Electronically Delivered

July 25, 2025

Licensee
Home From Home Assisted Living LLC
2613 93rd Way North
Brooklyn Park, MN 55444

RE: Project Number(s) SL38701016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on May 23, 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 . . ."

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

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

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the

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

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

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

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

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

If you have any questions, please contact me.

Sincerely,

Renee L. Anderson

Renee L. Anderson, Supervisor
State Evaluation Team
Email: Renee.L.Anderson@state.mn.us
Telephone: 651-201-5871 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38701	A. BUILDING: _____ B. WING _____	05/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME FROM HOME ASSISTED LIVING LLC	2613 93RD WAY NORTH BROOKLYN PARK, MN 55444

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0 000	Initial Comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. 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. INITIAL COMMENTS: SL38701016-0 On May 19, 2025, through May 23, 2025, the Minnesota Department of Health conducted an initial survey at the above provider, and the following correction orders are issued. At the time of the survey, there were zero (0) residents receiving services under the provider's Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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 SUBDIVISION 1-3.	
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness	0 680		

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0 680	Continued From page 1 (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 licensee failed to have a written emergency preparedness (EP) plan that included all required content. This had the potential to affect all residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when	0 680		

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0 680	Continued From page 2 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 undated EP plan lacked the following required content: - annual review and updated EP plan, policies, and procedures; - annual review and updated hazard vulnerability risk assessment by likelihood of occurrence; - process for emergency preparedness (EP) cooperation with state and local EP officials/organizations; - quarterly updated missing resident plan; - policies and procedures for use of volunteers; - policies and procedures to address role of facility under a waiver declared by the Secretary in accordance with section 1135 of the Act; - development of a communication plan, including the names/contact information: staff, entities providing services under agreement, residents' physicians, other facilities, volunteers; - communication plan including contact information for Federal, State, tribal, regional & local EP staff, State Licensing and Certification Agency, and MN Office of Ombudsman for LTC; - EP training and testing program; - EP training program for staff (including documentation of training provided); and - EP testing/annual testing requirements. On May 19, 2025, at 12:38 p.m., licensed assisted living director (LALD)-A stated the licensee's EP plan lacked the information noted above. LALD-A further stated licensee had a consultant prepare their EP plan; therefore, LALD-A was unaware of all the required content. Moreover, LALD-A stated licensee had not	0 680		

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0 680	Continued From page 3 reviewed the EP plan nor completed any full-scale or table-top exercises since the facility opened in 2023. The licensee's undated Emergency Preparedness Plan-Appendix Z Compliance policy indicated licensee would have an effective and compliant EP plan in place, and the plan would be aligned with the Centers for Medicare and Medicaid Services State Operation Manual Appendix Z, which provided interpretive guidance for emergency preparedness for all providers and certified supplier types. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 775 SS=E	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 comply with the requirements of Minnesota State Fire Code Rules, Chapter 7511. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more	0 775		

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0 775	Continued From page 4 than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On May 21, 2025, at 10:30 a.m., the surveyor toured the facility with licensed assisted living director (LALD)-A. During the facility tour, the surveyor observed the following: FIRE-RESISTANT WALL MAINTENANCE In the attached garage, there were two holes in the fire-resistant wall between the assisted living dwelling unit and the attached garage. During the facility tour interview on May 21, 2025, LALD-A verified the above listed fire-resistant wall observations. The fire-resistant wall on the garage side between the dwelling unit and the attached garage is required to be maintained free of holes and be sealed to prevent the passage of smoke or fire from one side of the wall to the other. EMERGENCY EXITS An exit sign was posted above the door leading into the attached garage from the assisted living dwelling unit. This door was labeled as an emergency exit on the facility floor plans. During the facility tour interview on May 21, 2025, LALD-A verified the above listed emergency exit observations. Emergency exits are required to lead directly to the exterior of the building and not through a higher hazard room. ELECTRICAL An exterior electrical wall outlet was not provided with a cover on the back of the garage, near the grill. During the facility tour interview on May 21, 2025, LALD-A verified the above listed observation. Weatherproof covers for electrical outlets are required in outdoor locations to prevent water damage, electrical shocks, and fires. TIME PERIOD FOR CORRECTION: Seven (7)	0 775		

