. Paul
651-201-5000

Type: Full
Date: *12/09/24*
Time: 09:30:00
Report: 1031241362

Food and Beverage Establishment Inspection Report

Location:
N&V Helpful Heart Care Inc
8159 Mount Curve Boulevard
Brooklyn Center, MN55445
Hennepin County, 27

Establishment Info:
ID #: 0038128
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7634420460
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.

4-700 Sanitizing Equipment and Utensils

4-703.11B ***** Priority 1 *****

MN Rule 4626.0905B Sanitize food contact surfaces of equipment and utensils after cleaning by using mechanical hot water operations that achieve a utensil surface temperature of 160 degrees F (71 degrees C) and are set up and maintained in accordance with the specifications of NSF International and the manufacturer's data plate.

UNABLE TO VERIFY DISH MACHINE TEMP.

PROVIDE DISH MACHINE TEMP TO INSPECTOR ASAP.

Comply By: 12/11/24

5-200C Plumbing: Maintenance, fixture location

5-205.11AB ***** Priority 2 *****

MN Rule 4626.1110AB The handwashing sink must be accessible at all times for employee use, and must be used only for handwashing.

HANDWASH SINK BLOCKED BY DISHES,
HAS STAFF MOVE DISHES TO RIGHT SINK.
KEEP HANDWASH SINK CLEAR AT ALL TIME FOR HANDWASHING.

Comply By: 12/09/24

6-300 Physical Facility Numbers and Capacities

6-301.12 ***** Priority 2 *****

MN Rule 4626.1445 Provide and maintain a supply of individual disposable towels, a continuous towel system, a heated-air hand drying device, or an approved ambient air temperature hand drying device at each handwashing sink or group of adjacent handwashing sinks.

REPEAT VIOLATION FROM 2021 INSPECTION.

KITCHEN HANDSINK MISSING PAPER TOWELS.

STORE EXTRA HAND SOAP AND PAPER TOWELS IN KITCHEN CUPBOARD.
Comply By: 12/10/24

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.
REPEAT VIOLATION FROM 2021 INSPECTION.

ESTABLISHMENT DOES NOT HAVE A CERTIFIED FOOD PROTECTION MANAGER (CFPM).
ESTABLISHMENT DOES HAVE SAFESERV OR SIMILAR POSTED.

SUBMIT CLASS COMPLETION USING LINKS PROVIDED IN REPORT EMAIL.
Comply By: 12/09/24

4-400 Equipment Location and Installation

4-402.11A

MN Rule 4626.0725A Space fixed equipment to allow access for cleaning along the sides, behind and above the unit, or seal to adjoining equipment or walls.
BACKSPLASHES ON BOTH SIDES OF STOVE AND LONG COUNTER ARE NOT SILICONED.

SILICONE BACKSPLASHES TO COUNTERS USING 100% SILICONE.
Comply By: 12/30/24

4-600 Cleaning Equipment and Utensils

4-602.13

MN Rule 4626.0855 Clean all non-food-contact surfaces of equipment at a frequency necessary to preclude accumulation of soil residues.
FRONT OF MICROWAVE IS DIRTY.
CLEAN MICROWAVE.
Comply By: 12/30/24

6-300 Physical Facility Numbers and Capacities

6-303.11B

MN Rule 4626.1470B Provide at least 20 foot candles (215 LUX) of light intensity at a distance of 30 inches from the floor for areas where food is provided for consumer self-service, including buffets and salad bars or where fresh produce or packaged foods are sold or offered for consumption, inside equipment including reach-in and under counter refrigerators, in utensil storage areas, warewashing areas, and in toilet rooms.

1. GARAGE REFRIGERATOR 2 LIGHT IS BURNT OUT.
2. STOVE LIGHTS (2) ARE BURNT OUT.

REPLACE ALL LIGHTS.
Comply By: 12/30/24

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.11

MN Rule 4626.1515 Maintain the physical facilities in good repair.

1. BACKSPLASH LEFT OF STOVE MISSING.
INSTALL BACKSPLASH
2. BACKSPLASH TO RIGHT OF STOVE NOT ATTACHED.
ATTACH BACKSPLASH.
3. CUPBAORD UNDER SINK PARTIALLY REMOVED.
FULLY REMOVE OR REPAIR CUT CABINETRY AND FILL AND HOLES AROUND PLUMBING.

Comply By: 12/30/24

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.12A

MN Rule 4626.1520A Clean and maintain all physical facilities clean.

1. 2 LOWER CUPBOARDS ARE DIRTY.
MOVE PANS, REMOVE AND DISCARD PAPER, AND CLEAN CUPBOARDS.
2. CLEAN PAINTED COUNTER BACKSPLASHES.
3. CLEAN FRONTS OF ALL CUPBOARDS.

Comply By: 12/30/24

Surface and Equipment Sanitizers

Quaternary Ammonia: = 150 at Degrees Fahrenheit
Location: Clorox Wipes
Violation Issued: No

Hot Water: = at ?? Degrees Fahrenheit
Location: Dish Machine
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Hold/Water
Temperature: 33 Degrees Fahrenheit - Location: Kitchen Refrigerator
Violation Issued: No

Process/Item: Cold Hold/Milk
Temperature: 33 Degrees Fahrenheit - Location: Garage Refrigerator 1
Violation Issued: No

Process/Item: Cold Hold/water
Temperature: 27 Degrees Fahrenheit - Location: Garage Refrigerator 2
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	1	2	6

Nurse Evaluator on site: Elyse Jones

All violations discussed with PIC during the inspection.

Type: Full
Date: *12/09/24*
Time: 09:30:00
Report: 1031241362
N&V Helpful Heart Care Inc

Food and Beverage Establishment Inspection Report

NOTES:

***ESTABLISHMENT NOT USING MAIN KITCHEN REFRIGERATOR. FOOD ITEMS MUST BE MOVED INTO MAIN KITCHEN REFRIGERATOR, WITH GARAGE REFRIGERATOR USED FOR OVERFLOW ONLY. THIS IS TO HELP PREVENT CONTAMINATION FROM UNCLEAN GARAGE AREA AND DOOR HANDLES.

- Establishment has a residential kitchen (4626.0506(G)(2)) Same-day service only. No saving and reheating of foods or preparation of foods the day prior to eating. Any remaining food from meals to be removed/discarded at end of day.

- Establishment does not have pasteurized eggs and does not prepare eggs for consumption under 145F. Purchase pasteurized eggs if intending to serve eggs undercooked.

- Make sure to datemark any prepared cold items that are kept in refrigerator.

- Employee food needs to be labeled and separated from residents food.

- Cutting boards should be utilized as food contact surfaces and not counters or plates.

- Establishment needs to check dish washer utensil temperature weekly (160F required). If utensil temp not reaching 160F, use washer to wash/rinse and sink basin with sanitizer solution to sanitize dishes then air dry, as discussed during inspection.

- 2-Comp sink has left basin designated for handwashing and the right basin for product washing/prep sink.

- When preparing food, make sure to use a thin-probe thermometer to check temperatures.

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

I acknowledge receipt of the Environmental Health inspection report number 1031241362 of 12/09/24.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Inspection report reviewed with person in charge and emailed.

Signed:_____
Vera Dixon
Person in Charge

Signed:_____
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