



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

March 26, 2025

Licensee

New Hope Health Care LLC
3721 104th Avenue North
Brooklyn Center, MN 55443

RE: Project Number(s) SL37379015

Dear Licensee:

On February 20, 2025, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on September 26, 2024. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the September 26, 2024 survey.

The Department of Health 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.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on September 26, 2024, found not corrected at the time of the February 20, 2025, follow-up survey and/or subject to penalty assessment are as follows:

0340 - Correction Orders - 144g.30 Subd. 5 - \$500.00

0510 - Infection Control Program - 144g.41 Subd. 3 - \$500.00

1760 - Documentation Of Administration Of Medication - 144g.71 Subd. 8

1820 - Prescriptions - 144g.71 Subd. 13

1880 - Storage Of Medications - 144g.71 Subd. 19 - \$500.00

The details of the violations noted at the time of this follow-up survey completed on February 20, 2025 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$1,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

IMPOSITION OF FINES:

Level 1: no fines or enforcement.

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

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

REQUESTING A HEARING

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

To submit a hearing request, please visit:

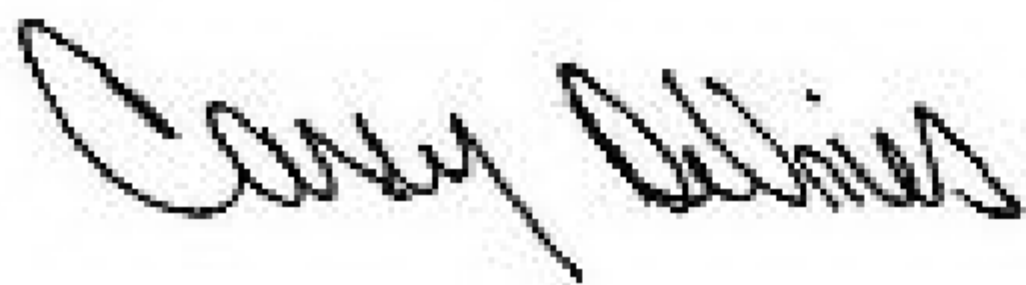
<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

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

We urge you to review these orders carefully. If you have questions, please contact Casey DeVries at 651-201-5917.

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

Sincerely,



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

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 02/20/2025
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443		
(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 FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS SL37379015-2 On February 19, 2025, to February 20, 2025, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on September 26, 2024, and follow up survey completed November 26, 2024. At the time of the survey, there were four residents, all of whom received services under the Assisted Living License. As a result of the follow-up survey, the following orders were reissued.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
{0 110} SS=C	144G.10 Subdivision 1a Assisted living director license required	{0 110}			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 02/20/2025
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443			
(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
{0 110}	Continued From page 1 Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by:	{0 110}	Not reviewed during this survey.		
{0 340} SS=F	144G.30 Subd. 5 Correction orders (a) A correction order may be issued whenever the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, an agent of the facility, or staff of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction. (b) The commissioner shall mail or email copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must: (1) document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed; and	{0 340}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 02/20/2025
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443		
(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
{0 340}	Continued From page 2 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have sufficient documentation with actions taken to comply with correction orders (tag identification: 0510, 1760, and 1820) for a survey completed on November 26, 2024. This had the potential to affect all residents, staff, and visitors at the facility. 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: During the follow-up survey on February 19, 2025, through February 20, 2025, the surveyor reviewed the licensee's plan of correction, policies and procedures, resident records, and conducted interviews with unlicensed personnel (ULP)-A, clinical nurse supervisor (CNS)-J, and owner (O)-D. The licensee's plan of correction dated November 25, 2024, included order numbers 0110, 0470, 0480, 0630, 0650, 0680, 0800, 0810, 1500, 1620, 1750, 1880, 1890, 1940, 1970, and 2290. The licensee's plan of correction did not address 0510, 1760, or 1820, issued on issued on November 26, 2024. On February 19, 2025, at 12:44 p.m., O-D stated for order 0510 they provided training and had a consultant reeducate on the topic to all ULP. O-D	{0 340}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 02/20/2025
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443			
(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
{0 340}	Continued From page 3 stated for order1760 they completed a four-hour training on medication documentation with all ULP who worked at the facility. O-D stated for order 1820 on November 26, 2025, they sent a list of R1's orders to the prescribers for signature however, they could not find the orders in their computer system. On February 20, 2025, at 9:20 a.m., clinical nurse supervisor (CNS)-J stated they were hired one month ago and were told the licensee retrained ULP after the follow up survey. On February 20, 2025, at 9:29 a.m., CNS-J stated they believe R1's orders were lost while they were trying to make corrections from the previous survey. On February 20, 2025, at 9:47 a.m., O-D stated they made corrections for order 0510, 1760, and 1820, however, they did not update their written plan of correction. Correction orders 0510, 1760, and 1820 were re-issued. Additionally, although the licensee obtained a lock box for refrigerated medications and provided education related to medication storage and security, the licensee failed to ensure compliance with medication security. No further information was provided.	{0 340}			
{0 480} SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626.	{0 480}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 02/20/2025
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
{0 480}	Continued From page 4 (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 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant	{0 480}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 02/20/2025
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
{0 480}	Continued From page 5 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:	{0 480}	Not reviewed during this survey.		
{0 510} SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program that complied with accepted health care, medical and nursing standards for needles for one of one resident (R1). This practice resulted in a level two violation (a	{0 510}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 02/20/2025
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443		
(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
{0 510}	Continued From page 6 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 admitted to the licensee on July 31, 2023, and began receiving assisted living services. R1's diagnoses included diabetes type 2 (DM2), hypertension, agitation, anxiety, cognitive impairment, and chronic kidney disease. R1's Service Plan (Waiver) - Addendum to Contract signed October 1, 2024, indicated R1 received assistance with appointments, bathing reminders, housekeeping, laundry, behavior management, meals, medication administration, shopping, and transportation. On February 19, 2025, at 10:12 a.m., the surveyor observed R1 self-administer Basaglar insulin and insulin lispro by use of a reusable pen, as unlicensed personnel (ULP)-A supervised the insulin administration. Owner (O)-D came into the kitchen area. O-D removed the insulin needle from R1's insulin lispro KwikPen and placed it into the sharps container. R1 covered the needle attached to the Basaglar KwikPen with the insulin cap and placed it into a secured black tote. The surveyor informed R1, ULP-A, O-D insulin needles needed to be discarded right after use. ULP-A stated R1 left the needle on the insulin pens and discarded them prior to the next use of the insulin pens. R1 stated their routine was to keep the needle on the insulin pen until their next	{0 510}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 02/20/2025
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443		
(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
{0 510}	Continued From page 7 dose and they used the needle on the pen as a "reminder" to change out the needle. R1 stated aides where normally in the living room when they administered their insulins. On February 19, 2025, at 12:08 p.m., the surveyor observed a secured tote in kitchens refrigerator that contained a Basaglar KwikPen with a needle still attached to the pen. O-D stated R1 liked to do things the way they wanted to do things. O-D stated they would remove the needle from the insulin pen. The surveyor then observed O-D remove the needle from the Basaglar KwikPen and place the needle in a sharps container. On February 19, 2025, at 12:44 p.m., O-D stated the licensee completed training on removing insulin needles from insulin pens with ULP two times after the previous follow up survey and had a consult come to the facility as well to provide additional training. O-D stated R1 could become temperamental and argumentative, and they believe this was why the needle was left on the insulin pen. On February 20, 2025, at 9:21 a.m., clinical nurse supervisor (CNS)-J stated ULP were trained to remove the needle off the insulin pen after use and dispose the needle right away into the sharps container. CNS-J stated they started their position with the licensee a month ago and were told all ULP were retrained to do this after the previous survey. The CDC document titled Considerations for Blood Glucose Monitoring and Insulin Administration dated August 7, 2024, recommended injection equipment should be disposed of at point of use in an approved sharps	{0 510}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 02/20/2025
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443		
(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	
{0 510}	Continued From page 8 container. The licensee's undated Infection Control / Gloves policy indicated when handling contaminated materials, employees should carefully remove and dispose of them in proper receptacles. This step helps prevent the spread of contaminants. The licensee's document titled Insulin Pen Medication Protocol with a Reusable Pen dated 2016 indicated after insulin was administered to a resident remove the needle from the pen and discard into sharps container. No further information was provided.	{0 510}			
{0 630} SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by:	{0 630}			
{0 650} SS=D	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of	{0 650}	Not reviewed during this survey.		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 02/20/2025
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443			
(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
{0 650}	Continued From page 9 each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by:	{0 650}	Not reviewed during this survey.		
{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;	{0 680}			