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0 775	Continued From page 5 days	0 775		
0 780 SS=E	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; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide interconnected smoke alarms that complied with fire protection requirements.	0 780		

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0 780	Continued From page 6 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On May 21, 2025, at 10:30 a.m., the surveyor toured the facility with licensed assisted living director (LALD)-A. During the facility tour, the surveyor observed two hardwired smoke alarm systems were installed. When the ADT smoke alarms were tested, the other dwelling unit smoke alarms were not actuated. During the facility tour interview on May 21, 2025, LALD-A stated the ADT smoke alarms were installed in 2021 and verified these alarms were not interconnected with the pre-existing hardwired smoke alarms installed in the home. All dwelling unit smoke alarms must be interconnected so that actuation of one alarm causes all alarms in the dwelling unit to operate. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 790 SS=E	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code;	0 790		

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0 790	Continued From page 7 (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to install and maintain the portable fire extinguishers as required by statute. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On May 21, 2025, at 10:30 a.m., the surveyor toured the facility with licensed assisted living director (LALD)-A. During the facility tour, the surveyor observed the following: - Portable fire extinguishers were stored in the following locations: In the laundry room on a shelving unit. Inside a cabinet under the sink in the kitchen. In the garage on a shelving unit. These fire extinguishers were not mounted or installed in a manner to prevent them from being moved or damaged. - A sign was not posted to identify the location of	0 790		

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0 790	Continued From page 8 the fire extinguisher stored inside a kitchen cabinet. A sign must be posted indicating the fire extinguisher's location if it is not visible. - The annual maintenance tags attached to the fire extinguishers were dated June 2023. Maintenance performed by certified service personnel is required annually for each portable fire extinguisher. - Monthly inspections recorded on the back of the tags attached to the fire extinguishers indicated these inspections had not been completed since July 2023. Monthly inspections were not recorded between August 2023 and May 2025. Fire extinguisher inspections must be conducted every month to ensure each extinguisher is in its designated place, it has not been tampered with, and there is no obvious physical damage or condition that would interfere with its use or operation. During the facility tour interview on May 21, 2025, LALD-A verified the portable fire extinguisher observations and stated the facility had been vacant since April 30, 2024. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement,	0 810		

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0 810	Continued From page 9 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, record review, and interview, the licensee failed to develop the fire safety and evacuation plan with required content and provide required training and drills. 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).	0 810		

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0 810	Continued From page 10 The findings include: On May 21, 2025, licensed assisted living director (LALD)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The FSEP failed to identify the number of resident sleeping rooms evident by the following: On May 21, 2025, at 10:30 a.m., the surveyor toured the facility with LALD-A. During the tour, the surveyor observed LALD-A verbally identified resident sleeping rooms as 1, 2, 3, and 4. Numbers identifiers were not posted at the sleeping room doors. Additionally, the FSEP floor plan did not include resident sleeping room number labels as verbally identified by LALD-A during the tour. Resident sleeping room identifiers are required to be included on the fire safety and evacuation floor plan and correspond with the identifiers installed at the resident sleeping room doors to provide efficient communication for exiting in the event of a fire or similar emergency. Record review of the available documentation indicated the licensee failed to maintain an accurate FSEP evident by the following: - Record review of the available documentation indicated the FSEP inaccurately referenced smoke compartment doors, fire sprinklers, fire doors on magnetic holders, and a fire alarm system wired to the fire station. These life safety systems were not installed in the building. - On May 21, 2025, at 10:30 a.m., the surveyor toured the facility with LALD-A. During the facility tour, the surveyor observed portable fire extinguishers were stored in the basement	0 810		

