



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

April 21, 2025

Licensee

Warm Touch Home Care Inc.
7548 Fremont Avenue North
Brooklyn Park, MN 55444

RE: Project Number(s) SL36282016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on March 26, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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 . . ."

IMPOSITION OF FINES

In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;

Level 3: a fine of \$3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.

Level 4: a fine of \$5,000 per incident, in addition to any enforcement mechanism authorized in

§ 144G.20.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this survey:

0780 - 144g.45 Subd. 2 (a) (1) - Fire Protection And Physical Environment - \$500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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>

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

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To submit a hearing request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration or a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **<https://forms.office.com/g/Bm5uQEPhVa>**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,



Renee Anderson, Supervisor

State Evaluation Team

Email: Renee.L.Anderson@state.mn.us

Telephone: 651-201-5871 Fax: 1-866-890-9290

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36282	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/26/2025
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NAME OF PROVIDER OR SUPPLIER WARM TOUCH HOME CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444
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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
0 000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER</p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey.</p> <p>Determination of whether a violation has been 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.</p> <p>INITIAL COMMENTS: SL36282016-0</p> <p>On March 24, 2025, through March 26, 2025, 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 (4) residents, all of whom were receiving services under the provider's Assisted Living license.</p>	0 000	<p>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.</p> <p>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.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p> <p>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.</p>	
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control	0 660		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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0 660	<p>Continued From page 1</p> <p>(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.</p> <p>(b) The facility must maintain written evidence of compliance with this subdivision.</p> <p>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 TB history and symptom screening upon hire for one of three employees (registered nurse (RN)-C.</p> <p>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).</p> <p>The findings include:</p> <p>The facility TB risk assessment dated October</p>	0 660		

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0 660	<p>Continued From page 2</p> <p>15, 2024, indicated the facility was a low risk setting for TB transmission.</p> <p>RN-C was hired May 25, 2023, and provided staff supervision and direct cares for residents of the facility.</p> <p>RN-C's employee record included documentation of a TB blood test completed August 30, 2022, and a chest x-ray completed March 15, 2023; however, lacked a TB history and symptom screen upon hire.</p> <p>On March 25, 2025, at 11:29 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-B stated she was unaware the TB symptom screening was missing from RN-C's employee file.</p> <p>The licensee's Tuberculosis Screening/Prevention policy dated August 1, 2021, indicated licensee would observe the recommended precautions related to TB prevention as identified by the CDC and the Minnesota Department of Health (MDH). Furthermore, baseline TB screening would be required at the time of hire, and TB testing would consist of three components: (1) assessing for current symptoms of active TB disease, (2) assessing TB history, and (3) TB testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step TST or single blood test</p> <p>The Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013 noted training was required at the time of hire and included: pathogenesis, signs symptoms, and the licensee's infection control plan. In addition, baseline screening for all health care workers</p>	0 660		

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0 660	<p>Continued From page 3</p> <p>(HCW) included a history and symptom screen and testing for the presence of TB infection. The regulations noted a blood test should include the date of the test. According to the regulations, if a HCW had documentation for latent TB, that documentation could be substituted for documentation of a previous positive TST or blood test.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	0 660		
0 780 SS=F	<p>144G.45 Subd. 2 (a) (1) Fire protection and physical environment</p> <p>for dwellings or sleeping units, as defined in the State Fire Code:</p> <p>(i) provide smoke alarms in each room used for sleeping purposes;</p> <p>(ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms;</p> <p>(iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics;</p> <p>(iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and</p> <p>(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;</p>	0 780		

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0 780	<p>Continued From page 4</p> <p>This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed provide interconnected smoke alarms in required locations. These deficient conditions had the ability to affect all staff and residents.</p> <p>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).</p> <p>The findings include:</p> <p>On March 25, 2025, at approximately 9:30 a.m., the surveyor toured the facility with owner (O)-A. During the tour, the surveyor observed the following:</p> <ol style="list-style-type: none"> 1. Smoke alarm was not installed in the unoccupied resident bedroom 0. 2. The upper-level and lower-level hallway smoke alarms where not interconnected with the remainder of the facility. <p>O-A verified the above findings while accompanying on the tour and stated they understood the requirements.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p>	0 780		

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0 800	Continued From page 5	0 800		
0 800 SS=F	<p>144G.45 Subd. 2 (a) (4) Fire protection and physical environment</p> <p>(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.</p> <p>This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment 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.</p> <p>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).</p> <p>The findings include:</p> <p>On March 25, 2025, at approximately 9:30 a.m. the surveyor toured the facility with owner (O)-A. The following was observed.</p>	0 800		

