Electronically Delivered

March 14, 2025

Licensee
Happy Care Inc
6703 89th Avenue North
Brooklyn Park, MN 55445

RE: Project Number(s) SL38616016-0

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on February 4, 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
	38616	A. BUILDING: _____ B. WING _____	02/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAPPY CARE INC	6703 89TH AVENUE NORTH BROOKLYN PARK, MN 55445

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments *****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: SL38616016-0 On Feburary 3, 2025, through February 4, 2025, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were two (2) residents; two 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.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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0 480	Continued From page 1 (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 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	0 480		

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0 480	Continued From page 2 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 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated Feburary 4, 2025, 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		

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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 licensee failed to have a written emergency preparedness (EP) plan with all the 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	0 680		

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0 680	Continued From page 4 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 EP plan dated April 7, 2023, lacked evidence it was reviewed annually, lacked the current facility address and phone number, and lacked the following requirements: - Policy and procedure with arrangement agreements with other facilities/providers to receive residents in the event of limitations/cessation of operations to maintain the continuity of services to residents; - Must conduct exercises to test the EP at least twice per year, including unannounced staff drills using the EP; - Must participate in an annual full-scale exercise that is community based OR conduct an annual, individual, facility-based functional exercise OR if the facility experiences an actual emergency requiring activation of plan, facility is exempt from engaging in its next required full-scale exercise; - Conduct an additional annual exercise that may include: a second full-scale exercise that is community-based or an individual, facility based functional exercise OR mock disaster drill OR table-top exercise; and - Analyze the facility's response to and maintain documentation of all drills, tabletop exercises and emergency events & revise plan as needed. On February 3, 2025, at 1:15 p.m., owner/unlicensed personnel (O/ULP)-A stated licensee received their EP plan from a third-party vendor and the EP plan lacked the information	0 680		

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0 680	Continued From page 5 listed above. O/ULP-A further stated licensee reviewed the EP plan at quarterly quality assurance meetings; however, he was unaware of all the content required in the EP plan. The licensee's Emergency Preparedness policy dated March 29, 2023, indicated, licensee would have an identified plan in place to assure the safety and well-being of resident's and staff during periods of an emergency or disaster that would disrupt services. Furthermore, licensee's EP policy indicated licensee would review and update the EP plan at least annually and fire drills would be conducted at the residence every other month, including at least two (2) drills for each shift for a total of six (6) fire drills annually. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 780 SS=D	144G.45 Subd. 2 (a) (1) Fire protection and physical environment for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in	0 780		

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0 780	Continued From page 6 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 an interconnected smoke alarm in a resident sleeping room. This had the potential to directly affect a limited number of residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: On February 4, 2025, at 2:10 p.m., the surveyor toured the facility with owner/unlicensed personnel (O/ULP)-A. During the tour, the surveyor observed when O/ULP-A tested the smoke alarms, the smoke alarm installed in unoccupied resident sleeping room 4 was not actuated. The smoke alarm in sleeping room 4 was not interconnected with the other dwelling unit smoke alarms as required by statute. During the facility tour interview on February 4, 2025,	0 780		

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0 780	Continued From page 7 O/ULP-A verified the above listed smoke alarm observation. TIME PERIOD FOR CORRECTION: Two (2) days	0 780		
0 790 SS=F	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; (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 maintain the portable fire extinguishers as required by statute. This deficient condition 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) 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:	0 790		

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0 790	Continued From page 8 On February 4, 2025, at 2:10 p.m., the surveyor toured the facility with owner/unlicensed personnel (O/ULP)-A. During the tour, the surveyor observed the following: 1. Tags or labels were not attached to the portable fire extinguishers showing annual maintenance had been performed by certified service personnel. The bottom of both fire extinguishers were date stamped 2021. 2. Tags or labels were not attached to the portable fire extinguishers showing monthly inspections had been completed. 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 February 4, 2025, O/ULP-A verified the above listed fire extinguisher observations. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
0 800 SS=E	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program.	0 800		