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0 810	Continued From page 11 laundry room, under the kitchen sink, and in the attached garage. The FSEP floor plans inaccurately labeled portable fire extinguishers were installed in the basement living room and main floor dining room. Record review of the available documentation indicated the licensee failed to develop a FSEP with procedures specific to the assisted living facility and the building occupants evident by the following: - The FSEP included templates from third party providers. - 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 employee actions were limited to the RACE (Remove, Alarm, Confine, Extinguish/Evacuate) and PASS (Pull, Aim, Squeeze, Sweep) acronyms. - The FSEP failed to identify specific fire protection procedures necessary for residents evident by inappropriate instructions directing residents to stay behind fire doors unless evacuation was necessary in a building without fire resistant construction. Site specific fire protection instructions for residents were not included in the FSEP evident by a lack of these procedures in the plan. - The FSEP included standard resident evacuation procedures but failed to provide site specific procedures for resident movement, relocation, and evacuation during a fire or similar emergency evident by a lack of these procedures in the plan. - The FSEP floor plan did not clearly label the main exit for the facility. Exit labels are required to be included on the floor plan to direct occupants to the exits in the event of an emergency.	0 810		

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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
0 810	Continued From page 12 During an interview on May 21, 2025, at 12:10 p.m., LALD-A verified the FSEP required revision. TRAINING Record review indicated the licensee failed to provide training to employees on the FSEP upon hire and at least twice per year evident by the lack of documentation to support this training had been completed. No FSEP training records were provided. During an interview on May 21, 2025, at 11:46 a.m., LALD-A stated there were currently no employees and the last resident had moved out on April 30, 2024. LALD-A did not know where these records were stored as the facility was not currently operating. The surveyor requested employee FSEP training records for 2023 and 2024 from LALD-A. LALD-A stated employee FSEP training records for 2023 and 2024 would be emailed to the surveyor if located no later than 4:00 p.m., on May 21, 2025. No further information was provided. DRILLS Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month evident by a review of completed fire drill reports for 2023 and 2024. Three fire drill records were provided, dated August 15, 2023, September 1, 2023, and January 2, 2024. During an interview on May 21, 2025, at 11:46 a.m., LALD-A stated there were currently no employees and the last resident had moved out on April 30, 2024. LALD-A verified the evacuation drill frequency was not met.	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38701	A. BUILDING: _____ B. WING _____	05/23/2025

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0 810	Continued From page 13 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. 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 practice resulted in a level one violation (a violation that has not 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 had an admission date of August 7, 2023.	0 910	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 (R2) with record reviewed. This practice resulted in a level one violation (a violation that has not 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:	

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0 910	Continued From page 14 R1's service plan dated August 7, 2023, indicated R1 received services including assistance with medication management. R1's individualized medication management plan dated November 17, 2023, indicated the registered nurse (RN) would setup R1's medications weekly and unlicensed personnel (ULP) would administer medications. R1's record contained a Residency Agreement/Assisted Living Contract dated August 7, 2023. The contract lacked the licensee's Health Facility Identification Number (HFID), facility name, and facility telephone number. On May 19, 2025, at 12:47 a.m., licensed assisted living director (LALD)-A stated R1's contract lacked the information noted above. LALD-A further stated they worked with an outside consultant on the contract, and they were not aware the contract did not contain all the required content. LALD-A stated the contract provided to the surveyor was used for all residents that lived at the facility. The licensee's undated Assisted Living Contracts policy indicated licensee would establish a contract with each client at the time of admission to the program. The contract would be inclusive of both the tenant-landlord relationship and the services to be provided. Prospective residents would receive an unsigned copy of the contract, and an unsigned copy would be provided to the Office of the Ombudsman for Long-Term Care. Furthermore, the contract would include the legal name and license number of the facility, telephone number, and physical mailing address, which would not be a post office box.	0 910	R2 had an admission date of July 24, 2023. R2's service plan dated July 28, 2024, indicated R2 received services which included medication administration, housekeeping, laundry, dressing, grooming, and bathing assistance, blood glucose (sugar) testing, oxygen management, mental health checks, and preparation of modified diet. R2's record contained an Assisted Living Residence and Care Agreement contract dated July 26, 2023. The contract lacked the licensee's Health Facility Identification Number (HFID) and the telephone number of the facility. On April 30, 2025, at 11:35 a.m., licensed assisted living director (LALD)-A stated when the facility first opened, licensee had an outside consultant assist with the drafting of the current contract; therefore, she was not aware the contract licensee was utilizing was missing information. LALD-A further stated the contract R2 signed was the contract licensee had been using for all the residents, since the time of their previous survey, which had been a couple of years ago. Moreover, licensee stated if she had known the contract was missing required information, she would have fixed the contract prior to the survey. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	