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

**3721 104TH AVENUE NORTH
BROOKLYN CENTER, MN 55443**

Minnesota Department of Health
STATE FORM

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 02/20/2025
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443		
(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 11	{0 810}			
{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. This MN Requirement is not met as evidenced by:	{0 810}			
			Not reviewed during this survey.		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 02/20/2025
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443		
(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
{01500} SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research	{01500}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 02/20/2025
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443			
(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
{01500}	Continued From page 13 based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by:	{01500}	Not reviewed during this survey.		
{01620} SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in	{01620}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 02/20/2025
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
{01620}	Continued From page 14 the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by:	{01620}	Not reviewed during this survey.		
{01760} SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to administer medications as directed by the medication administration record (MAR) and failed to accurately document medications administered	{01760}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 02/20/2025
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
{01760}	Continued From page 15 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, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 admitted to the licensee on July 31, 2023, and began receiving assisted living services. R1's diagnoses included diabetes type 2 (DM2), hypertension, agitation, anxiety, cognitive impairment, and chronic kidney disease. R1's Service Plan (Waiver) - Addendum to Contract signed October 1, 2024, indicated R1 received assistance with appointments, bathing reminders, housekeeping, laundry, behavior management, meals, medication administration, shopping, and transportation. R1's Med Admin Summary - Month dated February 1, 2025, through February 28, 2025, included the following morning medications: amlodipine 10 milligrams (mg), aspirin 81 mg, carvedilol 37.5 mg, chlorthalidone 25 mg, isosorbide ER 60 mg, metformin 500 mg, omeprazole 40 mg, vitamin D3 2000 units (u), Basaglar KwikPen 67 units, insulin lispro 15 u, losartan 50 mg, and Vescepa 2 grams (g). R1's unsigned print out from RTasks (a documenting software program) titled Providers	{01760}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 02/20/2025
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
{01760}	Continued From page 16 Order included all medications listed above with the exception of Vescepa 2 g and a different dosage was noted for insulin lispro which indicated R1 should receive 10 u to 15 u three times per day before meals. R1's record lacked signed providers orders. ADMINISTRATION On February 19, 2025, at 10:12 a.m., the surveyor observed unlicensed personnel (ULP)-A supervise R1's Basaglar insulin administration. The surveyor observed R1 dial a Basaglar KwikPen to 51 u without priming the insulin pen. ULP-A opened the electronic administration record (EMAR), R1 asked if they should show them the insulin pen prior to administration, ULP-A stated, "that is ok", and without ULP-A verifying a dose, R1 administered the insulin into their abdomen. R1 then took a new Basaglar KwikPen, dialed it to 13 units, wasted three units, and administered 10 U to their abdomen. R1 administered a total of 61 u of Basaglar. ULP-A marked verified, set up, administered on the EMAR. R1 stated they believed they administered the correct dosage of Basaglar. R1 stated they believed they administered 65 units of Basaglar and they did not administer 67 units because the 2 units they wasted for priming the insulin pen. R1 stated ULP were "normally" in the living room when they administered their insulins. ULP-A stated they added to the documentation on the EMAR that R1 administered 61 u of Basaglar. The surveyor explained to ULP-A they did not document 61 u being administered to R1 until after the surveyor inquired why R1 received less insulin. The licensee's Medication Administration policy dated April 13, 2022, indicated residents were entitled to the safe administration of medications	{01760}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 02/20/2025
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
{01760}	Continued From page 17 by qualified personnel according to a written medication management plan. DOCUMENTATION On February 19, 2025, at 10:12 a.m., the surveyor observed ULP-A administer the following oral medications to R1: amlodipine 10 mg, aspirin 81 mg, carvedilol 37.5 mg, isosorbide extended release (ER) 60 mg, metformin 500 mg, omeprazole 40 mg, vitamin D3 2000 u, losartan 50 mg, and Vescepa 2 g. The surveyor then observed ULP-A document the above medication as being administered along with chlorthalidone 25 mg. ULP-A stated, "I thought I saw it."(referring to the medication chlorthalidone in the medication bubble packet) Owner (O)-D reviewed with ULP-A how to verify medications with the EMAR. The surveyor inquired if they had the chlorthalidone 25 mg in stock at the facility. The surveyor observed O-D review R1's medications. O-D stated they were unable to find the medication at the facility. O-D stated they would contact the nurse to see if the medication was discontinued. On February 19, 2025, at 10:59 a.m., O-D stated the registered nurse (RN) told them the pharmacy was out of refills for the medication. O-D stated the RN contacted the pharmacy three days ago about the medication. On February 19, 2025, at 11:04 a.m., O-D stated they had trained all employees on medication administration and documentation. O-D stated they had trained ULP-A three times in the last couple of months on medication administration. On February 19, 2025, when the surveyor received the medication administration record from the licensee it showed a hold order placed	{01760}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 02/20/2025
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
{01760}	Continued From page 18 was placed on chlorthalidone 25 mg starting the February 19, 2025, at 11:10 a.m. On February 20, 2025, at 9:27 a.m., clinical nurse supervisor (CNS)-J stated R1's chlorthalidone had not been filled since last week. CNS-J stated they had attempted to contact the pharmacy and prescriber to see if the medication should have been discontinued. CNS-J stated R1 recently went to a medical appointment however, R1 did not return with orders or an after-visit summary. On February 20, 2025, at 9:24 a.m., CNS-J stated ULP were trained to use the five right of medication administration and were trained to cross check the bubble packs with the EMAR to verify the correct medications were being administered. CNS-J stated by cross checking the medications with the EMAR ULP were able to catch if a medication was omitted. The licensee's undated Medication & Treatment Record -Documentation & Refusal indicated, "1.Documentation Requirements: - o Document the date, time, quantity of dosage, and method of administration for all prescribed legend and over-the-counter medications, treatments, or therapies. - o Include the signature and title of the authorized person who provided the assistance and/or administration. - o If medication or treatment/therapy assistance and/or administration were not completed as prescribed, the reason and any follow-up procedures must be documented. - o Documentation of medication/treatment/therapy reminders, assistance, or administration must be completed immediately after the task is done."	{01760}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 02/20/2025
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
{01760}	Continued From page 19	{01760}			
	No further information was provided.				
{01820} SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure written or electronically recorded prescriptions were obtained for one of two residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 admitted to the licensee on July 31, 2023, and began receiving assisted living services. R1's diagnoses included diabetes type 2 (DM2), hypertension, agitation, anxiety, cognitive impairment, and chronic kidney disease. R1's Service Plan (Waiver) - Addendum to Contract signed October 1, 2024, indicated R1	{01820}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 02/20/2025
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
{01820}	Continued From page 20 received assistance with appointments, bathing reminders, housekeeping, laundry, behavior management, meals, medication administration, shopping, and transportation. On February 19, 2025, at 10:12 a.m., the surveyor observed unlicensed personnel (ULP)-A supervise R1's administration of 61 units (u) of Basaglar (incorrect dose) and observed ULP-A and owner (O)-D supervise R1's administration of insulin lispro 15 u. In addition, the surveyor observed ULP-A administer the following medications: amlodipine 10 milligrams (mg), aspirin 81 mg, carvedilol 37.5 mg, isosorbide extended release (ER) 60 mg, metformin 500 mg, omeprazole 40 mg, vitamin D3 2000 u, losartan 50 mg, and Vescepa 2 gram (g). R1's Med Admin Summary - Month dated February 1, 2025, through February 28, 2025, included the following morning medications: amlodipine 10 mg, aspirin 81 mg, carvedilol 37.5 mg, chlorthalidone 25 mg, isosorbide ER 60 mg, metformin 500 mg, omeprazole 40 mg, vitamin D3 2000 u, Basaglar KwikPen 67 units, insulin lispro 15 u, losartan 50 mg, and Vescepa 2 g. In addition to multiple verbal requests, the surveyor requested R1's signed prescriber's order via email on February 19, 2025, at 11:01 a.m., and 12:21 p.m. On February 19, 2025, at 7:03 p.m., via email, the surveyor received an unsigned print out from RTasks (a documenting software program) titled Providers Order dated November 8, 2024, which included all medications listed above with the exception of Vescepa 2 g and a different dosage was noted for insulin lispro which indicated R1 should receive 10 u to 15 u three times per day	{01820}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 02/20/2025
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
{01820}	Continued From page 21 before meals. In addition, the surveyor received prescriber's orders dated November 8, 2024, which included: - "Ok for resident to self-administer insulins and monitor blood sugar level with staff supervision."; - and - "Monitor Blood sugar level twice daily for DM [diabetes mellitus] with staff supervision." On February 19, 2025, via email at 7:20 p.m., O-D wrote, "I have looked everywhere for the signed copy that was faxed back, but unfortunately, I am unable to find it." Attached to the email was a fax confirmation that a document was transmitted to R1's prescriber on November 26, 2024. On February 20, 2025, at 9:29 a.m., clinical nurse supervisor (CNS)-J stated the licensee received faxes for prescriber's orders and then the orders were uploaded into the licensee's electronic system so they were able to easily access the information. CNS-J stated they began employment with the licensee a month ago and believe R1's orders were not uploaded into the computer system. CNS-J stated they believe R1's orders were lost while the licensee was trying to make corrections from the previous survey. The licensee's undated Medication & Treatment Order policy indicated a current written prescriber's order must be obtained for any treatment or medication administration provided to a resident. These orders must be received from an authorized prescriber. No further information was provided.	{01820}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 02/20/2025
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443		
(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
{01880}	Continued From page 22	{01880}			
{01880} SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to store prescription medication securely to permit only authorized personnel to have access. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On February 19, 2025, at 9:51 a.m., during a facility tour, the surveyor observed the licensee's kitchen refrigerator. The refrigerator was unlocked and unsecured and contained a box with two Mounjaro 2.5 milligrams (gm) / 0.5 milliliter (ml) injection pens for R1. In addition, the surveyor observed a secured black tote containing other medication in the kitchen's refrigerator. On February 19, 2025, at 12:08 p.m., owner (O)-D stated they did not know the medication listed above was in the kitchen refrigerator	{01880}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 02/20/2025
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443			
(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
{01880}	Continued From page 23 unsecured. O-D stated ULP were trained to keep all medication that needed refrigeration in the secured black tote in the kitchen refrigerator. O-D stated they have had multiple trainings with the ULP to correct this issue. O-D stated, "it looks like the aide was doing things she wanted to do." On February 19, 2025, at 12:08 p.m., O-D stated the medication listed above was delivered from pharmacy last week. On February 20, 2025, at 9:22 a.m., clinical nurse supervisor (CNS)-J stated ULP were trained to keep refrigerated medication in the locked tote located in the kitchen refrigerator. The licensee's plan of correction dated November 25, 2024, indicated the licensee obtained a lock box for climate-sensitive medications and the lock box key was entrusted exclusively to employees for its access, education provided to staff related to medication storage and security at the facility, and the registered nurse (RN) would conduct random checks weekly of medication storage and security to further ensure compliance. The licensee's undated Medication: Access to Medication policy indicated medications would be stored in secure, climate-controlled areas. No further information was provided.	{01880}			
{01940} SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written	{01940}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 02/20/2025
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443		
(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	
{01940}	Continued From page 24 statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by:	{01940}	Not reviewed during this survey.		
{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 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.	{02290}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 02/20/2025
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443			
(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	
{02290}	Continued From page 25 This MN Requirement is not met as evidenced by:	{02290}	Not reviewed during this survey.		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

February 10, 2025

Licensee

New Hope Health Care LLC
3721 104th Avenue North
Brooklyn Center, MN 55443

RE: Project Number(s) SL37379015

Dear Licensee:

On November 26, 2024, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on September 26, 2024. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the September 26, 2024, survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on September 26, 2024, found not corrected at the time of the November 26, 2024, follow-up survey and/or subject to penalty assessment are as follows:

1750-Delegation Of Medication Administration-144g.71 Subd. 7 - \$3,000.00
1880-Storage Of Medications-144g.71 Subd. 19 - \$500.00
1890-Prescription Drugs-144g.71 Subd. 20

The details of the violations noted at the time of this follow-up survey completed on November 26, 2024 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Also, at the time of this follow-up survey completed on November 26, 2024, we identified the following violation(s):

0340-Correction Orders-144g.30 Subd. 5 - \$3,000.00
0510-Infection Control Program-144g.41 Subd. 3 - \$500.00
1760-Documentation Of Administration Of Medication-144g.71 Subd. 8
1820-Prescriptions-144g.71 Subd. 13

The details of the violation(s) noted at the time of this follow-up survey are delineated on the attached State Form. Only the ID Prefix Tag in the left hand column without brackets will identify these state correction orders. It is not necessary to develop a plan of correction.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$7,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject

to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

IMPOSITION OF FINES:

Level 1: no fines or enforcement.

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

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

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

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

REQUESTING A HEARING

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

To submit a hearing request, please visit:

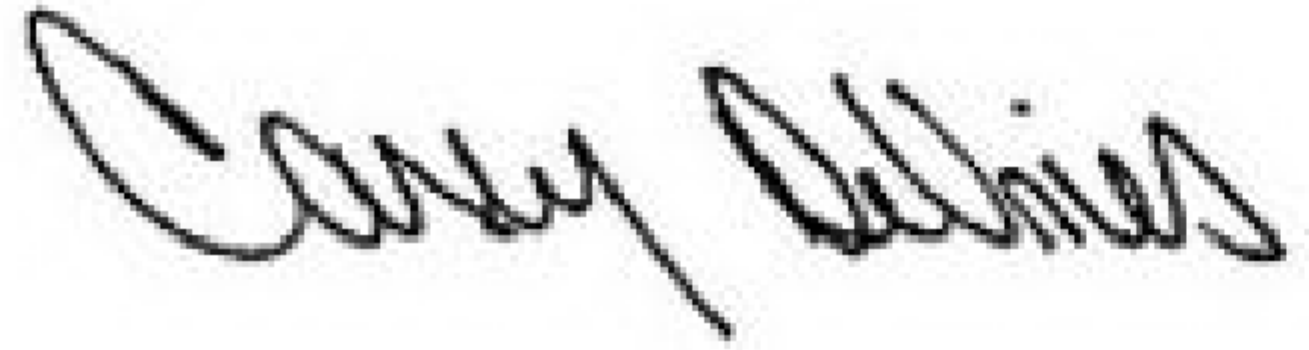
<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

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

We urge you to review these orders carefully. If you have questions, please contact Casey DeVries at 651-201-5917.