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0 800	Continued From page 9 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect more than a limited number of residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a 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 February 4, 2025, at 2:10 p.m., the surveyor toured the facility with owner/unlicensed personnel (O/ULP)-A. During the tour, the surveyor observed the following: 1. Two power strips were daisy chained together in the garage to supply power, creating a fire hazard. 2. The electrical panel in the garage was obstructed by storage in front of the panel. A clear space of at least 36 inches in front of the panel must be provided to allow for access. 3. The door knob was missing on the closet door under the stairs in the basement. 4. There was a small hole in the wall behind the door in occupied resident room 2. During the facility tour interview on February 4,	0 800		

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0 800	Continued From page 10 2025, O/ULP-A verified the above listed physical environment observations. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (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.	0 810		

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0 810	Continued From page 11 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with required content, and provide required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On February 4, 2025, owner/unlicensed personnel (O/ULP)-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 accurately identify the location and number of resident sleeping rooms evident by the following: - On the upper floor level, the number 5 was posted on the resident sleeping room door. On the FSEP floor plan this room was labeled as M Suite. - On the main floor, the numbers 1 and 2 were posted on the resident sleeping room doors. On the FSEP floor plan, these rooms were labeled as	0 810		

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0 810	Continued From page 12 3 and 4. - A floor plan was not posted for the basement. On February 4, 2025, at 2:10 p.m., the surveyor toured the facility with O/ULP-A. During the tour, O/ULP-A identified two resident sleeping rooms in the basement. The number 3 was posted on the door for the resident sleeping room verbally identified as 3 by O/ULP-A. A room identifier was not posted on or at the door for the resident sleeping room verbally identified as 4 by O/ULP-A. Resident sleeping rooms are required to be identified and correspond with the floor plan in order to provide efficient communication for exiting in the event of a fire or similar emergency. The FSEP floor plan failed to identify the main exit for the facility evident by the following: The posted floor plan did not label the main exit for the facility. On February 4, 2025, at 2:10 p.m., the surveyor toured the facility with O/ULP-A. During the tour, the surveyor observed an exit sign was posted at the front door. A label for the main exit is required to be included on the FSEP floor plan in order to direct occupants to this exit in the event of an emergency. The FSEP was a template from a third-party provider and had not been developed for use at this facility. 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) acronym. The licensee FSEP included a fire safety policy dated March 29, 2023, the policy inaccurately	0 810		

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	38616	A. BUILDING: _____ B. WING _____	02/04/2025

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HAPPY CARE INC	6703 89TH AVENUE NORTH BROOKLYN PARK, MN 55445

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0 810	Continued From page 13 directed the building occupants to pull the nearest fire alarm. Pull fire alarms were not installed at this facility. The FSEP did not identify specific fire protection procedures for residents evident by limited instructions directing residents to stoop or crawl to avoid smoke. No additional fire protection procedures necessary for residents were included. The FSEP included standard resident evacuation procedures, but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents evident by no procedures in the plan. During an interview on February 4, 2025, at 3:45 p.m., O/ULP-A verified the FSEP required revision. TRAINING Record review indicated the licensee failed to provide fire safety and evacuation training to residents at least once per year evident by the lack of documentation. During an interview on February 4, 2025, at 3:45 p.m., O/ULP-A stated residents were training during quality assurance meetings but this had not been recorded. Record review indicated the licensee failed to provide training to employees on the FSEP at least twice per year evident by records lacking the required documentation. Two quality assurance meeting records were provided, dated December 4, 2024, and January 2, 2025. The meeting agendas did not list FSEP training. During an interview on February 4, 2025, at 3:45 p.m., O/ULP-A verified the training records were	0 810		

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0 810	Continued From page 14 insufficient. Record review indicated the licensee failed to provide training to employees on the FSEP upon hire evident by the lack of training documentation. During an interview on February 4, 2025, at 3:45 p.m., O/ULP-A stated new hire employees were trained using a third party online training provider and verified this was not a site specific FSEP training. DRILLS Record review of the available documentation 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 logs lacking the required frequency. The surveyor requested fire drill records for the past year from O/ULP-A. Records were provided for nine fire drills completed between June 2024 and February 2025. Eight of these drills were completed during first shift. One drill was completed during second shift and no drills were conducted during third shift. The fire drill planning matrix indicated third shift drills were scheduled, but documentation was not provided to support these drills had been completed. During an interview on February 4, 2025, at 3:45 p.m., O/ULP-A verified the evacuation fire drill frequency was not met. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
02290 SS=F	144G.91 Subd. 2 Legislative intent The rights established under this section for the benefit of residents do not limit any other rights	02290		

