Electronically Delivered

July 29, 2026

Licensee
Heliopolis Home Healthcare LLC
1610 East 26th Street
Minneapolis, MN 55404

RE: Project Number(s) SL34768016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 30, 2026, 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;
Level 3: a fine of $1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

Level 4: a fine of $3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 5: a fine of $5,000 per violation, 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:

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00
St - 0 - 0780 - 144g.45 Subd. 2 (a) (1) - Fire Protection And Physical Environment - $500.00
St - 0 - 0810 - 144g.45 Subd. 2 (b-F) - 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 $1,500.00**. 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.

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

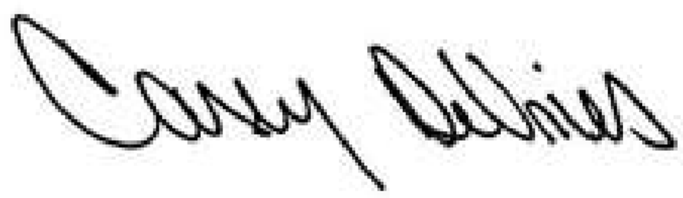
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms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

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

If you have any questions, please contact me.

Sincerely,



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

KKM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34768	A. BUILDING: _____ B. WING _____	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELIOPOLIS HOME HEALTHCARE LLC	1610 EAST 26TH STREET MINNEAPOLIS, MN 55404

(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: SL34768016-0 On April 27, 2026, through April 30, 2026, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were three residents: all of whom received services under the Assisted Living 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 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.	
0 345 SS=C	144G.30 Subd. 5. (c)(2), (d) Correction orders (c)(2) make available, in a manner readily accessible to residents and others, including	0 345		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34768	A. BUILDING: _____ B. WING _____	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELIOPOLIS HOME HEALTHCARE LLC	1610 EAST 26TH STREET MINNEAPOLIS, MN 55404

(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
0 345	Continued From page 1 provision of a paper copy upon request, the most recent plan of correction documenting the actions taken by the facility to comply with the correction order. (d) After the plan of correction is made available under paragraph (c), clause (2), the facility must provide a copy of the facility's most recent plan of correction to any individual who requests it. A copy of the most recent plan of correction must be provided within 30 days after the request and in a format determined by the facility, except the facility must make reasonable accommodations in providing the plan of correction in another format, including a paper copy, upon request. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to make available the most recent plan of correction in a manner readily accessible to residents and others, including provision of a paper copy upon request, documenting the actions taken by the facility to comply with the correction orders, after a survey conducted June 3, 2024, through June 6, 2024. 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). On April 27, 2026, at 1:10 p.m., licensed assisted living director (LALD)-D stated they did not have plan of correction to document the actions taken by the facility to comply with the correction orders.	0 345		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34768	A. BUILDING: _____ B. WING _____	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELIOPOLIS HOME HEALTHCARE LLC	1610 EAST 26TH STREET MINNEAPOLIS, MN 55404

(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
0 345	Continued From page 2 LALD-D stated, "Everything is corrected, and everything is fixed for everything that needs to be fixed, no we do not have documentation for plan of correction, but everything is fixed. You can see that for yourself, that is why you are here, plus there is no requirement that we have to document, unless you have one then we can go about it." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 345		
0 460 SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request 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:	0 460		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34768	A. BUILDING: _____ B. WING _____	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELIOPOLIS HOME HEALTHCARE LLC	1610 EAST 26TH STREET MINNEAPOLIS, MN 55404

(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
0 460	Continued From page 3 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 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 April 27, 2026, at 11:06 a.m., during the entrance conference, licensed assisted living director (LALD)-D stated there was no system in place for their residents to seek assistance; the residents did not need a call light; there was no one who needed a call light or other systems to call for help. LALD-D stated no resident was assessed for call light use; it was also not in their care plan, all residents were ambulatory, and staff check on the residents at night. LALD-D further stated none of the licensee's residents had chronic illness that would stop them from requesting help or from coming downstairs to find staff (two of the three resident's rooms were on the upper level of the house). On April 27, 2026, at 12:03 p.m., via telephone, clinical nurse supervisor (CNS)-C stated they did not have a system in place for residents to summon staff, but staff were supposed to knock on resident's doors and check on them. The surveyor asked how the residents would call for help in case of medical emergency. CNS-C	0 460		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34768	A. BUILDING: _____ B. WING _____	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELIOPOLIS HOME HEALTHCARE LLC	1610 EAST 26TH STREET MINNEAPOLIS, MN 55404