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0 800	<p>Continued From page 6</p> <p>GENERAL MAINTENANCE:</p> <p>The exterior siding had holes and was not secured in multiple places around the exterior of the facility. The soffit at the roof / 2nd story wall intersection above the overhead garage door had a hole. Survey staff explained to O-A that holes and gaps in the outside finish materials can serve as access points to pests and rodents and allow possible water damage to the facility.</p> <p>On March 25, 2025, O-A acknowledged the deficiencies and stated they would get the exterior fixed.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p>	0 800		
0 810 SS=F	<p>144G.45 Subd. 2 (b-f) Fire protection and physical environment</p> <p>(b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation.</p> <p>(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.</p> <p>(d) Fire safety and evacuation plans shall be</p>	0 810		

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0 810	<p>Continued From page 7</p> <p>readily available at all times within the facility.</p> <p>(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.</p> <p>(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.</p> <p>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.</p> <p>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).</p> <p>The findings include:</p> <p>On March 25, 2025, owner (O)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility.</p> <p>FIRE SAFETY AND EVACUATION PLAN:</p>	0 810		

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0 810	<p>Continued From page 8</p> <p>The licensee's FSEP failed to include the following:</p> <p>The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate) but the plan was designed for a building with life safety systems such as fire alarm system. The policy had not been updated to provide complete actions for employees to take in the event of a fire or similar emergency at the licensed facility which did not have fire alarm system.</p> <p>The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation nor did it include instructions for staff to follow in case of relocation.</p> <p>On March 25, 2025, O-A stated they understood the areas of their policy that were incomplete and would work on bringing them into compliance.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	0 810		
0 920 SS=F	<p>144G.50 Subd. 2 (c) Contract information</p> <p>(c) The contract must include: (1) a disclosure of the category of assisted living</p>	0 920		

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0 920	<p>Continued From page 9</p> <p>facility license held by the facility and, if the facility is not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license;</p> <p>(2) a description of all the terms and conditions of the contract, including a description of and any limitations to the housing or assisted living services to be provided for the contracted amount;</p> <p>(3) a delineation of the cost and nature of any other services to be provided for an additional fee;</p> <p>(4) a delineation and description of any additional fees the resident may be required to pay if the resident's condition changes during the term of the contract;</p> <p>(5) a delineation of the grounds under which the resident may be transferred or have housing or services terminated or be subject to an emergency relocation;</p> <p>(6) billing and payment procedures and requirements; and</p> <p>(7) disclosure of the facility's ability to provide specialized diets.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written assisted living contract with the required content for one of one resident (R1). This had the potential to affect all four (4) residents.</p> <p>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</p>	0 920		

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0 920	<p>Continued From page 10 of the residents).</p> <p>The findings include:</p> <p>R1's Service Plan dated February 18, 2025, indicated R1 received services including assistance with medication management, medication set-up, medication administration, housekeeping assistance, laundry assistance, meal preparation, mental health behavior management, appointment scheduling, and appointment reminders.</p> <p>R1's record included an assisted living contract signed February 18, 2025. The contract lacked the following required content:</p> <ul style="list-style-type: none"> - a disclosure that it does not hold an assisted living facility with dementia care license; - a disclosure of the facility's ability to provide specialized diets; and - a delineation of the cost and nature of any other services to be provided for an additional fee. <p>On March 26, 2025, at 2:25 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-B stated the contract lacked the required content as noted above, and further stated she was aware of the required content that would be in the contract; however, was not the person responsible for the contract content.</p> <p>The licensee's Assisted Living Contract policy dated February 21, 2023, indicated licensee's policy would ensure compliance with Minnesota Statute 144G, which governs assisted living contracts, protecting the rights of residents and ensuring transparency in services, fees, and expectations.</p> <p>No further information was provided.</p>	0 920		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36282	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/26/2025
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NAME OF PROVIDER OR SUPPLIER WARM TOUCH HOME CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444
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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
0 920	Continued From page 11 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 920		
01060 SS=D	<p>144G.52 Subd. 9 Emergency relocation</p> <p>(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.</p> <p>(b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum:</p> <ul style="list-style-type: none"> (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. <p>(c) The notice required under paragraph (b) must be delivered as soon as practicable to:</p> <ul style="list-style-type: none"> (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 	01060		

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER WARM TOUCH HOME CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7548 FREMONT AVENUE NORTH BROOKLYN PARK, MN 55444
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01060	<p>Continued From page 12</p> <p>256S and section 256B.49, the resident's case manager; and</p> <p>(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.</p> <p>(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</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide the resident, legal representative, and designated representative a written notice with all required content related to an emergency relocation for one of two residents (R1).</p> <p>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).</p> <p>The findings include:</p> <p>R1's Service Plan dated February 18, 2025, indicated R1 received services including assistance with medication management, medication set-up, medication administration, housekeeping assistance, laundry assistance, meal preparation, mental health behavior management, appointment scheduling, and appointment reminders.</p> <p>R1's progress notes on March 16, 2025, indicated</p>	01060		