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02290	Continued From page 15 available under law. No facility may request or require that any resident waive any of these rights at any time for any reason, including as a condition of admission to the facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to requested residents waive their rights, by enacting house rules that included resident rights violations, for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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 R1's diagnoses included but not limited to unspecified convulsions (medical condition that causes rapid, involuntary muscle contractions and uncontrollable shaking), post-traumatic stress disorder, anxiety, chronic kidney disease, unspecified dementia with mood disturbances, primary hypertension, and liver disease. R1's Service Plan dated August 30, 2024, indicated R1 received services including assistance with dressing and grooming as needed, shower reminders, laundry, housekeeping, medication management, blood glucose testing once weekly, and use of C-Pap (treatment used to manage breathing disorders)	02290		

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02290	Continued From page 16 placement. R1's medical record included undated House Rules and Regulations. R2 R2's diagnoses included but not limited to traumatic brain injury, R2's Care Plan dated November 1, 2022, indicated R2 received services including assistance with behavior monitoring, laundry, housekeeping, weekly shopping, dressing and grooming as needed, shower reminders, and medication management. R2's medical record included House Rules and Regulations dated October 29, 2022. R1's and R2's Assisted Living Contracts signed on August 30, 2024, and May 23, 2023, respectively, indicated under section entitled "Resident Responsibilities" that residents would be free to leave the premises independently whenever they wanted to. On February 3, 2025, at 11:50 a.m., during a self-guided facility tour, surveyor observed a document titled House Rules and Regulations posted near the facility entrance, which indicated the following: - all residents shall be familiar with the house rules along with fire and safety procedures; - absolutely no alcohol will be permitted while you are a resident of the home. This applies to the usage of drugs and possession of drug paraphernalia. Violations of this will result in immediate discharge and possible prosecution according to the law. This same rule applies to visitors and relatives;	02290		

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02290	Continued From page 17 with the approval of the medical team and/or house director; - residents are subject to random drug and alcohol tests at any time the house director decides to test. Failure of these tests or refusal of these tests will result in immediate discharge from the home; - the director and staff reserve the right to perform a room search at any time it is deemed necessary to insure the serenity and security of the home. This includes personal items and vehicles if appropriate; - threats or acts of violence toward the staff and/or other residents will not be tolerated and will result in immediate discharge and prosecution according to the law; - no firearms, hunting knives, or any other weapons are permitted by the residents of the home.; - smoking in the home is not permitted and will result in immediate discharge. Smoking is permitted in the smoking area out back of the home until 11:00 p.m., unless otherwise approved by the director; - gambling is strictly prohibited, including the purchase of lottery tickets; - no resident will borrow or loan money to other residents; - any resident that has access to a vehicle may bring their vehicle to the home after 30 days if they are working, or after sixty days if not. This is at the discretion of the house director; - house curfew is 10:00 p.m., every night. The doors will be locked at that time. Unless approved by the staff, any resident returning after 10 must find other sleeping arrangements for the night. Failure to return by curfew will result in discharge from the home; - all residents must use the sign in/out sheet when leaving the property. This must be done to	02290		

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02290	Continued From page 18 ensure that the staff knows where residents are at all times; - all residents must live in the home for three days before they can sign themselves out. Each resident will become, at the house director's discretion, eligible for a three (3) hour pass on their free days; - all residents must live at the home for thirty days before they can become eligible for an overnight or weekend pass. This time period may be waived by the director for emergencies and special circumstances. Two (2) passes per month may be approved on alternating weekends. Should an emergency arise that prevents you from returning on specified date or time, you must contact the staff immediately. Passes must be filled out by Wednesday at noon of the week request; - all visitors are subject to the approval by staff. No visitors are permitted on the property while under the influence of alcohol or drugs. Female visitors are allowed only at the discretion of the director. No visitors will be permitted inside the house without prior consent from house director; - there are to be no loud conversational {sic} or excessive phone calls after 5:00 p.m., on weekdays unless an emergency exists. Personal calls must be taken in the bedroom. Cell phones are permitted at the directors' discretion; - all residents are to assist in keeping the home and surrounding grounds neat and clean. This included daily assigned chores, special work assignments and your own room. Beds will be made daily, and chores completed daily; - if a resident goes to work, they are still responsible for their chores. You may ask another resident to do them and repay him by doing his/her chore. The responsibility of the chores being done will fall upon the resident originally assigned the chore;	02290		