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

Sincerely,

A handwritten signature in black ink, appearing to read "Casey DeVries". The signature is written in a cursive, flowing style.

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

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 11/26/2024
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443		
(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: SL37379015-1 On November 25, 2024, through November 26, 2024, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on September 26, 2024. At the time of the survey, there were four residents all of whom received services under the Assisted Living license. As a result of the follow-up survey, the following orders were reissued and/or issued.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
{0 110} SS=C	144G.10 Subdivision 1a Assisted living director license required	{0 110}			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 11/26/2024
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443		
(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	
{0 110}	Continued From page 1 Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by:	{0 110}	Not reviewed during this survey.		
0 340 SS=I	144G.30 Subd. 5 Correction orders (a) A correction order may be issued whenever the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, an agent of the facility, or staff of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction. (b) The commissioner shall mail or email copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must: (1) document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed; and	0 340			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 11/26/2024
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443		
(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
0 340	Continued From page 2 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to comply with the correction plan for immediate order 144G.71 subdivision 7. Delegation of medication administration, issued on September 26, 2024, by the period of a follow-up survey, for one of one resident (R1) with insulin administration. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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: During the follow-up survey on November 25, 2024, through November 26, 2024, the surveyor reviewed the licensee's plan of correction, policies and procedures, resident records, and conducted interviews with unlicensed personnel (ULP)-A, ULP-H, office manager (OM)-F, clinical nurse supervisor (CNS)-G, and owner (O)-D. The licensee's plan of correction dated November 25, 2024, during the follow-up survey, included the following: Correction: o Employees have successfully completed medication administration (insulin) training in Educare (online training program) and have been assessed by the RN as competent to administer medications-Insulin and blood sugar check. o Staff received training and education to confirm	0 340			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 11/26/2024
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443			
(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
0 340	Continued From page 3 the dosage on resident (R1)'s insulin pen, properly prime the pens before use, and monitor the administration process. o The tasks assigned to staff regarding medications labeled as "self-administered" on the MAR have been designed to enable ULPs to review the medication orders or instructions. o Newly hired employees will need to undergo medication administration (insulin/blood sugar check) training in Educare and demonstrate their competency in medication administration with the RN before they are allowed to administer medication (insulin/blood sugar check). Education: o Education/training provided to nursing staff that prior and after medication administration to residents who have orders to self-administer medications, the staff must observe and verify the dosage prior to the residents administering the medication. o Staff received training on insulin administration, the use of gloves, cleaning the insulin pen tip before attaching a needle, priming the pen, and cleaning the injection site prior to administering the insulin shot. Audits: The registered nurse will perform a monthly random audit of staff medication competency to ensure that staff are properly performing medication administration and observing residents self-administer medications. Each month, any negative trends will be brought to the attention of QM meeting for thorough evaluation and suggestions. On November 25, 2024, at 8:03 a.m., CNS-G stated they were recently hired on October 28, 2024, and the previous CNS worked on the correction orders. CNS-G stated they believed there was training related to medication	0 340			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 11/26/2024
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443		
(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
0 340	Continued From page 4 administration provided to staff after the previous survey. On November 25, 2024, at 10:08 a.m., ULP-H stated R1 self-administered insulin, and they supervised. The surveyor inquired how they made sure R1 injected the correct amount of insulin. ULP-H stated they were only documenting the blood glucose and not the insulin given. The surveyor inquired again how much insulin R1 received. ULP-H stated, "it is normally calculated by him, but I was told he is independent with that, but I am not really sure on that." On November 26, 2024, at 9:44 a.m., the surveyor observed ULP-A complete supervision of insulin administration for R1. The surveyor observed ULP-A was unable to locate specific instructions for how to supervise R1's insulin administration, which lead to a medication error. ULP-A stated they were trained by the nurse for insulin administration, and they were to check the resident's name, the dose, and wash hands prior to administration. On November 26, 2024, at 10:40 a.m., CNS-G stated after the last survey ULP were trained to open the electronic medication record (EMAR) to look at the insulin dosages. On November 26, 2024, at 2:00 p.m., O-D stated they trained the ULP multiple times on how to find the insulin dosages in the EMAR. In addition, they contacted RTasks (a documenting software company) to see if they could add a task for the ULP for to document on the supervision of insulin. O-D stated they were unable to add a task for the insulin because R1 self-administered insulin. Although training was provided to ULP after the	0 340			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 11/26/2024
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443		
(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
0 340	Continued From page 5 previous survey the licensee failed to ensure ULP knew where to locate specific instructions related to insulin administration and failed to ensure ULP were competent to supervise R1 with insulin administration. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 340			
{0 480} SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with 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	{0 480}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 11/26/2024
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
{0 480}	Continued From page 6 operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by:	{0 480}			
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the	0 510	Not reviewed during this survey.		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 11/26/2024
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443		
(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
0 510	Continued From page 7 national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program that complied with accepted health care, medical and nursing standards for needles 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 admitted to the licensee on July 31, 2023, and began receiving assisted living services. R1's diagnoses included diabetes type 2 (DM2), hypertension, agitation, anxiety, cognitive impairment, and chronic kidney disease. R1's Service Plan (Waiver) - Addendum to Contract signed October 1, 2024, indicated R1 received assistance with appointments, bathing reminders, housekeeping, laundry, behavior management, meals, medication administration,	0 510			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 11/26/2024
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443		
(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
0 510	Continued From page 8 shopping, and transportation. On November 25, 2024, at 9:54 a.m., the surveyor observed a tackle box in the unsecured kitchen refrigerator that contained an insulin lispro KwikPen with a needle still attached to the pen. On November 26, 2024, at approximately 9:44 a.m., the surveyor observed R1 self-administer Basalgar KwikPen and insulin lispro KwikPen. R1 placed the caps of the KwikPens back over the top of the needles and placed both KwikPens back into the tackle box. Unlicensed personnel (ULP)-A stated R1 kept the insulin needles on the KwikPens until there were about to administer insulin and then they would change the needle from the previous day. ULP-A stated R1 did not reuse the needles. On November 26, 2024, at 10:40 a.m., clinical nurse supervisor (CNS)-C stated insulin needles from the KwikPen should be disposed into the sharps container after use. CNS-C stated staff were trained to remove the needles and were unsure why it did not occur. The CDC document titled Considerations for Blood Glucose Monitoring and Insulin Administration dated August 7, 2024, recommended injection equipment should be disposed of at point of use in an approved sharps container. The licensee's undated Infection Control / Gloves indicated when handling contaminated materials, employees should carefully remove and dispose of them in proper receptacles. This step helps prevent the spread of contaminants. No further information was provided.	0 510			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 11/26/2024
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443		
(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	
0 510	Continued From page 9	0 510			
	TIME PERIOD FOR CORRECTION: Seven (7) days				
{0 630} SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by:	{0 630}			
{0 650} SS=D	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including	{0 650}	Not reviewed during this survey.		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 11/26/2024
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443		
(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	
{0 650}	Continued From page 10 qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by:	{0 650}	Not reviewed during this survey.		
{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	{0 680}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 11/26/2024
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
{0 680}	Continued From page 11 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:	{0 680}			
{0 800} SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by:	{0 800}	Not reviewed during this survey.		
{0 810} SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and	{0 810}	Not reviewed during this survey.		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 11/26/2024
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443			
(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 (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by:	{0 810}			
{01500} SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557;	{01500}	Not reviewed during this survey.		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 11/26/2024
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443			
(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
{01500}	Continued From page 13 (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations,	{01500}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 11/26/2024
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443		
(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
{01500}	Continued From page 14 isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by:	{01500}	Not reviewed during this survey.		
{01620} SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.	{01620}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 11/26/2024
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
{01620}	Continued From page 15	{01620}	Not reviewed during this survey.		
{01750} SS=I	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) documented in writing, specific instructions for medication administration related to insulin for one of one resident (R1) which led to a medication error. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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).	{01750}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 11/26/2024
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443		
(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
{01750}	Continued From page 16 The findings include: R1 admitted to the licensee on July 31, 2023, and began receiving assisted living services. R1's diagnoses included diabetes type 2 (DM2), hypertension, agitation, anxiety, cognitive impairment, and chronic kidney disease. R1's Service Plan (Waiver) - Addendum to Contract signed October 1, 2024, indicated R1 received assistance with appointments, bathing reminders, housekeeping, laundry, behavior management, meals, medication administration, shopping, and transportation. On November 25, 2024, at 7:31 p.m., via email, the surveyor received R1's unsigned After Visit Summary (AVS) dated November 8, 2024. The email indicated the AVS was the current prescribing orders for R1. The AVS included the following: - insulin glargine (Basaglar) inject 67 units (u) subcutaneously every morning. Another medication with the same name was removed. Continue taking this medication and follow the directions you see here. According to our records, you may have been taking this medication differently; and - insulin lispro inject 15 u subcutaneously three times daily before meals. R1's unsigned prescribers orders dated November 8, 2024, was a written request sent to the prescriber for signature by the licensee however, the licensee did not receive back the following orders with signature: - ok for resident to self-administer insulin with staff supervision;	{01750}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 11/26/2024
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443		
(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
{01750}	Continued From page 17 - lantus 67 u subcutaneously one time a day as soon as awakens for the day. May self-administer after set-up of units on pen; and - NovoLog FlexPen (different medication than after visit summary) inject 10-15 u subcutaneously three times before each meal for diabetes. Resident may self-administer after set-up. R1's Med Admin Summary - Actual - Month dated November 2024, included the following: - NovoLog inject 10 to 15 u subcutaneously three times a day before each meal for diabetes. Resident may self-administer after setup; - Lantus 67 u subcutaneously once per day as soon as awakens for the day. Resident may self-administer after setup. R1's medication administration record (MAR) lacked documentation of any insulin being administered due to the insulin being listed on the MAR as a self-administered medication. RTasks (a documenting software program) did not provide an option to record medications as being administered when the self-administered option was chosen, however, would include the prescriber order if the MAR was printed to keep record of the medications prescribed for the resident. In addition, when a medication was set up as "self-administered" on the MAR, it did not create a task for staff including providing the opportunity for unlicensed personnel (ULP) to see the medication order or instructions. Staff were unable to observe the medication dosage or times to be administered unless they ran a printout of R1's entire medication administration record. On November 26, 2024, at 9:44 a.m., the surveyor observed R1 dial Basalgar to 71 u then	{01750}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 11/26/2024
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443		
(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
{01750}	Continued From page 18 press the button until the dosage reached 69 u. ULP-A stated "ok" to tell R1 it was ok to administer the dose of insulin. The surveyor intervened and stated the after-visit summary and the administration record (MAR) indicated they should only be receiving 67 u of insulin. R1 stated that dose was not correct and they really needed to administer 65 u "that is what I am supposed to get." R1 again pressed the button to release more insulin until they were at the dose of 65 u and administered the insulin to their abdomen. R1 then picked up the insulin lispro pen and dialed the dose to 18 u before pressing the button to release insulin until the dose went to 15 u. R1 administered 15 u of insulin lispro to their abdomen. The surveyor inquired how much insulin R1 received. ULP-A stated R1 received 15 u of the second insulin. The surveyor inquired how much Basaglar (the first insulin) R1 should receive. ULP-A picked up the box for the insulin and attempted to read the prescription label. ULP-A stated R1 was supposed to receive 80 u in the morning and afternoon. ULP-A continued to read the prescription label and stated "so he has 67 units but not yet because it is twice a day." R1 inquired if the surveyor was discussing their insulin with ULP-A. The surveyor explained the MAR indicated they should receive 67 u of Basaglar. R1 stated, "no, my doctor told me 65 and that is what I go by, not the 67." ULP-A stated they knew how much insulin to administer by looking at the prescription label. ULP-A stated it was not in the medical record because R1 self-administered insulins. ULP-A stated they were trained by the nurse for insulin administration, and they were to check the resident's name, the dose, and wash hands prior to administration. R1's Individualized Medication Management Plan	{01750}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 11/26/2024
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443		
(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
{01750}	Continued From page 19 dated August 1, 2024, indicated the following for R1: - self-administered insulin after set up; and - medication management tasks that may be delegated to ULP "oral insulin [sic] is self-administer but staff has to observe and make sure it is set on the correct amount. Oral medications are administered by to [sic] him by staff." R1's ongoing assessment dated August 1, 2024, indicated the following for R1: - needed assistance with topical medications and insulin; - medication management tasks that may be delegated to ULP "oral insulin [sic] is self administer but staff has to observe and make sure it is set on the correct amount. Oral medications are administered by to [sic] him by staff."; and - self-administered insulin after setup. R1's Diabetic Flow sheet dated November 4, 2024, through November 25, 2024, indicated R1's blood glucose was taken once per day. R1's blood glucose was in the 100's throughout the month of November. On November 25, 2024, at 10:08 a.m., ULP-H stated R1 self-administered insulin, and they supervised. The surveyor inquired how they made sure R1 injected the correct amount of insulin. ULP-H stated they were only documenting the blood glucose and not the insulin given. The surveyor inquired again how much insulin R1 received. ULP-H stated, "it is normally calculated by him, but I was told he is independent with that, but I am not really sure on that." On November 26, 2024, at 10:11 a.m., R1 stated	{01750}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 11/26/2024