(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
0 460	Continued From page 4 stated they had not had that issue before and none of their residents were susceptible to strokes or heart attacks. On April 27, 2026, at 12:08 p.m., LALD-D stated, "I want the state to know that anything that happens in the room [referring to resident's room] could happen anywhere and we cannot prevent that from happening." LALD-D stated the staff did one to two-hour safety checks on residents. On April 27, 2026, at approximately 12:25 p.m., unlicensed personnel (ULP)-K stated they did do safety checks on residents every hour, but they did not do documentation of the safety checks. On April 27, 2026, at approximately 12:30 p.m., during a facility tour, the surveyor observed a split-level home with no bells, call lights, pendants, or other means for the residents to seek staff 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: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with	0 480		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34768	A. BUILDING: _____ B. WING _____	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELIOPOLIS HOME HEALTHCARE LLC	1610 EAST 26TH STREET MINNEAPOLIS, MN 55404

(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
0 480	Continued From page 5 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 and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part	0 480		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34768	A. BUILDING: _____ B. WING _____	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELIOPOLIS HOME HEALTHCARE LLC	1610 EAST 26TH STREET MINNEAPOLIS, MN 55404

(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
0 480	Continued From page 6 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 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: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated April 28, 2026, 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		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current	0 660		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34768	A. BUILDING: _____ B. WING _____	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELIOPOLIS HOME HEALTHCARE LLC	1610 EAST 26TH STREET MINNEAPOLIS, MN 55404

(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
0 660	Continued From page 7 tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included a two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test, for four of four employees (unlicensed personnel (ULP)-A, ULP-B, ULP-E, ULP-F). This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34768	A. BUILDING: _____ B. WING _____	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELIOPOLIS HOME HEALTHCARE LLC	1610 EAST 26TH STREET MINNEAPOLIS, MN 55404

(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
0 660	Continued From page 8 ULP-A ULP-A was hired on January 3, 2025, to provide direct care services to residents. ULP-A's employee record included a Baseline TB Screening Tool for Healthcare Workers dated December 30, 2024, TST Report for the first step TST placed on ULP-A's right forearm on January 3, 2025, and a negative result of the TST read January 6, 2025. ULP-A's employee record did not include evidence that a second step TST was placed or other evidence of TB screening such as a blood test, was completed. ULP-B ULP-B was hired on January 6, 2025, to provide direct care services to residents. ULP-B's employee record included a Baseline TB Screening Tool for Healthcare Workers dated January 6, 2025, TST Report for the first step TST placed on ULP-B's left lower forearm on January 6, 2025, and a negative result of the TST, read negative January 6, 2025. ULP-B's employee record did not include evidence that a second step TST was placed or other evidence of TB screening such as a blood test, was completed. ULP-E ULP-E was hired on January 29, 2021, to provide direct care services to residents. ULP-E's employee record included a Baseline TB Screening Tool for Healthcare Workers dated January 28, 2021, and a negative Chest X-Ray Reading dated January 28, 2021. ULP-E's employee record did not include evidence a two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test,	0 660		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34768	A. BUILDING: _____ B. WING _____	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELIOPOLIS HOME HEALTHCARE LLC	1610 EAST 26TH STREET MINNEAPOLIS, MN 55404

(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
0 660	Continued From page 9 was completed. ULP- F ULP- F was hired on July 21, 2025, to provide direct care services to residents. ULP-F's employee record included a Baseline TB Screening Tool for Healthcare Workers dated July 15, 2025, TST Report for the first step TST placed on ULP-F's left lower forearm on July 15, 2025, and a negative result of the TST read July 17, 2025. ULP-F's employee record did not include evidence that a second step TST was placed or other evidence of TB screening such as a blood test, was completed. On April 28, 2026, via telephone, at approximately 3:10 p.m., ULP-A stated they had to retake a TST because they missed the 48 to 72 hours mark for reading the TST result. ULP-A stated they did not do the second TST and the clinic did not inform them that they had to do second step TST. On April 30, 2026, at approximately 2:15 p.m., via telephone, clinical nurse supervisor (CNS)-C stated the licensee's TB screening and testing protocol was they did the TB screening for all employees and then they did the TST. The surveyor asked if they had done a second step TST for the employees mentioned above. CNS-C stated, "the provider will not sign it [referring to the signed TST Report] unless both steps are done. They cannot say the value is negative unless they do both steps. I do not understand what you mean by second step, if the value is negative. Unless they completed both steps, they cannot say it is negative". The surveyor inquired about why ULP-E did not have any evidence of TB screening such as a blood test or TST. CNS-C stated ULP-E could not do a TST or blood	0 660		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34768	A. BUILDING: _____ B. WING _____	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELIOPOLIS HOME HEALTHCARE LLC	1610 EAST 26TH STREET MINNEAPOLIS, MN 55404