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02290	Continued From page 19 - all food and snack items will be eaten in the dining room. No eating in the bedrooms, television lounge or other areas in the home. No alcoholic drinks to be consumed at any time; - all residents will be responsible for keeping the kitchen cleaned. any violations of this such as dirty microwave, crumbs, spills not cleaned up, etc... will result in discharge from the home. All dishes must be washed using hot, soapy water and must be dried; - residents must be fully clothed when around other residents and visitors. Residents are also expected to maintain good hygiene and personal cleanliness. This includes taking a shower daily; - each resident is to be in his own room by 11:30 p.m., with the exception of Friday and Saturday; - laundry is to be done during assigned times unless approved by staff. No resident will put laundry in and leave the premises. Lint filters will be cleaned after each load. At no time will laundry be done after 6:00 p.m., unless approved by staff; - no resident is to enter another resident's room without the other resident being there. We want safety for each room. Keeping doors locked is the resident's responsibility; - residents will keep the volume of their radios at a level not to be heard in the hallways or stairways. Failure to do so will result in loss of this privilege. Headphones must be used after 11:00 p.m.; - televisions will be at moderate volume after 5:00 p.m., weekdays unless approved by staff; - there will be no nude or partially nude pictures on the walls of the resident's rooms; - all appointments should be scheduled through the house director; - all residents must attend scheduled house meetings; - anyone needing to miss a scheduled house meeting, must have the staff's permission.	02290		

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02290	Continued From page 20 Residents under 30 days will not miss scheduled house meetings groups for any reason; - all residents that are able to work, must start looking for full or part time work after 30 days unless waived by Director and Counselors. All scheduled meetings will still be attended unless resident has a W-2 paying job and schedule showing he is working. Individuals freelining that they cannot work, must be on disability or have a statement from a doctor explaining the reason; - all residents are responsible for finding their own transportation to and from work; - the home will not accept responsibility for damage and/or other expenses incurred by the resident while staying at the home; - if a resident is discharged or leaves the home, all sums of money paid to the home shall be forfeited to the home; - when discharged from the home, all personal effects must be removed immediately. The house will not accept responsibility for items that have been left. The home will make every effort to protect personal items and will hold them for 5 days (without assuming responsibility) to give time for resident to make arrangements to pick them up. After 5 days, items will be donated to local mission and will not be stored at the home. The same applies to personal items of individuals residing in the home. Valuables may be turned over to the staff for safekeeping; - The Director of the Home has the final decision as to whether a resident is following the rules and whether the resident can remain in the Home. Every effort will be made to ensure that the resident understands the rules and is complying with the rules of the Home before resident is discharged; and - If a resident has a grievance against the Home, another client, and/or a staff member, resident must ask for a meeting with the Director. Do not	02290		

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02290	Continued From page 21 take-home business out in the public community. Resident should ask to meet with the House Director in order to come to a resolution. Furthermore, rules would be subject to change without notice. Every resident of the home would agree to follow the rules. When there are new rules, the new rules would apply to all residents and would fall under the same previous agreement of the resident of the house rules. The House Rules and Regulations included several items that limited residents' rights. On February 4, 2025, at 12:20 p.m., R2 stated he remembered reading through the house rules; however, did not think they were right. In addition, R2 stated he had been to other facilities that did not have these kind of rules, and was not going to follow them because the house rules because "the others here don't follow them, either". On February 4, 2025, at 1:21 p.m., owner/unlicensed personnel (O/ULP)-A stated the house rules were developed by a third-party consulting company and given to licensee to use. O/ULP-A further stated although the house rules had been posted in the facility, licensee had not been enforcing the rules. The licensee's Notifications policy dated March 29, 2023, indicated all residents or resident's representative of licensee would be provided with a written notice of rights upon admission and before the date that services would first be provided to the resident. Furthermore, all residents would understand their rights as recipients of assisted living and the services provided. In addition, the resident or resident's representative would be provided with names and contact information, including telephone numbers	02290		