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443		
(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
{01750}	Continued From page 20 they were administering 65 u of the gray insulin pen (Basaglar) and 15 u of the blue pen (insulin lispro). R1 stated they were priming their insulin pen by dialing the Basaglar to 70 units and insulin lispro to 18 u then they pressed the button down to get to 65 u and 15 units, respectively. R1 stated staff just make sure they are administering insulin and "most the time they just smile at me." On November 26, 2024, at 10:40 a.m., clinical nurse supervisor (CNS)-G stated R1 was supposed to receive 67 u of Lantus once daily and staff were to verify the number R1 dialed on the insulin pen was the correct dose and then R1 would self-administer the medication. CNS-G stated R1 was supposed to receive 10-15 u of NovoLog (different medication than the supply on hand) depending on blood sugar level. The surveyor inquired what levels the ULP were to use to determine the dose. CNS-G stated if R1 ate a full meal they would receive 15 u and if R1 did not eat much they would receive 10 u. CNS-G stated after the last survey ULP were trained to open the electronic medication record (EMAR) to look at the insulin dosages. On November 26, 2024, at 9:53 a.m., via email, office manager (OM)-I indicated the unsigned prescribed orders dated November 8, 2024, were faxed to the prescriber for signature however, they never received a response after multiple attempts. In addition, the unsigned orders were changed in September during a virtual appointment. During the appointment the licensee requested the orders however, they were not received, so the staff planned to obtain a signature during R1's medical appointment on November 8, 2024, however the staff member forgot to address the orders at the appointment.	{01750}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 11/26/2024
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443		
(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
{01750}	Continued From page 21 On November 26, 2024, at 2:00 p.m., owner (O)-D stated they trained the ULP multiple times on how to find the insulin dosages in the EMAR. In addition, they contacted RTasks (a documenting software company) to see if they could add a task for the ULP for to document on the supervision of insulin. O-D stated they were unable to add a task for the insulin because R1 self-administered insulin. The licensee's undated Supervision of Staff-Delegated Services policy indicated staff who provided delegated nursing or therapy tasks to the resident must be supervised by a RN or appropriate health professional. This supervision was to verify that work was being performed competently and to identify and address any problems related to staff's ability to perform the tasks. The licensee's undated Delegation of Assisted Living Services policy indicated the registered nurse or licensed health professional must document instructions for delegated tasks in the resident record. In addition, medication management delegation "involves instructing unlicensed personnel in proper medication administration methods, verifying their competency, specifying instructions in writing for each resident, and maintaining communication about individual resident needs". The American Nurses Association document titled "National Guidelines for Nursing Delegation" dated April 1, 2019, indicated a licensed nurse was responsible for ensuring an assignment was carried out completely and correctly. In addition, the nurse cannot delegate nursing judgment or any activity that would involve nursing judgment or critical decision making.	{01750}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 11/26/2024
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443			
(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
{01750}	Continued From page 22	{01750}			
	No further information was provided.				
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to accurately document medications administered for one of two residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include:	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 11/26/2024
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01760	Continued From page 23 R1 admitted to the licensee on July 31, 2023, and began receiving assisted living services. R1's diagnoses included diabetes type 2 (DM2), hypertension, agitation, anxiety, cognitive impairment, and chronic kidney disease. R1's Service Plan (Waiver) - Addendum to Contract signed October 1, 2024, indicated R1 received assistance with appointments, bathing reminders, housekeeping, laundry, behavior management, meals, medication administration, shopping, and transportation. R1's unsigned After Visit Summary dated November 8, 2024, included Jardiance 10 milligrams (mg) by mouth daily and Vascepa 2 grams (g) twice per day with meals. R1's unsigned prescriber orders printed November 8, 2024, included Jardiance 10 mg by mouth at bedtime. The unsigned orders did not contain Vascepa. R1's Med Admin Summary - Actual - Month dated November 2024, included Jardiance 10 mg take at night. The medication administration record did not include Vascepa 2 g twice per day with meals. On November 26, 2024, the surveyor observed a pre-packaged medication packet that contained amlodipine 10 milligrams (mg), aspirin enteric coated (ec) 81 mg, three tablets of carvedilol 12.5 mg, isosorbide mononitrate 60 mg, Jardiance 10 mg, losartan 50 mg, metformin 500 mg, omeprazole 40 mg, two capsules of Vascepa 1 gm, and two vitamin D3 1,000 unit (u) capsules. The surveyor observed ULP-A look at the medications listed on the electronic medication	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 11/26/2024
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01760	Continued From page 24 administration record (EMAR) and then look for the medication in the medication packet. The surveyor did not observe Jardiance 10 mg or Vascepa 2 g on the EMAR. ULP-A opened the bubble pack after they found each medication located on the EMAR in the medication packet, dumped the medication from the medication packet into a medication cup, and administered the medications listed above to R1. On November 26, 2024, at 10:13 a.m., ULP-A stated they were trained by the nurse for medication administration. ULP-A stated they looked to make sure it was the right person and dose of medication. ULP-A stated they looked at the EMAR and then found the medication in the medication packet to ensure the right medication was being given. The surveyor inquired where they documented for the administration of the Jardiance and Vascepa. ULP-A was unable to show the surveyor where they document the two medications and stated the nurse made them believe the correct medication should be located in the medication packet. In addition, ULP-A stated pharmacy must have added those two medications to the medication packet. On November 26, 2024, at 10:19 a.m., the surveyor observed the evening medication packet, the packet did not contain Jardiance 10 mg. On November 26, 2024, at 10:40 a.m., clinical nurse supervisor (CNS)-G stated Jardiance should be administered in the evening per the EMAR. CNS-G stated they believed there was a paper medication administration record for Vascepa at the facility the ULP used to sign off the medication. The surveyor requested the documentation. CNS-G stated medications	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 11/26/2024
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01760	Continued From page 25 should be documented right after administration. The surveyor did not receive any documentation related to Vascepa prior to the end of survey. The licensee's undated Medication & Treatment Record -Documentation & Refusal read, "1.Documentation Requirements: o Document the date, time, quantity of dosage, and method of administration for all prescribed legend and over-the-counter medications, treatments, or therapies. o Include the signature and title of the authorized person who provided the assistance and/or administration. o If medication or treatment/therapy assistance and/or administration were not completed as prescribed, the reason and any follow-up procedures must be documented. o Documentation of medication/treatment/therapy reminders, assistance, or administration must be completed immediately after the task is done." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by:	01820			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 11/26/2024
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01820	Continued From page 26 Based on observation, interview, and record review, the licensee failed to ensure written or electronically recorded prescriptions were obtained for one of two residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 admitted to the licensee on July 31, 2023, and began receiving assisted living services. R1's diagnoses included diabetes type 2 (DM2), hypertension, agitation, anxiety, cognitive impairment, and chronic kidney disease. R1's Service Plan (Waiver) - Addendum to Contract signed October 1, 2024, indicated R1 received assistance with appointments, bathing reminders, housekeeping, laundry, behavior management, meals, medication administration, shopping, and transportation. On November 24, 2024, at 9:44 a.m., the surveyor observed unlicensed personnel (ULP)-A supervise R1's administration of 65 units (u) of basalgar and 15 u of insulin lispro. In addition, ULP-A administered 2 grams (g) of Vascepa, and 10 milligrams (mg) of Jardiance to R1. R1's Med Admin Summary -Actual - Month dated November 2024, included the following:	01820			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 11/26/2024
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01820	Continued From page 27 - NovoLog inject 10 to 15 u subcutaneously three times a day before each meal for diabetes. Resident may self-administer after setup; - Lantus 67 u subcutaneously once per day as soon as awakens for the day. Resident may self-administer after setup. On November 25, 2024, at 7:31 p.m., via email, the surveyor received R1's After Visit Summary (AVS) dated November 8, 2024, from office manager (OM)-I. The email indicated the AVS was the current prescribing orders for R1. The AVS included the following: - Jardiance 10 mg daily; - Vascepa 2 grams (g) by mouth two times a day with meals; - insulin glargine (basaglar) inject 67 u subcutaneously every morning. Another medication with the same name was removed. Continue taking this medication and follow the directions you see here. According to our records, you may have been taking this medication differently; and - insulin lispro inject 15 u subcutaneously three times daily before meals. The AVS lacked a prescriber signature. R1's unsigned prescribers orders dated November 8, 2024, sent to the prescriber for signature but not received back to the licensee included the following: - Jardiance 10 mg at night; - ok for resident to self-administer insulin with staff supervision; - lantus 67 u subcutaneously one time a day as soon as awakens for the day. May self-administer after set-up of units on pen; and - NovoLog FlexPen (different medication than after visit summary) inject 10-15 u subcutaneously three times before each meal for	01820			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 11/26/2024
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01820	Continued From page 28 diabetes. Resident may self-administer after set-up. On November 26, 2024, at 8:09 a.m., clinical nurse supervisor (CNS)-G stated they believed they had signed orders for R1 and would have OM-I email the orders to the surveyor. On November 26, 2024, at 9:53 a.m., via email, OM-I wrote "It appears we initially faxed it [the orders] to them [the provider] for signature and return, but it seems they did not respond. I recently faxed it again, requesting their prompt attention to this matter. I also spoke with our nurse, who mentioned that this change was discussed during a phone appointment in September. At that time, she requested the provider to fax the updated order, but it was not received. Additionally, she followed up with the staff who accompanied [R1] on 11/8, but they forgot to address it. To ensure this is resolved, she has faxed the order again." The licensee's undated Medication & Treatment Order policy indicated a current written prescriber's order must be obtained for any treatment or medication administration provided to a resident. These orders must be received from an authorized prescriber. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820			
{01880} SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and	{01880}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 11/26/2024
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443		
(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
{01880}	Continued From page 29 substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to store prescription medication securely to permit only authorized personnel to have access. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On November 25, 2024, at 9:54 a.m., during a facility tour, the surveyor observed the licensee's kitchen refrigerator. The refrigerator was unlocked and unsecured and contained R1's: six 3 milliliter (ml) prefilled insulin lispro kwickpens, one 3 ml prefilled Basaglar kwikpen, two prefilled Ozempic 2 milligram (mg)/ 3ml pens. In addition, on the kitchen counter was a pill multidose medication packet which contained three tablets of 12.5 milligrams (mg) of carvedilol, one tablet of losartan 50 mg, one tablet of metformin 500 mg, two tablets of Vascepa 1 gram (g), one tablet of atorvastatin 80 mg. On November 25, 2024, at 10:01 a.m., unlicensed personnel (ULP)-H stated the insulins were always kept in the kitchen refrigerator. The	{01880}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 11/26/2024
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443		
(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
{01880}	Continued From page 30 surveyor inquired if they had a locking mechanism to lock the medications in the refrigerator. ULP-H stated they did not have a way to lock the medications located in the kitchen refrigerator. ULP-H stated medications should be locked in the cabinet if not administering them. ULP-H stated the medications were supposed to be administered "today" however, they did not place the medications on the kitchen counter. On November 25, 2024, at 10:19 a.m., clinical nurse supervisor (CNS)-G stated insulins and Ozempic should be kept in the kitchen refrigerator in a locked box. CNS-G stated the last time they were in the facility, the refrigerator contained the locked box, but someone must have removed it, and they would look into what happened. In addition, CNS-G stated all oral medications should be kept in the locked medication cabinet. On November 25, 2024, at 1:38 p.m., the surveyor observed a black lock box delivered to the facility. On November 26, 2024, at 8:03 a.m., CNS-G stated they were unable to find out what happened to the lock box for the medication in the kitchen refrigerator. CNS-G stated they told another staff member to bring a lock box to the facility. On November 26, 2024, at 9:44 a.m., the surveyor saw a black lock box in use to hold R1's refrigerated medications. The licensee's plan of correction dated November 25, 2024, indicated the licensee obtained a lock box for climate-sensitive medications and the lock box key was entrusted exclusively to employees	{01880}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 11/26/2024
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443			
(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
{01880}	Continued From page 31 for its access, education provided to staff related to medication storage and security at the facility, and the registered nurse (RN) would conduct random checks weekly of medication storage and security to further ensure compliance. The licensee's undated Medication: Access to Medication policy indicated medications would be stored in secure, climate-controlled areas. No further information was provided.	{01880}			
{01890} SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to discard expired medication for one of four residents (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, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include:	{01890}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 11/26/2024
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443		
(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
{01890}	Continued From page 32 On November 25, 2024, at 10:43 a.m., unlicensed personnel (ULP)-H stated the nurse reviewed the medications. The surveyor observed the secured medication cabinet and observed the following expired medications: - two bottles of Biktarvy 50-200-25 milligram (mg) for R2 with an expiration date of November 1, 2024. During the previous survey on September 23, 2024, at 12:11 p.m., CNS-C stated expired medications were disposed of at a pharmacy or hospital medication drop box. CNS-C stated they audited the medication cabinet weekly for expired or discontinued medications. The licensee's plan of correction dated November 25, 2024, indicated the registered nurse (RN) would complete an audit of the facility medication cabinet weekly to ensure discontinued and expired medications were destroyed in a timely manner. The licensee's undated Medication Disposal policy indicated expired medications managed by the licensee were disposed of according to the practices of the Minnesota Board of Pharmacy, and labels from the containers were destroyed. No further information was provided.	{01890}			
{01940} SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare	{01940}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 11/26/2024
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443			
(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
{01940}	Continued From page 33 and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by:	{01940}	Not reviewed during this survey.		
{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 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	{02290}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 11/26/2024
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443		
(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	
{02290}	Continued From page 34 condition of admission to the facility. This MN Requirement is not met as evidenced by:	{02290}	Not reviewed during this survey.		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