(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
0 660	Continued From page 10 test. The surveyor asked how they determined ULP-E needed a chest X ray. CNS-C stated the employees determine for themselves whether they needed a chest X ray or not. If they have had BCG vaccine it always comes back positive. ULP-E cannot do a blood test because it always comes back positive, so they did a chest X ray. Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, indicated baseline TB screening is required for all health care workers. Baseline TB screening consists of three components: 1. Assessing for current symptoms of active TB disease, 2. Assessing TB history, and 3. Testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step TST or single TB blood test (IGRA). An employee may begin working with patients after a negative TB symptom screen (i.e., no symptoms of active TB disease) and a negative IGRA or TST (i.e., first step) dated within 90 days before hire. The second TST may be performed after the HCW starts working with patients. The Minnesota Department of Health Assisted Living Frequently Asked Questions for TB Screening last updated April 30, 2026, indicated a chest X ray (CXR) alone is not acceptable documentation. Health care workers either need - documentation of a positive two-step Tuberculin Skin Test (TST) or Interferon-Gamma Release Assay (IGRA) test, and - a CXR with provider evaluation after that date or - documentation of refusal of both the two-step TST and IGRA	0 660		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34768	A. BUILDING: _____ B. WING _____	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELIOPOLIS HOME HEALTHCARE LLC	1610 EAST 26TH STREET MINNEAPOLIS, MN 55404

(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
0 660	Continued From page 11 - followed by a new CXR and provider evaluation. Further, if the health care worker had a prior positive TB test result, and they only have the CXR but no other test documentation, then they need to take a new TB test. If the result is positive, a new CXR needs to be completed. The CXR needs to be done within 90 days of the positive test date or dated any time after the positive test date. The Licensee's 8.16 Tuberculosis Screening Policy, dated January 1, 2024, read, "Staff Screening Staff whose essential job functions require work within the same air space of home care clients will be screened and tested for tuberculosis prior to the staff being exposed to clients. Baseline (upon hire) screening will be completed, but serial (annual) screening will only be required with increased occupational risk or exposure. Screening will be conducted as follows: 1. New staff will be screened for active signs of TB using the Baseline TB Screening Tool for HCWs . 2. New staff will have an IGRA blood test or a two-step Mantoux conducted with results documented on the Baseline TB Screening Tool for HCWs. 3. No staff will be permitted to begin work where the work involves sharing the air space with residents until the negative results of the first Mantoux are read and documented or a negative IGRA blood test result is received and documented. 4. Staff TB screening results will be kept in each employee medical file. 5. Staff should be screened for signs and	0 660		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34768	A. BUILDING: _____ B. WING _____	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELIOPOLIS HOME HEALTHCARE LLC	1610 EAST 26TH STREET MINNEAPOLIS, MN 55404

(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
0 660	Continued From page 12 symptoms on an annual basis." 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 requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review the	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34768	A. BUILDING: _____ B. WING _____	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELIOPOLIS HOME HEALTHCARE LLC	1610 EAST 26TH STREET MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 680	Continued From page 13 licensee failed to maintain a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all residents under the assisted living license. 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: The licensee's EPP last reviewed January 1, 2026, lacked evidence of the following required content: - policies and procedures for volunteers; and - subsistence needs for staff and residents. On April 30, 2026, at approximately 12:20 p.m., licensed assisted living director (LALD)-D stated they did not have the above-mentioned items in the EPP and stated they would take a note to make corrections. The licensee's 9.02 Disaster planning and Emergency Preparedness Policy dated February 15, 2024, indicated the licensee will have in place a general emergency preparedness plan, that is in alignment with facility's requirement to also comply with CMS Appendix Z. Minnesota Administrative Rule 4659.0100 Emergency Disaster and Preparedness Plan dated August 11, 2021, indicated assisted living facilities shall comply with the federal emergency	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34768	A. BUILDING: _____ B. WING _____	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELIOPOLIS HOME HEALTHCARE LLC	1610 EAST 26TH STREET MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 680	Continued From page 14 preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.73, or successor requirements. The code references documents, specifications, methods, and standards in the State Operations Manual Appendix Z - Emergency Preparedness for All Provider and Certified Supplier Types. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. 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 the potential to affect a large portion or all of the residents). The findings include:	0 775		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34768	A. BUILDING: _____ B. WING _____	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELIOPOLIS HOME HEALTHCARE LLC	1610 EAST 26TH STREET MINNEAPOLIS, MN 55404