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02290	Continued From page 22 and email addresses of at least three (3) organizations that provide advocacy or legal services to residents, including the designated protection and advocacy organization in Minnesota that provides advice and representation to individuals with disabilities, including how to file a complaint with: a. The Office of Health Facility Complaints at the Minnesota Department of Health. b. The Office of Ombudsman for Long-Term Care. c. The Ombudsman for Mental Health and developmental Disabilities. d. The Mid-Minnesota Legal Aid/Minnesota Disability Law Center. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02290		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the required notice was posted at all entrances to the establishment to display statutory language to disclose electronic monitoring activity. This had	03090		

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03090	Continued From page 23 the potential to affect all current residents in the assisted living facility, staff, and visitors. 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: On February 3, 2025, at 10:00 a.m., the surveyor observed outside the front entrance and just inside the front entrance to the facility. There was no required posting for electronic monitoring devices. On February 3, 2025, at 11:50 a.m., during a self-guided facility tour, surveyor was unable to locate the required notice to disclose electric monitoring activity at any entrance to the establishment. On February 3, 2025, at 12:10 p.m., licensed assisted living director (LALD)-B stated licensee was aware the electronic monitoring notice was required to be posted, and indicated the notice had been posted in the past. LALD-B further stated that one of the residents had removed the notice without licensee's knowledge. The licensee's Electronic Monitoring policy dated March 29, 2023, indicated licensee would post a sign at each facility entrance accessible to visitors that stated: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons or activities."	03090		

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03090	Continued From page 24 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090		

Minnesota Department of Health
Division of Environmental Health, FPLS
PO Box 64975
Saint Paul, 55164-0975
651-201-4500

Type: Full
Date: *02/04/25*
Time: 11:39:56
Report: 1023251044

Food and Beverage Establishment Inspection Report

Location:

Happy Care Inc
6703 89th Avenue N
Brooklyn Park, MN55443
Hennepin County, 27

Establishment Info:

ID #: 0041116
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/23

Operator:

Kamal Obsa
Phone #:
ID #: 59570

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

The following orders were issued during this inspection.

2-100 Supervision

2-102.12AMN

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

TO GET A CFPM YOU MUST TAKE EIGHT HOUR MANAGER CLASS, PASS TEST, AND CERTIFY WITH MDH WITHIN 6 MONTHS. YOU CAN SIGN UP FOR FOOD MANAGER COURSES AND CERTIFY WITH MDH HERE:
https://www.health.state.mn.us/communities/environment/food/cfpm/howto.html

Comply By: 02/04/25

4-100 Equipment Construction Materials

4-101.17

MN Rule 4626.0490 Discontinue using wood and wood wicker as a food contact surface.

OPERATOR USING WOODEN UTENSILS.

Comply By: 02/04/25

Surface and Equipment Sanitizers

Chlorine: = at Degrees Fahrenheit
Location:
Violation Issued: No

Hot Water: = at Degrees Fahrenheit
Location: ANSI 184 DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Type: Full
Date: *02/04/25*
Time: 11:39:56
Report: 1023251044
Happy Care Inc

Food and Beverage Establishment Inspection Report

Process/Item: Cold Hold/MILK
Temperature: 41 Degrees Fahrenheit - Location: REACH IN COOLER
Violation Issued: No

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

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

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 IS PROVIDED BY FACILITY STAFF.

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.

THESE TOPICS WERE DISCUSSED WITH 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

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1023251044 of 02/04/25.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed:_____
KAMAL OBSA
PERSON IN CHARGE

Signed: Gregory T Nelson
Gregory T. Nelson
Public Health Sanitarian
Freeman Building
651-201-4259
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