Minnesota Department of Health

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01060	<p>Continued From page 13</p> <p>the licensee sent R1 to the emergency room (ER) for further evaluation for mental health behavior concerns, and was informed R1 would be admitted to the hospital for further evaluation.</p> <p>R1's discharge summary dated March 20, 2025, at 2:12 p.m., indicated R1 returned to the facility on March 20, 2025.</p> <p>R1's record lacked evidence the resident, legal representative, and designated representative were provided a written notice that contained, at a minimum:</p> <ul style="list-style-type: none"> - the contact information for the location to which the resident has been relocated and any new service provider; - contact information for the Office of Ombudsman for Long-Term Care (OOLTC) and the Office of Ombudsman for Mental Health and Developmental Disabilities (OMHDD); - 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. <p>On March 25, 2025, at approximately 2:00 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-B stated R1's record lacked the information noted above. LALD/CNS-B further stated she did notify R1's case manager of hospitalization via email; however, was unaware of all the required content that needed to be completed.</p>	01060		

Minnesota Department of Health

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01060	<p>Continued From page 14</p> <p>The licensee's Discharge and Transfer of Residents policy dated August 1, 2021, indicated licensee would, as soon as possible, provide written notice of emergency relocation to the following:</p> <ul style="list-style-type: none"> - the resident; - the resident's legal representative; - the resident's designated representative; - if the resident was receiving home and community-based services, the resident's case manager; and - if the resident was relocated and had not returned to the licensee within four (4) days, the OOLTC. <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	01060		
01290 SS=F	<p>144G.60 Subdivision 1 Background studies required</p> <p>(a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information.</p> <p>(b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12.</p> <p>(c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits.</p>	01290		

Minnesota Department of Health

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01290	<p>Continued From page 15</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure all employees had a cleared Department of Human Services (DHS) NETStudy 2.0 background study affiliated to the current license for three of four employees (licensed assisted living director/clinical nurse supervisor (LALD/CNS)-B, registered nurse (RN)-C, and unlicensed personnel (ULP)-D).</p> <p>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).</p> <p>The findings include:</p> <p>LALD/CNS-B LALD/CNS-B was hired August 10, 2022, and provided staff supervision and direct cares for residents of the facility.</p> <p>LALD/CNS-B's employee record included a NETStudy 2.0 background study clearance form dated August 10, 2022. The background study was affiliated with Health Facility Identification Number (HFID) 35721. LALD/CNS-B's record lacked a cleared NETStudy 2.0 background study affiliated to the surveyed licensee's facility, HFID number 36282.</p> <p>RN-C RN-C was hired May 25, 2023, and provided staff</p>	01290		

Minnesota Department of Health

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01290	<p>Continued From page 16</p> <p>supervision and direct cares for residents of the facility.</p> <p>RN-C's employee record included a NETStudy 2.0 background study clearance form dated May 25, 2023. The background study was affiliated with Health Facility Identification Number (HFID) 35721. RN-C's record lacked a cleared NETStudy 2.0 background study affiliated to the surveyed licensee's facility, HFID number 36282.</p> <p>ULP-D ULP-D had a hire date of May 25, 2023, and provided direct care and services to residents.</p> <p>On March 25, 2025, at 8:30 a.m., ULP-D was observed assisting R1 with medication administration.</p> <p>ULP-D's employee record included a NETStudy 2.0 background study clearance form dated March 27, 2023. The background study was affiliated with Health Facility Identification Number (HFID) 35721. ULP-D's record lacked a cleared NETStudy 2.0 background study affiliated to the surveyed licensee's facility, HFID number 36282.</p> <p>On March 25, 2025, at 10:26 a.m., licensed assisted living director/clinical nursing supervisor (LALD/CNS)-B stated owner (O)-A was responsible for completion of background studies for new hires.</p> <p>On March 25, 2025, at 10:45 a.m., O-A stated nine (9) total employee records lacked a background study for the current assisted living license. O-A further stated he was unaware he did not affiliate all licensee's employees with the current assisted living licensee's HFID# 36282, and that he would work with the DHS to get the</p>	01290		