(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
0 775	Continued From page 15 Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated April 28, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Two (2) days	0 775		
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 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;	0 780		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34768	A. BUILDING: _____ B. WING _____	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELIOPOLIS HOME HEALTHCARE LLC	1610 EAST 26TH STREET MINNEAPOLIS, MN 55404

(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
0 780	Continued From page 16 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. 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 the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated April 28, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
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	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34768	A. BUILDING: _____ B. WING _____	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELIOPOLIS HOME HEALTHCARE LLC	1610 EAST 26TH STREET MINNEAPOLIS, MN 55404

(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
0 810	Continued From page 17 rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive 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 ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34768	A. BUILDING: _____ B. WING _____	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELIOPOLIS HOME HEALTHCARE LLC	1610 EAST 26TH STREET MINNEAPOLIS, MN 55404

(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
0 810	Continued From page 18 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 the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated April 28, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty one (21) days	0 810		
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 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	0 930		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34768	A. BUILDING: _____ B. WING _____	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELIOPOLIS HOME HEALTHCARE LLC	1610 EAST 26TH STREET MINNEAPOLIS, MN 55404

(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
0 930	Continued From page 19 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 interview and record review, the licensee failed to execute a written assisted living contract with all required content for three of three residents (R1, R2, R3). 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: R1 R1 was admitted to the licensee on November 6, 2019. R2 R2 was admitted to the licensee on December 9, 2023. R3 R3 was admitted to the licensee on December 23, 2022. R1, R2, and R3's Assisted Living Contract lacked a statement to describe the right under section 144G.54 to appeal the termination of an assisted living contract.	0 930		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34768	A. BUILDING: _____ B. WING _____	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELIOPOLIS HOME HEALTHCARE LLC	1610 EAST 26TH STREET MINNEAPOLIS, MN 55404

(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
0 930	Continued From page 20 On April 30, 2026, at approximately 12:10 p.m., via telephone, licensed assisted living director (LALD)-D stated they did not see the right to appeal termination in the assisted living contract; LALD-D stated they did tell the residents to call the ombudsman and department of health upon admission, if residents had any problem. LALD-D stated, "We are telling the clients to call the ombudsman and department of health. I am going to take a note." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 930		
01620 SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse:	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34768	A. BUILDING: _____ B. WING _____	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELIOPOLIS HOME HEALTHCARE LLC	1610 EAST 26TH STREET MINNEAPOLIS, MN 55404

(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
01620	Continued From page 21 (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident assessment and reassessment, not to exceed 90 calendar days from the last date of the assessment for two of three residents (R1, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34768	A. BUILDING: _____ B. WING _____	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELIOPOLIS HOME HEALTHCARE LLC	1610 EAST 26TH STREET MINNEAPOLIS, MN 55404

(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
01620	Continued From page 22 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). The findings include: R1 R1 was admitted to the licensee on November 6, 2019, with diagnoses including major depressive disorder. R1's Service Plan signed and dated October 1, 2025, indicated R1 received services for appointment reminders/assistance, CPAP/BIPAP, housekeeping, laundry, manage behavior, meal assistance, medication set up, medication administration, socialization, transportation assistance, and record vital signs. R1's resident record included 90-day nursing assessments completed on October 9, 2025, January 8, 2026, and April 8, 2026. The assessment completed on January 8, 2026, was late by one day. R3 R3 was admitted to the licensee on December 23, 2022, with diagnoses including schizoaffective disorder (bipolar type), and essential hypertension. R3's Service Plan signed and dated October 1, 2025, indicated R3 received services for appointment reminders/assistance, day/evening check in, housekeeping, laundry, manage	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34768	A. BUILDING: _____ B. WING _____	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELIOPOLIS HOME HEALTHCARE LLC	1610 EAST 26TH STREET MINNEAPOLIS, MN 55404