October 23, 2024

Licensee

New Hope Health Care LLC
3721 104th Avenue North
Brooklyn Center, MN 55443

RE: Project Number(s) SL37379015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on September 26, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement.

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

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

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

In accordance with Minn. Stat. § 144G.31, Subd. 4(a)(5), MDH may impose fine amounts of either \$1,000 or \$5,000 to licensees who are found to be responsible for maltreatment. MDH may impose a fine of \$1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or

financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. MDH also may impose a fine of \$5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

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

St - 0 - 1750 - 144g.71 Subd. 7 - Delegation Of Medication Administration - \$3,000.00

St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - \$3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$6,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

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

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this

section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. to submit a hearing request, please visit:

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

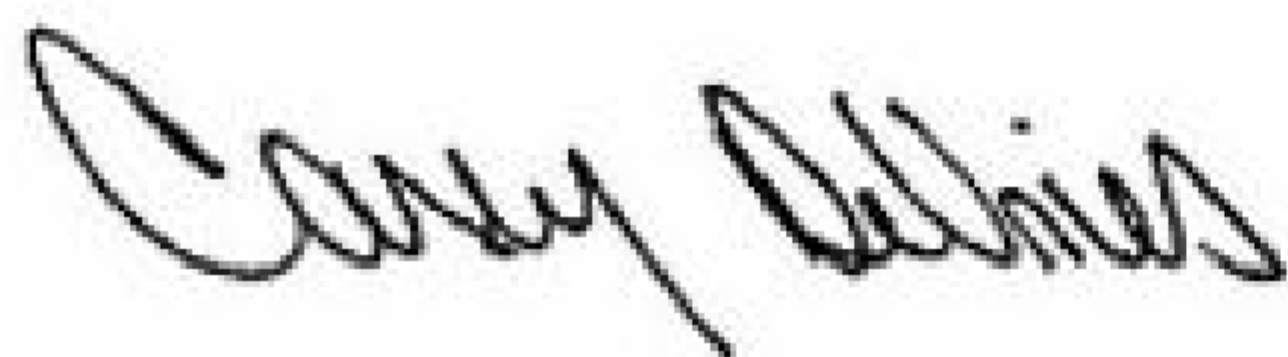
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **<https://forms.office.com/g/Bm5uQEPhVa>**. Your input is important to us and will enable MDH to improve its processes and communication with providers. 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,

A handwritten signature in black ink that reads "Casey DeVries". The signature is written in a cursive, flowing style.