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0 910	Continued From page 15 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 910		
0 920 SS=C	144G.50 Subd. 2 (c) Contract information (c) The contract must include: (1) a disclosure of the category of assisted living 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; (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; (3) a delineation of the cost and nature of any other services to be provided for an additional fee; (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; (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; (6) billing and payment procedures and requirements; and (7) disclosure of the facility's ability to provide specialized diets. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written assisted living	0 920	Based on interview and record review, the licensee failed to execute a written	

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0 920	Continued From page 16 contract with the required content for one of one resident (R1). This practice resulted in a level one violation (a violation that has not 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 had an admission date of August 7, 2023. R1's service plan dated August 7, 2023, indicated R1 received services which included assistance with medication management. R1's individualized medication management plan dated November 17, 2023, indicated the registered nurse (RN) would setup R1's medications weekly and unlicensed personnel (ULP) would administer medications. R1's record contained a Residency Agreement/Assisted Living Contract dated August 7, 2023. The contract lacked a disclosure of the category of assisted living facility license held by the facility and, if the facility was not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license. On May 19, 2025, at 12:47 a.m., licensed assisted living director (LALD)-A stated R1's contract lacked the information noted above. LALD-A further stated they worked with an outside consultant on the contract, and were not	0 920	assisted living contract with the required content for one of one resident (R2). This practice resulted in a level one violation (a violation that has not 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: R2 had an admission date of July 24, 2023. R2's service plan dated July 28, 2024, indicated R2 received services which included medication administration, housekeeping, laundry, dressing, grooming, and bathing assistance, blood glucose (sugar) testing, oxygen management, mental health checks, and preparation of modified diet. R2's record contained an Assisted Living Residence and Care Agreement contract dated July 26, 2023. The contract lacked a disclosure of the category of assisted living 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. On April 30, 2025, at 11:35 a.m., licensed assisted living director (LALD)-A stated when the facility first opened, licensee had	

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0 920	Continued From page 17 aware the contract did not contain all the required content. LALD-A stated the contract provided to surveyor was used for all residents that lived at the facility. The licensee's undated Assisted Living Contracts policy indicated licensee would establish a contract with each client at the time of admission to the program. The contract would be inclusive of both the tenant-landlord relationship and the services to be provided. Prospective residents would receive an unsigned copy of the contract, and an unsigned copy would be provided to the Office of the Ombudsman for Long-Term Care. Furthermore, the contract would contain all terms concerning the provision of Housing, Assisted Living Services, and the resident's service plan, if applicable. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 920	an outside consultant assist with the drafting of the current contract; therefore, she was not aware the contract licensee was utilizing was missing information. LALD-A further stated the contract R2 signed was the contract licensee had been using for all the residents, since the time of their previous survey, which had been a couple of years ago. Moreover, licensee stated if she had known the contract was missing required information, she would have fixed the contract prior to the survey. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	
0 950 SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain	0 950		

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0 950	Continued From page 18 information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to offer the opportunity to identify a designated representative before or at the time of execution of an assisted living contract, for one of one resident (R1). This practice resulted in a level one violation (a violation that has not 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 had an admission date of August 7, 2023. R1's service plan dated August 7, 2023, indicated	0 950		