(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
01620	Continued From page 23 behavior, meal assistance, medication set up, medication administration, socialization, transportation assistance, and record vital signs. R3's resident record included 90-day nursing assessments completed on October 9, 2025, January 7, 2026, and April 8, 2026. The assessment completed on April 8, 2026, was late by one day. On April 30, 2026, at approximately 2:00 p.m., via telephone, clinical nurse supervisor (CNS)-C stated, they were aware the assessments were late. CNS-C stated, "I did it on time; I forgot to send it. I think I am going to go back to paper to be honest that is a problem with electronic things". The licensee used Residex (electronic medical record software), for assessments. The licensee's 6.01 Assessment and Reviews & Monitoring policy dated January 1, 2024, indicated resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34768	A. BUILDING: _____ B. WING _____	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELIOPOLIS HOME HEALTHCARE LLC	1610 EAST 26TH STREET MINNEAPOLIS, MN 55404

(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
01760	Continued From page 24 resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure medication orders were accurately transcribed to the medication administration record for one of three residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of 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 to the licensee on November 6, 2019, with diagnoses including major depressive disorder. R1's Service Plan signed and dated October 1, 2025, indicated R1 received services for appointment reminders/assistance, CPAP/BIPAP,	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34768	A. BUILDING: _____ B. WING _____	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELIOPOLIS HOME HEALTHCARE LLC	1610 EAST 26TH STREET MINNEAPOLIS, MN 55404

(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
01760	Continued From page 25 housekeeping, laundry, manage behavior, meal assistance, medication set up, medication administration, socialization, transportation assistance, and record vital signs. R1's unsigned After Visit Summary (AVS) indicated the following orders: - azithromycin take one tablet (500mg) by mouth daily for three days; and - cefuroxime take one tablet (500mg) by mouth twice daily for three days. R1's Medication Administration Summary- Month (MAR) for the month of April 2026, indicated R1 had taken the following prescribed medication: - azithromycin take one tablet (500mg) by mouth daily for three days, (Starts: 04/09 4:30PM) (Ends: 04/11/26 7:00 PM), however azithromycin was entered into Residex (charting software) to be given twice a day at 7:00 a.m. and 7:00 p.m. The pharmacy label indicated a quantity of three tablets for a three-day supply was dispensed, however, the MAR indicated R1 took five doses of Azithromycin; and - cefuroxime take one tablet (500mg) by mouth twice daily for three days, (Starts: 04/09 5:00 PM) (Ends: 04/11/26 9:00 PM) however cefuroxime was entered into Residex to be given once a day at 7:00 p.m. The pharmacy label indicated a quantity of six tablets for a three day supply was dispensed, however, the MAR indicated R1 took only three doses of cefuroxime over three days. On April 30, 2026, at 1:25 p.m., via telephone, clinical nurse supervisor (CNS)-C stated they scheduled the azithromycin twice a day because R1 often refused their medications so they scheduled it for twice a day so R1 could take it in the evening if they refused it in the morning. The surveyor asked how that statement was reflected	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34768	A. BUILDING: _____ B. WING _____	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELIOPOLIS HOME HEALTHCARE LLC	1610 EAST 26TH STREET MINNEAPOLIS, MN 55404

(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
01760	Continued From page 26 in the MAR. CNS-C then changed their explanation and stated it was a system error. The surveyor asked CNS-C to clarify whether it was a system error, or whether the medication was purposely scheduled twice. CNS-C again stated it was system error. The surveyor asked the CNS to clarify what they meant by system error. CNS-C stated staff made the error. The surveyor asked who entered the medication into the system. CNS-C stated, "I entered it. This happens all the time, I am not happy about this, and I will look into it." The surveyor then asked if it was transcription error. CNS-C stated yes, it was a transcription error. CNS-C stated the cefuroxime was also a transcription error. CNS-C further stated there was no way to tell if R1 got the right doses of the above-mentioned medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain signed medication orders for one of three residents (R1). This practice resulted in a level two violation (a	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34768	A. BUILDING: _____ B. WING _____	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELIOPOLIS HOME HEALTHCARE LLC	1610 EAST 26TH STREET MINNEAPOLIS, MN 55404