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

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2024
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL37379015-0 On September 24, 2024, through September 26, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were five residents all of whom received services under the Assisted Living license. An immediate correction order was identified on September 24, 2024, issued for SL37379015-0, tag identification 2310. During the survey, the licensee took action to mitigate the immediate risk. However, noncompliance remained, and the scope and level remain unchanged. An immediate correction order was identified on September 25, 2024, issued for SL37379015-0, tag identification 1750.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2024
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443		
(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	Continued From page 1	0 000			
0 110 SS=C	During the survey, the licensee took action to mitigate the immediate risk. However, noncompliance remained, and the scope and level remain unchanged. 144G.10 Subdivision 1a Assisted living director license required Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the licensed assisted living director (LALD) was listed as the Director of Record for the licensee. This had the potential to affect all the licensee's residents, staff, and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On September 23, 2024, at 9:59 a.m., the surveyor observed the Board of Executives for Long-Term Services and Supports (BELTSS) website which indicated licensed assisted living	0 110			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2024
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443			
(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
0 110	Continued From page 2 director (LALD)-F held a current assisted living director license, however, was not listed as the director of record for the licensee. Owner (O)-D stated they were familiar with the LALD being listed as the director of record however, they believed LALD-F accidentally added the sister facility site multiple times instead of the licensee's facility. The licensee's undated Assisted Living Director policy indicated the licensee expected the licensed or permitted director to comply with all requirements set by BELTSS. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110			
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or	0 470			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2024
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443		
(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
0 470	Continued From page 3 safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have a daily work schedule that complied with Assisted Living Facilities: Minnesota Rules Chapter 4659.0180 Subpart 4 posted in a central location accessible to staff, residents, volunteers, and the public as required. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On September 23, 2024, at 9:20 a.m., the surveyor observed unlicensed personnel (ULP)-A working alone within the facility. On September 23, 2024, at 9:26 a.m., the surveyor observed ULP-B enter the facility to	0 470			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2024
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443		
(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
0 470	Continued From page 4 relieve ULP-A from their shift. On September 23, 2024, at 9:30 a.m., the surveyor observed an undated document posted on the living room wall titled Weekly Schedule [licensee's location]. The document was a grid, the rows were titled morning and evening, the columns were dated with days of the week, and the inner blocks contained names of ULP, and work shifts 7:00 a.m. to 7:00 p.m. and 7:00 p.m. to 7:00 a.m. The schedule did not accurately reflect who was working at the facility or the shifts that were being worked. On September 23, 2024, at approximately 10:22 a.m., during the entrance conference, owner (O)-D stated it was an oversight that the staff schedule was not updated. On September 24, 2024, at 2:08 p.m., clinical nurse supervisor (CNS)-C stated it was their responsibility to ensure there was one ULP scheduled every shift. CNS-C stated ULP worked eight-hour shifts. The surveyor inquired why the schedule did not have a date and did not accurately reflect ULP shifts. CNS-C stated O-D was responsible for the staff schedule posting however, the licensee staffing was stable, and it may have been an oversight that the staff schedule was not updated. The licensee's undated 4.06 Staffing & Scheduling policy read, "The daily work schedule must be posted, after redacting direct-care staff members' resident assignments, at the beginning of each work shift in a central location in each building of a facility or campus, accessible to staff, residents, volunteers, and the public. The facility shall not disclose any information that is protected by law from public disclosure."	0 470			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2024
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443		
(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
0 470	Continued From page 5 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470			
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and 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 September 23, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.	0 480			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2024
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 480	Continued From page 6	0 480			
0 630 SS=D	TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates. 144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for one of two residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include:	0 630			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2024
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443		
(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
0 630	Continued From page 7 R3 admitted to the licensee on January 30, 2023, and began receiving assisted living services. R3's Service Plan (Wavier) - Addendum to Contract signed January 30, 2024, indicated R3 received assistance with activities, appointments, bathing, dressing, grooming, glasses care, housekeeping, behavior management, meals, medication administration, blood glucose monitoring, shopping, transfers, transportation, and wheelchair use. R3's Individual Abuse Prevention Plan dated July 17, 2024, indicated R3 was at risk to be abused by others and R3 had a history of aggression that needed redirection. R3's IAPP record lacked an individualized review or assessment of the resident's risk of abusing other vulnerable adults, and the specific measures to be taken to minimize the risk of abuse to the resident or other vulnerable adults and risk of self-abuse. On September 24, 2024, at 2:12 p.m., clinical nurse supervisor (CNS)-C stated R3 was not at risk to abuse others because R3 treated others nicely and had no altercations with other residents. CNS-C stated they were unaware of the requirement to assess the resident risk of abusing others. The licensee's undated Individual Abuse Prevention Plan policy read, "2. Procedure for Abuse Prevention Plan: - The plan includes an individualized review or assessment of the person's susceptibility to abuse by others, including other vulnerable adults. - It assesses the resident's risk of abusing other vulnerable adults. - The plan outlines specific measures to minimize	0 630			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2024
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443		
(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
0 630	Continued From page 8 the risk of abuse to both the individual and other vulnerable adults. - The definition of abuse in this context includes self-abuse." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630			
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by:	0 650			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2024
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443		
(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
0 650	Continued From page 9 Based on interview and record review, the licensee failed to ensure the employee record contained the required content for one of three employees (clinical nurse supervisor (CNS)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: CNS-C was hired on September 17, 2021, to provide supervision and oversight to unlicensed personnel (ULP) and to provide direct care services to residents. CNS-C's employee record lacked documentation of an annual performance review that identified areas of improvement needed and training needs. On September 24, 2024, at 1:45 p.m., owner (O)-D stated they believed they completed a performance evaluation for CNS-C however, they were unable to locate one. On September 24, 2024, at 2:14 p.m., CNS-C stated they could not remember if they received a performance evaluation. The licensee undated Employee Record policy indicated employee records would include evidence of current professional licensure, training, in-service education, competency	0 650			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2024
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443		
(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
0 650	Continued From page 10 testing, job description, annual performance reviews, tuberculosis health screenings, criminal background study, reference checks, orientation, and training. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650			
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.	0 680			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2024
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 680	Continued From page 11 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. 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 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 emergency disaster preparedness plan dated 2022, lacked evidence of the following required content: - annual review; - develop strategies for addressing facility and community-based risks including staffing surges and shortages and evacuation plans; - quarterly review of missing resident policy; - emergency plan (EP) patient population; - policies and procedures for evacuation including transportation; - policies and procedures for medical documents; - names and contact information; and - emergency prep testing requirements. On September 25, 2024, at 12:28 p.m., owner (O)-D stated the licensee reviewed the EPP twice per year, however, did not document the reviews. O-D stated the licensee reviewed the missing resident plan four times per year during quality	0 680			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2024
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 680	Continued From page 12 management meetings, however, did not have the documentation. O-D stated the licensee's back up plan for a shortage in staffing was for O-D and clinical nurse supervisor (CNS)-C to cover the shifts at the facility. O-D stated the licensee has their own vehicle and would transport the residents in the vehicle in case of emergency. O-D verified the EPP lacked information related to transportation. On September 25, 2024, at 1:09 p.m., O-D stated they believed CNS-C completed the drills at the facility however, they were unable to locate documentation. The licensee's undated Disaster Planning and Emergency Preparedness policy indicated the licensee would develop a written emergency disaster plan that included a detailed strategy for evacuation, addresses elements during a disaster or emergency. This plan would incorporate all the necessary elements outline in Appendix Z. No other information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 800 SS=F	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			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2024
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 800	Continued From page 13 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 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: On September 25, 2024, survey staff toured the facility with owner (O)-D. During the tour, the surveyor observed the following: 1. An exit sign was posted above the door leading into the attached garage from the facility. Emergency exits are required to lead directly to the exterior of the building and not through a higher hazard room. 2. There was an accumulation of lint on the walls behind the clothes dryer, creating a potential fire hazard. 3. In occupied resident bedroom 3, an extension cord was plugged in and being used to supply power. The improper use of extension cords creates a fire hazard. During the facility tour interview on September 25, 2024, O-D verified the above listed observations	0 800			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2024
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 800	Continued From page 14 while accompanying on the tour. 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) employee 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) Employees 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 employees 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	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2024
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443		
(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 15 drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with 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 September 25, 2024, owner (O)-D provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee failed to develop a FSEP floor plan evident by the following: The number of resident sleeping rooms were not identified on the posted floor plan dated December 14, 2024. The number of resident sleeping rooms were not identified in the floor plan dated December 29, 2023, in the FSEP located in the emergency preparedness binder. On September 25, 2024, at 10:30 a.m., survey	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2024
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443		
(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 16 staff toured the facility with O-D. During the tour, the surveyor observed number identifiers were posted on resident sleeping room doors. Resident sleeping room identifiers are required to be included on the fire safety and evacuation floor plan. The identifiers installed on the resident sleeping room doors must correspond with the floor plan to provide efficient communication for exiting in the event of a fire or similar emergency. The posted FSEP floor plan dated December 14, 2023, failed to identify the location of the main exit of the facility. The main exit is required to be identified on the plan in order to direct occupants to the exit in the event of an emergency. The licensee failed to develop and maintain a FSEP evident by a record review of the available documentation. The FSEP included a fire safety policy dated April 13, 2022. This policy was a template from a third-party provider and not developed for use at this facility location. The FSEP fire extinguisher location section was blank. The FSEP inappropriately referenced pull fire alarms, which were not installed at this facility. The FSEP 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 evident by a lack of these actions in the plan. The employee actions were limited to the RACE acronym (Rescue, Alarm, Contain, Extinguish/Evacuate). The FSEP failed to include specific fire protection procedures necessary for residents evident by the lack of these procedures in the plan. The FSEP resident procedures were limited to directing residents to stoop or crawl to avoid smoke.	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2024
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 810	Continued From page 17 The FSEP failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. One resident was identified as requiring full assistance during an evacuation, but no procedures were included in the plan. During an interview on September 25, 2024, at 12:10 p.m., O-D verified the FSEP required revision. TRAINING Record review indicated the licensee failed to provide training to employees on the FSEP upon hire and/or at least twice per year. No employee FSEP training records were provided. During an interview on September 25, 2024, at 12:10 p.m., O-D stated employees completed emergency preparedness training using a third-party online training provider and verified this training did not include the facility FSEP. O-D stated employees completed FSEP training, but this was not documented. O-D verified FSEP training records were not available to support this training had been completed. Record review indicated the licensee failed to provide fire safety and evacuation training to residents at least once per year. No resident training records were provided. During an interview on September 25, 2024, at 12:10 p.m., O-D stated residents participated in the facility fire drills and no additional training had been completed. DRILLS Record review indicated the licensee failed to conduct evacuation drills for employees twice per	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2024
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 810	Continued From page 18 year, per shift with at least one evacuation drill every other month evident by a review of completed fire drill records lacking the required frequency and documentation. Seven fire drills were recorded in 2024. The last names of the employees who participated in these drills were not recorded on all of the logs. No evacuation fire drill records were provided for 2023. During an interview on September 25, 2024, at 12:10 p.m., O-D verified the 2024 evacuation drills had not been documented correctly. O-D stated the licensee would email the 2023 fire drill records by the end of the day if located. As of September 27, 2024, at 4:00 p.m., the surveyor had not received any drill records for 2023. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such	01500			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2024