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0 950	Continued From page 19 R1 received services which included assistance with medication management. R1's individualized medication management plan dated November 17, 2023, indicated the registered nurse (RN) would setup R1's medications weekly and unlicensed personnel (ULP) would administer medications. R1's assisted living contract lacked the opportunity to identify a designated representative before or at the time of execution of an assisted living contract. Furthermore, R1's contract lacked the exact statutory notice language about the designated representative. On May 19, 2025, at 12:47 a.m., licensed assisted living director (LALD)-A stated R1's contract lacked the information noted above. LALD-A further stated they worked with an outside consultant on the contract, and were not aware the contract did not contain all the required content. LALD-A stated the contract provided to the surveyor was used for all residents that lived at the facility. The licensee's undated Assisted Living Contracts policy indicated licensee would establish a contract with each client at the time of admission to the program. The contract would be inclusive of both the tenant-landlord relationship and the services to be provided. Prospective residents would receive an unsigned copy of the contract, and an unsigned copy would be provided to the Office of the Ombudsman for Long-Term Care. Furthermore, the contract would contain all terms concerning the provision of Housing, Assisted Living Services, and the resident's service plan, if applicable.	0 950		

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0 950	Continued From page 20 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 950		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and	01060		

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01060	Continued From page 21 community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with required content for an emergency relocation. The licensee further failed to notify the Office of Ombudsman for Long-Term Care (OOLTC) of the emergency relocation when the resident was relocated longer than four days, for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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: R1's Progress Note dated April 4, 2024, indicated licensed assisted living director (LALD)-A sent R1 to the hospital on April 2, 2024. R1's progress noted further indicated that on April 4, 2024, at 8:54 a.m., LALD-A called the hospital, and confirmed that R1 was admitted to the hospital.	01060		

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01060	Continued From page 22 R1's Discharge/Transfer Summary dated April 30, 2024, indicated R1 was discharged from the hospital to another care facility on April 30, 2024, and therefore, discharged from licensee's current facility. R1's record lacked evidence that, upon being relocated to the hospital, a written notice was provided to the resident, legal representative, and designated representative that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident had been relocated and any new service provider; - contact information for the 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 was expected to return to the facility, or a statement that a return date was not currently known; and - a statement that, if the facility refused 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. Furthermore, R1's record lacked notification to the OOLTC when R1 had not returned to the facility within four days. On May 23, 2025, at 10:16 a.m., licensed assisted living director (LALD)-A stated via email that none of the following noted above had occurred when R1 was hospitalized. LALD-A further stated she sent an email to R1's case manager which contained R1's progress note; however, was unaware of all the other	01060		

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01060	Continued From page 23 requirements. The licensee's undated Emergency Relocation policy indicated licensee 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 posed to the health or safety of another facility resident or facility staff member. Furthermore, in the event of an emergency, licensee would provide a written notice that contained, at a minimum: - 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; 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: and - notification to the Office of Ombudsman for Long-Term Care if the resident had been relocated and had not returned to the facility within four days. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current	01650		

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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
01650	Continued From page 24 assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plan included the required content for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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).	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38701	A. BUILDING: _____ B. WING _____	05/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME FROM HOME ASSISTED LIVING LLC	2613 93RD WAY NORTH BROOKLYN PARK, MN 55444

(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
01650	Continued From page 25 The findings include: R1's service plan dated August 7, 2023, indicated R1 received services which included assistance with medication reminders. R1's individualized medication management plan dated November 17, 2023, indicated the registered nurse (RN) would setup R1's medications weekly and unlicensed personnel (ULP) would administer medications. R1's medication administration record dated August 2023, indicated medication had been administered to R1 by the RN and licensed practical nurse (LPN) August 15, 2023, through August 31, 2023. R1's medication setup summary dated April 1, 2024, through April 3, 2024, indicated licensed assisted living director (LALD)-A who was also the clinical nurse supervisor (CNS) setup medication for R1 during those dates. R1's 24-hour customized living plan dated August 7, 2023, through July 31, 2024, indicated licensee would receive reimbursement for the following provided services: meal service, light housekeeping, heavy housekeeping, personal laundry, shopping, making appointments, non-medical transportation, standby grooming, medication administration three times daily and as needed, medication set-up/management, behavioral support, and standby assistance during therapeutic exercises. R1's service plan dated August 7, 2023, lacked the following: (1) a description of the services to be provided, the fees for services, and the frequency of each	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38701	A. BUILDING: _____ B. WING _____	05/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME FROM HOME ASSISTED LIVING LLC	2613 93RD WAY NORTH BROOKLYN PARK, MN 55444