(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
01820	Continued From page 27 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 to the licensee on November 6, 2019, with diagnoses including major depressive disorder. R1's Service Plan signed and dated October 1, 2025, indicated R1 received services for appointment reminders/assistance, CPAP/BIPAP, housekeeping, laundry, manage behavior, meal assistance, medication set up, medication administration, socialization, transportation assistance, and record vital signs. R1's Medication Administration Summary- Month for the month of April 2026, indicated R1 had taken the following prescribed medication: - Azithromycin take one tablet (500mg) by mouth daily for three days; and - Cefuroxime take one tablet (500mg) by mouth twice daily for three days. On April 29, 2026, at 2:41p.m., via email correspondence, licensed assisted living director (LALD)-D provided page one of four of R1's After Visit Summary (AVS) dated April 9, 2026, and pharmacy labels for the above-mentioned medications. On April 29, 2026, at 3:18 p.m., via email correspondence, LALD-D indicated "Those lebels	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34768	A. BUILDING: _____ B. WING _____	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELIOPOLIS HOME HEALTHCARE LLC	1610 EAST 26TH STREET MINNEAPOLIS, MN 55404

(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
01820	Continued From page 28 [sic] is [sic] what he [R1] got from the pharmacy at the HCMC for our instructions. I'll get you the summary of the visit as I only saved the 1st page for the order and the lables [sic] for instructions. I just left the facility and will get you the rest of the summary later when I get back to the facility." On April 29, 2026, at 4:49 p.m., via email correspondence, LALD-D provided four pages of R1's AVS dated April 9, 2026. The AVS lacked a physician signature for the above mentioned newly prescribed medications. On April 30, 2026, at 1:25 p.m., via telephone, clinical nurse supervisor (CNS)-C stated they did not see doctors' signatures on the AVS. CNS-C stated they did have another AVS and stated they would look for it and send it to the surveyor. On April 30, 2026, at 5:58 p.m., after the close if the survey, LALD-D emailed emergency department (ED) medication order documents dated April 9, 2026, for the above mentioned two medications. LALD-D's email read, "Upon organizing our files after the survey we were able to find the MD [medical doctor] order for both meds. This survey is fast-paced, and this is [sic] the things that are important but missed. I'm attaching both orders for your review." None of the additional documents provided contained the prescribers' handwritten or electronic signature. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34768	A. BUILDING: _____ B. WING _____	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELIOPOLIS HOME HEALTHCARE LLC	1610 EAST 26TH STREET MINNEAPOLIS, MN 55404

(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
02320	Continued From page 29	02320		
02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure residents received appropriate care and services from one of one unlicensed personnel ((ULP)-K) observed during medication administration. 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: R3 was admitted to the licensee on December 23, 2022, with diagnoses including schizoaffective disorder (bipolar type), and essential hypertension. R3's Service Plan signed and dated October 1, 2025, indicated R3 received services for appointment reminders/assistance, day/evening check in, housekeeping, laundry, manage	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34768	A. BUILDING: _____ B. WING _____	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELIOPOLIS HOME HEALTHCARE LLC	1610 EAST 26TH STREET MINNEAPOLIS, MN 55404

(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
02320	Continued From page 30 behavior, meal assistance, medication set up, medication administration, socialization, transportation assistance, and record vital signs. On April 27, 2026, at approximately 12:15 p.m., the surveyor observed ULP-K perform hand hygiene, walk downstairs where the medication cabinet was located, open the cabinet, and retrieve R3's noon medication bubble pack. ULP-K locked the cabinet and went back upstairs where R3 was sitting; gave the medication to R3, sat the computer station, logged into Residex (electronic medical record software) and charted the medication as administered. On April 27, 2026, at 12:22 p.m., ULP-K stated they were trained to check the medication against the computer before administering the medication to residents. ULP-K stated their process was to check the computer in the morning to make sure there were no medication order changes and then they chart the medication after they give it. ULP-K stated they had been doing this for the last five years. On April 30, 2026, at approximately 2:35 p.m., via telephone, clinical nurse supervisor (CNS)-C stated all ULPs were trained to check the orders against the computer before administering medication to residents. CNS-C stated they had already addressed the issue with ULP-K, and they would reenforce it with all staff as well. ULP-K's employee record included a Comprehensive Home Care Orientation Training and Competencies Manual for Oral Medication Competency dated May 1, 2025. The document indicated ULP-K had passed the training and competency for oral medication administration.	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34768	A. BUILDING: _____ B. WING _____	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELIOPOLIS HOME HEALTHCARE LLC	1610 EAST 26TH STREET MINNEAPOLIS, MN 55404

(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
02320	Continued From page 31 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		

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

Food & Beverage Inspection Report

Establishment Info

Heliopolis home Healthcare LLC
1610 E 26th Street
Minneapolis, MN 55404
Hennepin County
Parcel:

Phone:

License Info

License: HFID 34768

Risk:
License:
Expires on:
CFPM: Kenadid Mohamed Abdiaziz
CFPM #: CFPM-62354; Exp: 10/21/2028

Inspection Info

Report Number: F1039261123
Inspection Type: Full - Single
Date: 4/28/2026 Time: 11:45 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 1
Total Priority 2 Orders: 1
Total Priority 3 Orders: 1
Delivery: Emailed

New Order: 2-100 Supervision
2-102.11ABCQ *Priority Level: Priority 2 CFP#: 1*
MN Rule 4626.0030ABCQ The person in charge must be able to demonstrate their knowledge to the inspector of the following factors associated with employee health and the transmission of foodborne disease: symptoms of illness frequently associated with foodborne diseases; food worker illness reporting requirements; and medical conditions requiring exclusion of an employee from work or the restriction of their work duties.
COMMENT: PERSON-IN-CHARGE NOT AWARE OF EMPLOYEE ILLNESS LOGGING REQUIREMENT. LOG ALL INSTANCES OF EMPLOYEE FOODBORNE ILLNESS/SYMPTOMS. LOG SHEET SENT WITH THIS REPORT.
Comply By: 4/28/2026 Originally Issued On: 4/28/2026

New Order: 4-500 Equipment Maintenance and Operation
4-501.11AB *Priority Level: Priority 3 CFP#: 47*
MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.
COMMENT: DISHWASHING MACHINE IS NOT FUNCTIONING. RETURN TO FUNCTION AND MONITOR TO CONFIRM RINSE TEMPERATURE IS 160 DEGREES F OR GREATER.
Comply By: 7/28/2026 Originally Issued On: 4/28/2026

! **New Order: 4-700 Sanitizing Equipment and Utensils**
4-702.11 *Priority Level: Priority 1 CFP#: 16*
MN Rule 4626.0900 Sanitize utensils and food contact surfaces of equipment before use, after cleaning.
COMMENT: DISHWASHING MACHINE IS OUT-OF-SERVICE. STAFF ARE WASHING DISHES WITH SOAP AND WATER, NOT SANITIZING. USE 50-200 PPM CHLORINE BLEACH SOLUTION IN DISH TUB TO SANITIZE DISHES AFTER WASHING.
Comply By: 4/28/2026 Originally Issued On: 4/28/2026

Food & Beverage General Comment

MILK - COLD HOLD, COOLER - 39 DEGREES F
BASEMENT REFRIGERATOR AND CHEST FREEZER
ALL FREEZERS - FROZEN

This inspection was completed as part of MDH HRD assisted living facility survey. The inspection was conducted with the person-in-charge and reviewed with MDH HRD nurse evaluator Dee Mosissa.

The kitchen is of residential build and should serve food for same-day service only.

The kitchen has wood cabinets with hollow base and laminate countertops, decorative tile backsplash, wood floor, painted walls and ceiling. These equipment and finishes are in good condition an well maintained.

A 2-compartment sink is present in kitchen. 1 compartment is designated for handwashing only.

Verified hand sink correctly set-up, gloves, probe thermometer, sanitizer test strips, UST thermo strips.

Discussed the following with the person-in-charge: minimum cook temps for animal proteins, food source, foodborne illness symptoms and exclusion of ill employees, date marking, avoiding bare hand contact with ready to eat foods, handwashing, sanitizing, all orders on this report.

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Metro District Office inspection report number F1039261123 from 4/28/2026

Nuruldin Nur
person-in-charge

Aron Goodner,
Public Health Sanitarian
651-201-4910
aron.goodner@state.mn.us

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

Sanitizer Observations/Recordings

Establishment Info

Heliopolis home Healthcare LLC
Minneapolis
County/Group: Hennepin County

Inspection Info

Report Number: F1039261123
Inspection Type: Full
Date: 4/28/2026
Time: 11:45 AM

Sanitizing Chemical: Product: Chlorine**; Sanitizing Process:** Spray Bottle
Location: Equal To 200 PPM
Comment:
Violation Issued?: No

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL34768016-0	**Date:** April 28, 2026
Facility Name: Heliopolis Home Healthcare LLC	
Facility Address: 1610 E 26th Street, Minneapolis, MN 55404	

☒ **TAG IDENTIFICATION: 0775**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Two (2) days

1. Each assisted living facility must comply with the provisions of the Minnesota State Fire Code (MSFC) in Minnesota Rules chapter 7511. [Minn. Stat. 144G.45 subd. 2]