Minnesota Department of Health

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01290	<p>Continued From page 17</p> <p>issue resolved.</p> <p>The licensee's Background Studies policy dated March 25, 2025, indicated licensee was committed to maintaining a safe and secure environment for its residents by ensuring that all staff, contractors, and volunteers meet the legal background study requirements set forth by DHS. Furthermore, the policy would establish procedures for conducting background studies and ensuring compliance with state regulations. Moreover, all prospective employees, contractors, and volunteers would complete a DHS background study before providing care or having access to residents.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Two (2) days</p>	01290		
01500 SS=F	<p>144G.63 Subd. 5 Required annual training</p> <p>(a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include:</p> <p>(1) training on reporting of maltreatment of vulnerable adults under section 626.557;</p> <p>(2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;</p> <p>(3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective</p>	01500		

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01500	<p>Continued From page 18</p> <p>gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases;</p> <p>(4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders;</p> <p>(5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and</p> <p>(6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person.</p> <p>(b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics:</p> <p>(1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication;</p> <p>(2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or</p> <p>(3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions.</p>	01500		

Minnesota Department of Health

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01500	<p>Continued From page 19</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure employees received at least eight hours of annual training for each 12 months of employment for three of three employees (registered nurse (RN)-C, unlicensed personnel (ULP)-D, ULP-E).</p> <p>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).</p> <p>The findings include:</p> <p>RN-C, ULP-D and ULP-E's employee records lacked evidence of eight hours of annual training.</p> <p>RN-C RN-C was hired May 25, 2023, and provided staff supervision and direct cares for residents of the facility.</p> <p>RN-C's record lacked evidence of at least 8 hours of annual training, and in the following topics: - review of provider's policies and procedures: and - principles of person-centered planning/service delivery.</p> <p>ULP-D ULP-D had a hire date of May 25, 2023, and provided direct care and services to residents.</p>	01500		

Minnesota Department of Health

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01500	<p>Continued From page 20</p> <p>On March 25, 2025, at 8:30 a.m., ULP-D was observed assisting R1 with medication administration.</p> <p>ULP-D's record lacked evidence of at least 8 hours of annual training, and in the following topics: - review of provider's policies and procedures.</p> <p>ULP-E ULP-E was hired December 15, 2023, and provided direct cares for residents of the facility.</p> <p>ULP-E's record lacked evidence of at least 8 hours of annual training, and in the following topics: - review of provider's policies and procedures.</p> <p>On March 25, 2025, at 11:23 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-B stated she was unaware of all the required annual training topics: therefore, annual training had not been assigned to, or completed for RN-C, ULP-D and ULP-E, on the topics as noted above. -at 11:36 a.m., LALD/CNS-B stated annual training via EduCare (training software system) would be completed on employee's yearly employment anniversary. LALD/CNS-B further stated EduCare was assigned to RN-C: however, she did not follow up with RN-C to ensure all annual training classes had been completed.</p> <p>The licensee's Staff Orientation and Education policy dated August 1, 2021, indicated annual education may include training on providing services to residents with hearing loss, and additional topics for education would be based on the identified needs of the organization's assisted</p>	01500		

Minnesota Department of Health

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01500	Continued From page 21 living residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		



Type: Full
Date: 03/24/25
Time: 11:00:00
Report: 1051251078

Food and Beverage Establishment Inspection Report

Location:

Warm Touch Home Care Inc.
7548 Fremont Avenue N
Brooklyn Park, MN55443
Hennepin County, 27

Establishment Info:

ID #: 0040595
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/22

Operator:

Phone #:
ID #:

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

No NEW orders were issued during this inspection.

Food and Equipment Temperatures

Process/Item: Upright Cooler
Temperature: 40 Degrees Fahrenheit - Location: MILK
Violation Issued: No

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

MET WITH THE NURSE EVALUATOR, RHONDA MAKELA.

DISCUSSED THE FOLLOWING WITH THE PERSON IN CHARGE, IBRAHIM:

- EMPLOYEE ILLNESS LOG
- VOMIT CLEAN-UP PROCEDURE
- HANDWASHING & GLOVE USE

THE KITCHEN HAS A NSF 184 DISHWASHER, VINYL PLANK FLOORS, STONE COUNTERTOPS WITH HOLLOW BASES, LAMINATE CABINETS, AND A POPCORN TEXTURE CEILING.

Type: Full
Date: 03/24/25
Time: 11:00:00
Report: 1051251078
Warm Touch Home Care Inc.

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1051251078 of 03/24/25.

Certified Food Protection Manager: Ibrahim Demmaj

Certification Number: 56643 Expires: 03/06/28

Inspection report reviewed with person in charge and emailed.

Signed: _____

Ibrahim Demmaj

Signed: 

Kai Yang
Public Health Sanitarian 1
St. Cloud
320 640-3532
Kai.Yang@state.mn.us