(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
01650	Continued From page 26 service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; and (4) the schedule and methods of monitoring staff providing services. On May 22, 2025, at 3:04 p.m., during a telephone call, LALD-A stated R1 received medication administration and medication setup completed by LALD-A while living at the facility. LALD-A further stated she was not aware that R1's service plan was missing the required content. The licensee's undated Service Plan policy indicated assisted living services would be provided according to a suitable and current written service plan. Furthermore, the service plan would be developed with the resident/representative and would be based on resident needs and preferences. Moreover, a service plan would be finalized with each resident no later than 14 calendar days after the start of service. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		

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

Home From Home Assisted Living
2613 93rd Way N
Brooklyn Park, MN 55444
Hennepin County
Parcel:

Phone:

License Info

License: HFID 38701

Risk:
License:
Expires on:
CFPM: Stella Ijeora Iteghete
CFPM #: 118243; Exp: 6/29/2026

Inspection Info

Report Number: F1023251009
Inspection Type: Full - Single
Date: 5/20/2025 Time: 10:48:42 PM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery:

No orders were issued for this inspection report.

Food & Beverage General Comment

THIS INSPECTION WAS CONDUCTED IN CONJUNCTION WITH MDH HEALTH REGULATORY DIVISION (HRD) SURVEY. INSPECTION CONDUCTED IN PRESENCE OF THE PERSON IN CHARGE.

THESE TOPICS WERE DISCUSSED WITH THE PERSON IN CHARGE:
- EMPLOYEE ILLNESS EXCLUSION
- HAND WASHING PROCEDURE
- NO BARE HAND CONTACT WITH RTE FOOD
- VOMIT CLEAN UP PROCEDURE
- FULLY COOKING FOOD FOR HIGH RISK POPULATIONS

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

FOOD SERVICE AREA FLOORS, WALLS, CEILINGS, COUNTERTOPS, AND FINISH MATERIALS MUST BE NON-ABSORBANT, SMOOTH, DURABLE, AND EASILY CLEANABLE. CEILINGS CANNOT HAVE POPCORN TEXTURE. CABINETS CANNOT HAVE HOLLOW BASES. EXPOSED WOOD IS NOT APPROVED FOR FOOD SERVICE AREAS. WOOD IS NOT AN APPROVED FOOD CONTACT SURFACE.

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 F1023251009 from 5/20/2025

Gregory T Nelson

Stella Ijeora Iteghete
Person in Charge

Greg Nelson,
Public Health Sanitarian 3
651-201-4259
greg.nelson@state.mn.us

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

Temperature Observations/Recordings

Establishment Info

Home From Home Assisted Living
Brooklyn Park
County/Group: Hennepin County

Inspection Info

Report Number: F1023251009
Inspection Type: Full
Date: 5/20/2025
Time: 10:48:42 PM

Equipment Temperature: Product/Item/Unit: ; Temperature Process: Cold-Holding
Location: Refrigerator at 41 Degrees F.
Comment:
Violation Issued?: No

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

Sanitizer Observations/Recordings

Establishment Info

Home From Home Assisted Living
Brooklyn Park
County/Group: Hennepin County

Inspection Info

Report Number: F1023251009
Inspection Type: Full
Date: 5/20/2025
Time: 10:48:42 PM

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Kitchen **Equal To** Degrees F.
Comment: ANSI 184
Violation Issued?: No

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