2. Fueled equipment including, but not limited to, motorcycles, mopeds, lawn-care equipment, portable generators and portable cooking equipment, shall not be stored, operated or repaired within a building. [Minn. Stat. 144G.45 subd. 2; MSFC 313.1]

   Comments: There was a gas powered lawn mower being stored inside of the front door of the facility. At time of discovery licensed assisted living director (LALD)-D stated that the lawn mower was no longer used and did not have any gasoline in it. The surveyor requested that LALD-D remove the gas cap on the mower to inspect the gas tank and verify it was empty. When LALD-D opened the gas cap the surveyor was able to smell gasoline and see gasoline in the tank. In an email on April 28, 2026, at 5:36 p.m. LALD-D stated that the lawn mower had been removed from the facility.

☒ **TAG IDENTIFICATION: 0780**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Seven (7) days

1. Smoke alarms shall be interconnected so that actuation of one alarm causes all alarms in the individual dwelling or sleeping unit to operate where more than one smoke alarm is required within an individual dwelling or sleeping unit. [Minn. Stat. 144G.45 subd.2]

   Comments: During the facility tour it was discovered that the facility was equipped with hard wired smoke alarms and additional smoke alarms in all required locations. When the surveyor requested that LALD-D test the interconnected smoke alarms LALD-D retrieved their cell phone from their pocket and explained that they can set off all the interconnected smoke alarms using an app on their phone. The

surveyor requested that LALD-D not use the app as that only demonstrates that the smoke alarms are connected to the app and not interconnected within the facility. After several minutes of discussion, LALD-D tested what they stated were their interconnected smoke alarms by pushing the test button in one of the residents' rooms. The smoke alarm only sounded locally and was not interconnected. LALD-D again retrieved their cell phone from their pocket and stated that the smoke alarms were interconnected since they can set them off from the app on their phone.

The surveyor again explained that the app is not an appropriate way of demonstrating that the system is interconnected so that the activation of one alarm causes the activation of all. LALD-D stated that everyone uses the app to test their smoke alarms and that they felt it was appropriate. The surveyor asked if the app would also set off the hard wired smoke alarms. LALD-D stated that it would not. After several more minutes of discussion about the statutory requirements for smoke alarms, LALD-D stated that they would just remove the hard wired smoke alarms. The surveyor explained that removal of the hard wired smoke alarms would not be an appropriate resolution, and that hard wired smoke alarms are required to be maintained as hard wired.

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Twenty One (21) days

---

1. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that include employee actions to be taken in the event of a fire or similar emergency. [Minn. Stat. 144G.45 subd.2]

   Comments: During record review on April 28, 2026, at 1:52 p.m. LALD-D provided an FSEP that 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 provided FSEP was from a third-party provider and had not been updated to the specific facility. The FSEP also lacked resident actions to take in the event of a fire or similar emergency.

   At 2:03 p.m. LALD-D stated that there was a medical emergency regarding a family member and requested they be able to email the remaining documentation to the surveyor. LALD-D stated that they would email the remaining documentation by 8:00 p.m. on April 28, 2026. On April 28, 2026, at 5:36 p.m. the surveyor received an email from LALD-D stating that there had been a different emergency at the facility and they were not able to attend to their family member's emergency. LALD-D stated that they would try to provide the documentation by 8:00 p.m. as they had stated, but if they were unable to meet the timeline they provided, they would provide the requested documentation before the start of the workday on April 29, 2026.

   On April 29, 2026, at 1:50 p.m. the surveyor received an email from LALD-D with a new, up-to-date fire safety policy that included staff actions. The policy was signed by LALD-D and dated April 29, 2026.

2. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that include fire protection procedures necessary for residents. [Minn. Stat. 144G.45 subd.2]

   Comments: LALD-D provided an FSEP on site, and in an email on April 29, 2026, at 1:50 p.m. Neither of the FSEP's provided by LALD-D identified specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency.

3. Employees of assisted living facilities shall receive training on the fire safety and evacuation plans (FSEP) upon hiring and at least twice per year thereafter. [Minn. Stat. 144G.45 subd.2]

   Comments: No staff training on the FSEP was provided while the surveyor was on site for record review, or in any of the emails that LALD-D sent providing additional documentation after the surveyor left the facility.

4. 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. [Minn. Stat. 144G.45 subd.2]

   Comments: No resident training on the FSEP was provided while the surveyor was on site for record review, or in any of the emails that LALD-D sent providing additional documentation after the surveyor left the facility.