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443		
(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
01500	Continued From page 19 as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by:	01500			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2024
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443		
(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
01500	Continued From page 20 Based on interview and record review, the licensee failed to ensure employees received at least eight (8) hours of training for each 12 months of employment for one of two employees (clinical nurse supervisor (CNS)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: CNS-C was hired on September 17, 2021, to provide supervision and oversight to unlicensed personnel (ULP) and to provide direct care services to residents. CNS-C's employee records included training from 2021 and 2022. CNS-C's employee record lacked training after 2022. On September 24, 2024, at 1:45 p.m., owner (O)-D stated they were unable to locate documentation of annual training for 2023 for CNS-C. On September 24, 2024, at approximately 2:14 p.m., CNS-C stated they did not remember if they completed annual training in 2023. In addition, CNS-C stated O-D had not scheduled 2024 training for the year. The licensee's undated Annual Required Staff Training Policy indicated all staff who performed	01500			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2024
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443		
(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
01500	Continued From page 21 direct care services for the licensee must complete at least eight hours of annual training for each 12 months of employment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500			
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by:	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2024
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01620	Continued From page 22 Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed ongoing resident reassessments that did not exceed 90 days for one of two residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3 admitted to the licensee on January 30, 2023, and began receiving assisted living services. R3's diagnoses included cerebral vascular accident (stroke), unable to ambulate expressive aphasia, diabetes mellitus type 2 with neuropathy, hypertension, myopia of left eye, mild neurocognitive disorder due to traumatic brain injury, cataracts, and urinary incontinence. R3's Service Plan (Wavier) - Addendum to Contract signed January 30, 2024, indicated R3 received assistance with activities, appointments, bathing, dressing, grooming, glasses care, housekeeping, behavior management, meals, medication administration, blood glucose monitoring, shopping, transfers, transportation, and wheelchair use. R3's record included an ongoing 90-day assessments completed January 15, 2024, April 16, 2024, and July 27, 2024, indicating 92 days	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2024
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01620	Continued From page 23 passed between the January 15, 2024, and April 16, 2024, assessment and 102 days passed between the April 16, 2024, and July 27, 2024, assessment. On September 24, 2025, at 2:14 p.m., clinical nurse supervisor (CNS)-C stated they completed assessments upon admission, day 14, every 90 days, and as needed (PRN) with change of condition. CNS-C stated R3 attended a day program and "was not available when I was available". CNS-C stated they respected the R3's wishes and completed the assessment on the date agreed upon. The surveyor inquired if they documented the attempts to complete the assessments on time. CNS-C stated no. The licensee's undated Assessment, Reviews & Monitoring policy indicated ongoing reassessments happen as needed, but not exceeding 90 days from the last assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620			
01750 SS=I	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions	01750			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/26/2024
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443		
(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
01750	Continued From page 24 in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) specified in writing, specific instructions for medication administration related to insulin for one of one resident (R1) which led to a medication error. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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: R1 admitted to the licensee on July 31, 2023, and began receiving assisted living services. R1's diagnoses included diabetes type 2 (DM2), hypertension, agitation, anxiety, cognitive impairment, and chronic kidney disease. R1's Service Plan (Waiver) - Addendum to Contract signed August 30, 2024, indicated R1 received assistance with appointments, bathing reminders, housekeeping, laundry, behavior management, meals, medication administration, blood glucose monitoring six time per day, shopping, and transportation.	01750	During the survey, the licensee took action to mitigate the immediate risk. However, noncompliance remained, and the scope and level remain unchanged.		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2024
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443		
(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
01750	Continued From page 25 R1's prescriber orders signed August 22, 2024, indicated Lantus (Basaglar/insulin glargine, a long-acting insulin) "as soon as [R1] awakens for the day, Inject 69 units subcutaneously once daily". The order indicated "Resident may self-administer after set-up of units on pen". In addition, the orders indicated for NovoLog flex-pen (a fast-acting insulin) "2 x a day", however the instructions read, "Inject 10-15 Units subcutaneously three times daily before each meal for diabetes. Resident may self-administer after set-up". On September 24, 2024, at 9:05 a.m., during a medication administration observation, the surveyor observed R1 dial Basaglar (insulin) Kwikpen to 55 units (U) and insulin lispro Kwikpen (different medication than what was prescribed) to 15 U. The surveyor did not observe R1 prime the insulin pen. The surveyor did not observe ULP-A verify a dosage on the insulin pens prior to administration. R1 administered both insulins to the abdomen while ULP-A observed. The surveyor asked R1 how they primed the insulin pens. R1 stated they dialed the insulin pen to one additional unit more than the required dose and injected it. R1 then ingested the oral medication provided to them by ULP-A. ULP-A documented on the electronic medication administration record (EMAR) all oral medications were received. The surveyor inquired where they documented on R1's insulin. ULP-A attempted to look in the EMAR and was unable to find the insulins in the tasks they were to perform for the day. In the presence of the surveyor, ULP-A asked owner (O)-D where the information for the insulin was located. O-D stated they would call clinical nurse supervisor ((CNS)-C). The surveyor inquired if ULP-A always watched R1 administer insulins. ULP-A stated yes.	01750			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2024
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443		
(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
01750	Continued From page 26 R1's ongoing assessment dated August 1, 2024, indicated the following for R1: - needed assistance with topical medications and insulin; - medication management tasks that may be delegated to an unlicensed personnel (ULP) "oral insulin is self administer but staff has to observe and make sure it is set on the correct amount. Oral medications are administered by to him by staff."; and - self-administered insulin after setup. R1's Individualized Medication Management Plan dated August 1, 2024, indicated the following for R1: - self-administered insulin after set up; and - medication management tasks that may be delegated to ULP "oral insulin is self-administer but staff has to observe and make sure it is set on the correct amount. Oral medications are administered by to [sic] him by staff." R1's lab results dated August 8, 2024, indicated R1's hemoglobin A1C was 11.1 (blood test that measures the percentage of hemoglobin coated with glucose (sugar), which is an indicator of how well a person with diabetes is managing their condition). *On September 25, 2024, The American Diabetes Association's undated document titled "Understanding A1C" indicated the goal for most adults with diabetes was an A1C of less than seven (7) percent. R1's Diabetic Flow sheet dated June 25, 2024, through September 3, 2024, indicated R1's blood glucose was taken twice per day. R1's blood glucose was in the 200's 89 times and 300's two	01750			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2024
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443		
(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
01750	Continued From page 27 times. *On September 25, 2024, The American Diabetes Association's undated document titled "The Big Picture: Checking Your Blood Glucose" suggested the following targets for nonpregnant adults with diabetes: - before meal 80 -130 milligrams (mg)/deciliter (dl); and - 1-2 hours after beginning of the meal less than 180 mg/dl. R1's Med Admin Summary -Actual -Month dated September 2024 included the following: - Lantus 69 units (U) as soon as they awake for the day. Resident may self-administer after set-up of units on pen; and - NovoLog inject 10 to 15 U three times daily before each meal for diabetes. Resident may self-administer after set up. The medication administration record (MAR) lacked documentation of any insulin being delivered/administered due to the insulin being set up on the MAR as a self-administered medication. RTasks (a documenting software program) did not record medications as being administered when self-administered option was chosen, however, would include the prescriber order on the MAR print out to keep record of the medication prescribed for the resident. In addition, when a medication was set up as "self-administered" on the MAR, it did not create a task for staff including providing the opportunity for ULPs to see the medication order or instructions. Staff were unable to observe the medication dosage or times to be administered unless they ran a printout of R1's entire medication administration record. On September 24, 2024, at 9:36 a.m., O-D stated R1 self-administered insulin so it was removed	01750			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2024
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443		
(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
01750	Continued From page 28 from the EMAR. On September 24, 2024, at 10:56 a.m., the surveyor inquired if ULP-A knew the dose of insulin R1 was supposed to administer. ULP-A stated they were there just to ensure R1 took the insulins and they trusted R1 to take the appropriate dose. ULP-A stated they were never instructed to dial the dose for R1 or ensure the correct dose was received. In addition, ULP-A stated R1 was started on Ozempic due to high morning blood sugars in the 200's to 300's. ULP-A stated since Ozempic was started, R1's blood glucose levels had decreased to 110 or 120 in the mornings. On September 24, 2024, at 2:20 p.m., CNS-C stated R1 self-injected their insulins. CNS-C stated R1 knew how to dial the amount and verbalized the amount to the staff members. The surveyor inquired how staff knew how many units R1 should inject. CNS-C stated they communicated to them. CNS-C also stated the ULPs were supposed to remind R1 to prime the insulin pen and if R1 dialed the wrong number of units, ULPs should stop them and change the dose. The surveyor again inquired how staff knew the correct units of insulin ordered. CNS-C repeated they verbally communicated with R1 and ULPs about the dosages and when there was a change to the dose they were updated with that information. The surveyor told CNS-C about observing the wrong dosage being provided to R1. CNS-C stated they would reach out to the doctor as he (R1) may no longer be appropriate to self-administer insulin. On September 25, 2024, at 9:05 a.m., ULP-B stated they prime the insulin pens for R1, dial the dosage, and provide the Kwipens to R1 to	01750			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2024
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443		
(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
01750	Continued From page 29 administer. The surveyor inquired where they find the insulin dosages. ULP-B opened RTasks. The surveyor observed ULP-B browsing through different shifts and tasks, however, was unable to find information related to the insulins. The surveyor asked when the last time was they were able to document on the insulins administration (in Rtasks). ULP-B stated, "a couple of days ago or so". The surveyor observed R1's September 2024 MAR contained zero record/opportunity for ULPs to verify dosages of insulin or administration of insulin. On September 25, 2024, at 9:15 a.m., the surveyor intervened when R1 was administering morning insulin because the insulin on hand (lispro) did not match the current prescriber order (NovoLog). On September 25, 2024, at 9:51 a.m., the surveyor asked CNS-C to observe what insulins were in R1's medication bin. CNS-C stated Basaglar and insulin lispro. The surveyor showed CNS-C the current order for NovoLog and asked why they were administering a different medication (lispro). CNS-C stated they received the insulin lispro from the pharmacy and stated, "they're almost the same (fast-acting) so maybe it is something with insurance". The surveyor inquired why it was not clarified if R1 should receive insulin lispro verses NovoLog. CNS-C stated, "I can't speak in terms of that. Maybe it was an oversight." The surveyor inquired if they had an order for insulin lispro. CNS-C stated they would have to contact the pharmacy for the order. In addition, CNS-C stated Ozempic was ordered on September 3, 2024, and began on September 9, 2024, for R1's high hemoglobin A1C. CNS-C stated they trained ULPs to dial the number of units for R1 however, there was no task set in	01750			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2024
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443		
(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
01750	Continued From page 30 RTasks to direct staff to do so or for them to document they completed the action. CNS-C stated R1 had been self-administering insulin after set-up since they admitted to the facility. CNS-C state R1 may have administered the wrong dose of insulin because they were nervous about the surveyor watching. On September 25, 2024, at 10:05 a.m., certified pharmacy technician (CPT)-E stated R1 was to receive 15 U of insulin lispro three times per day before meals. CPT-E stated the medication was changed because the insulin aspart (NovoLog) that was covered by insurance had been out of stock for a period of time. CPT-E stated they received a prior authorization from the prescriber to send the insulin lispro to the facility. On September 25, 2024, at 11:57 a.m., CNS-C stated they received a verbal order on August 9, 2024, to administer 15 units of Novolog three times per day. The surveyor requested to see the verbal order. CNS-C stated they would have to look for it as they were currently unable to locate it. CNS-C stated after one of R1's medical appointments, R1 returned with an After Visit Summary which indicated R1 received Novolog three times per day. The surveyor inquired how staff would know to give 10 units verses 15 units. CNS-C stated, "that is a question for the doctor, we are supposed to clarify it." The licensee's undated Supervision of Staff-Delegated Services policy indicated staff who provided delegated nursing or therapy tasks to the resident must be supervised by a RN or appropriate health professional. This supervision was to verify that work was being performed competently and to identify and address any problems related to staff's ability to perform the	01750			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2024
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443		
(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
01750	Continued From page 31 tasks. The licensee's undated Delegation of Assisted Living Services policy indicated the registered nurse or licensed health professional must document instructions for delegated tasks in the resident record. In addition, medication management delegation "involves instructing unlicensed personnel in proper medication administration methods, verifying their competency, specifying instructions in writing for each resident, and maintaining communication about individual resident needs". The American Nurses Association document titled "National Guidelines for Nursing Delegation" dated April 1, 2019, indicated a licensed nurse was responsible for ensuring an assignment was carried out completely and correctly. In addition, the nurse cannot delegate nursing judgment or any activity that would involve nursing judgment or critical decision making. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01750			
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to store prescription	01880			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2024
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443		
(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
01880	Continued From page 32 medication securely to permit only authorized personnel to have access. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On September 23, 2024, at approximately 9:30 a.m., during a facility tour, the surveyor observed the licensee's kitchen refrigerator. The refrigerator was unlocked and unsecured and contained the following medications: -R1: four 3 milliliter (ml) prefilled insulin lispro kwickpens, three 3ml prefilled Basaglar kwikpens, one prefilled Ozempic 2 milligram (mg)/ 3ml pen; and -one bottle of over-the-counter milk of magnesia not labeled with any resident's name. On September 23, 2024, at 9:44 a.m., unlicensed personnel (ULP)-B stated insulins were normally kept in the kitchen refrigerator. On September 23, 2024, at 10:52 a.m., the surveyor observed R1's seven-day medication planner with five days of unidentified medications unsecured on the kitchen counter. Owner (O)-D stated medications should be locked in the medication cabinet. O-D stated they believed the ULP forgot to put the medication planner back into the locked medication cabinet this morning. In addition, O-D stated the licensee's medication	01880			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2024
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443			
(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
01880	Continued From page 33 refrigerator broke a few weeks ago and resident medications were moved to the kitchen refrigerator. O-D stated they were supposed to order a new medication refrigerator however, it was their oversight that an order was not placed to replace the medication refrigerator. On September 23, 2024, at 12:11 p.m., clinical nurse supervisor (CNS)-C stated the medications should be locked in the medication cabinet. The surveyor inquired where refrigerated medications were kept. CNS-C stated the licensee had a small medication fridge that broke, and they were currently storing them in the kitchen refrigerator. CNS-C stated they believed a new medication refrigerator was on order. The licensee's undated Medication: Access to Medication policy indicated medications would be stored in secure, climate-controlled areas. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880			
01890 SS=E	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	01890			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2024
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443		
(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
01890	Continued From page 34 review the licensee failed to discard expired medication for two of four 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, 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 September 23, 2024, at approximately 10:52 a.m., the surveyor observed the medication cabinet and observed the following expired medications: -R1's triple antibiotic ointment with and expiration date of June 22, 2023; and -R2's MiraLAX 3350 grams (g) with and expiration date of April 20, 2022. Owner (O)-D stated clinical nurse supervisor (CNS)-C normally took expired medication to the pharmacy for destruction, and they were unaware of why expired medications were left in the medication cabinet. On September 23, 2024, at 12:11 a.m., CNS-C stated expired medications were disposed of at a pharmacy or hospital medication drop box. CNS-C stated they audited the medication cabinet weekly for expired or discontinued medications. The surveyor inquired why the medications listed above were not destroyed. CNS-C stated, "it may have been an oversight." In addition, CNS-C stated R2 no longer took	01890			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2024
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443		
(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
01890	Continued From page 35 MiraLAX. The licensee's undated Medication Disposal policy indicated expired medications managed by the licensee were disposed of according to the practices of the Minnesota Board of Pharmacy, and labels from the containers were destroyed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy	01940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2024
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443		
(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
01940	Continued From page 36 received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a current treatment or therapy management plan to include all required content for one of two residents (R3) who received treatments. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3 admitted to the licensee on January 30, 2023, and began receiving assisted living services. R3's diagnoses included cerebral vascular accident (stroke), unable to ambulate expressive aphasia, diabetes mellitus type 2 with neuropathy, hypertension, myopia of left eye, mild neurocognitive disorder due to traumatic brain injury, cataracts, and urinary incontinence. R3's Service Plan (Wavier) - Addendum to Contract signed January 30, 2024, indicated R3	01940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2024
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443		
(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
01940	Continued From page 37 received assistance with activities, appointments, bathing, dressing, grooming, glasses care, housekeeping, behavior management, meals, medication administration, blood glucose monitoring, shopping, transfers, transportation, and wheelchair use. R3's prescriber orders signed March 27, 2024, included blood glucose monitoring daily. R3's Med Admin Summary - Actual - Month dated September 2024 lacked information related to blood glucose monitoring. R3's ongoing assessment dated July 27, 2024, included R3's history of diabetes and R3 needed assistance with blood glucose monitoring. R3's Master Care Plan dated July 27, 2024, included R3 required assistance with blood glucose monitoring daily. R3's individual treatment plan comprised of multiple documents lacked procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services. On September 24, 2024, at 12:27 p.m., owner (O)-D stated the nurse did not document in RTasks (a documenting software program) when unlicensed personnel (ULP) should contact a nurse with a concern related to blood glucose monitoring. On September 24, 2024, at approximately 2:14 p.m., clinical nurse supervisor (CNS)-C stated they believed they documented when to contact a nurse under the service section of RTasks. CNS-C stated if the instructions were not listed in	01940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2024
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443			
(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
01940	Continued From page 38 the section of RTasks, they were unsure why it would not have been placed there. The surveyor requested CNS-C to provide the documentation. Although requested, the surveyor did not receive documentation related to when a ULP should contact a nurse prior to completion of the survey. The licensee's undated Treatment & Therapy Management Plan policy read, "2. Development of Individualized Record: The agency develops and maintains a current, individualized treatment and therapy management record for each resident. This record contains: - o A statement of the types of services provided. - o Documentation of specific resident instructions relating to treatment or therapy administration. - o Identification of treatment or therapy tasks that can be delegated to unlicensed personnel. - o Procedures for notifying a registered nurse or appropriate licensed health professional in case of issues with treatments or therapy services. - o Any resident-specific requirements related to documentation of received treatment and therapy. - o Verification that all treatments and therapies are administered as prescribed. - o Monitoring of treatment or therapy to prevent complications or adverse reactions." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940			
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a	01970			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2024
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443		
(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
01970	Continued From page 39 description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure there was an accurate prescriber's order for treatments for one of two residents (R1) who received treatments. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 admitted to the licensee on July 31, 2023, and began receiving assisted living services. R1's diagnoses included diabetes type 2 (DM2), hypertension, agitation, anxiety, cognitive impairment, and chronic kidney disease. R1's Service Plan (Waiver) - Addendum to Contract signed August 30, 2024, indicated R1 received assistance with appointments, bathing reminders, housekeeping, laundry, behavior management, meals, medication administration, blood glucose monitoring six time per day, shopping, and transportation.	01970			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2024
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443		
(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
01970	Continued From page 40 On September 24, 2024, at 9:05 a.m., the surveyor observed R1 perform blood glucose monitoring with unlicensed personnel (ULP)-A assisting with set up. R1's prescribers orders signed August 22, 2024, included blood glucose monitoring six time daily. R1's Diabetic Flow sheet dated June 25, 2024, through September 3, 2024, indicated R1's blood glucose was supposed to be taken three time per day, however, was taken twice per day due to resident refusal. R1's ongoing assessment dated August 1, 2024, indicated blood glucose monitoring three times per day with meals however, R1 requested the times of 8:00 a.m., 12:00 p.m., and 7:00 p.m. On September 25, 2024, at 9:46 a.m., clinical nurse supervisor (CNS)-C stated R1 was supposed to receive blood glucose monitoring three times per day however, R1 would refuse one time per day. The surveyor inquired how they knew R1 was supposed to have blood glucose monitoring three times per day. CNS-C stated the computer. The surveyor had CNS-C observe the service plan and provider order which indicated blood glucose monitoring should be conducted six times daily. CNS-C stated that was in error. CNS-C stated in RTasks, (a documenting software program) they entered the blood glucose under "chores" and under "blood glucose monitoring" causing a duplication of the number of times the blood glucose should be taken. CNS-C stated R1's orders were printed out from RTasks and sent with R1 to an appointment. The prescriber who signed the orders was a new doctor for R1. CNS-C stated R1's previous blood glucose monitoring order was for three times per	01970			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2024
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443			
(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
01970	Continued From page 41 day. CNS-C stated they did not clarify the order when it was received. The licensee's Medication & Treatment Orders - Receiving policy indicated all orders must be current and consistent with the nursing assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970			
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 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 interview and record review, the licensee limited the rights of the residents who resided in the facility when the licensee required residents to follow certain house rules. This had the potential to affect all resident residing in the assisted living facility. 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).	02290			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2024
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443		
(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
02290	Continued From page 42 The findings include: On September 23, 2024, at 1:16 p.m., owner (O)-D provided the surveyor with the licensee's admission paperwork that the licensee would provide to prospective residents and residents residing in the facility. An undated document titled Resident Responsibilities / House Rules included: - residents were not allowed to keep knives, sharp object, chemicals, or hazardous material in their rooms; - alcoholic drinks were not allowed anywhere within the premises of the facility; - residents were expected to be home by 10:00 p.m.; and - meals should be consumed at the dining room table. The document indicated by residing in the facility, the resident agreed to abide by the house rules listed above. On September 25, 2024, at 1:09 p.m., O-D stated all residents who resided in the facility signed the house rules. O-D stated the house rules were put into place because of previous issues they had. O-D stated they did not enforce the curfew rule if they know the resident is out with family. O-D stated they did enforce the alcohol due to a previous past experience. O-D stated they were aware the licensee infringed upon the resident's rights however, they thought they could have their own house rules. The licensee's undated Assisted Living Bill of Rights policy indicated the licensee's staff may not request nor obtain from the resident any waiver of any of their rights. No further information was provided.	02290			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2024
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443			
(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
02290	Continued From page 43	02290			
	TIME PERIOD FOR CORRECTION: Twenty-one (21) days				
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical or nursing standards for one of one resident (R3) who utilized bed rails. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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: R3 admitted to the licensee on January 30, 2023, and began receiving assisted living services. R3's diagnoses included cerebral vascular accident (stroke), unable to ambulate expressive aphasia, diabetes mellitus type 2 with neuropathy,	02310	During the survey, the licensee took action to mitigate the immediate risk. However, noncompliance remained, and the scope and level remain unchanged.		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2024
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443			
(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
02310	Continued From page 44 hypertension, myopia of left eye, mild neurocognitive disorder due to traumatic brain injury, cataracts, and urinary incontinence. R3's Service Plan (Wavier) - Addendum to Contract signed January 30, 2024, indicated R3 received assistance with activities, appointments, bathing, dressing, grooming, glasses care, housekeeping, behavior management, meals, medication administration, blood glucose monitoring, shopping, transfers, transportation, and wheelchair use. On September 23, 2024, at 11:02 a.m., during a facility tour, the surveyor observed R3's bed had bilateral (two sides) quarter rail hospital-style bed rails located at the head of the hospital bed. The bed rails were firmly attached to the bed. R3's ongoing assessment dated July 27, 2024, indicated R3 had a bed with side rails. The assessment indicated the side rails were appropriate based on need, were functioning well, and the side rail met FDA guidelines. R3's Bed Safety Assessment dated July 27, 2024, reviewed R3's diagnoses and indicated R3 had a bed with side rails, the side rails were appropriate based on need, were functioning well, and the side rail met FDA guidelines. R3's FDA Hospital Bed Dimensional Limit Recommendations dated September 16, 2024, included the following measurements: -zone one: ten centimeters (cm); -zone two: 6 cm; -zone three: 7 cm; and -zone four 8 cm. R3's record lacked:	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2024
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443		
(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
02310	Continued From page 45 -documentation of R3's cognitive and physical status as they pertain to bed rails to determine the intended purpose for the bed rail and whether R3 was at a high risk for entrapment or falls; -documentation of bed rails for areas of entrapment, stability, and correct installation; -documentation the bed rails were installed, used, and maintained per manufacturer's guidelines; and -documentation the licensee explained the risk versus benefits of the bed rail usage with R3 and/or R3's representative. On September 24, 2024, at 1:28 p.m., clinical nurse supervisor (CNS)-C stated they reviewed the risks and benefits of bed rails with R3 however, did not have documentation of discussion. CNS-C stated they were unaware of the requirement to assess R3's cognitive and physical status as it pertained to the bed rail. CNS-C stated they did complete a cognitive and physical status assessment as it pertained to bed rails upon the initiation of the bed rail however, they did not document the assessment. CNS-C stated because they did not document the information above it was like it was not completed. CNS-C stated the licensee would work with RTasks (a documenting software) to add additional information to the bed rail assessment. The Food and Drug Administration's (FDA), A Guide to Bed Safety, dated December 11, 2017, indicated following information: "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2024
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443		
(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
02310	Continued From page 46 team will help to determine how best to keep the patient safe." The Minnesota Department of Health (MDH) document titled Resources & Frequently - Asked Questions (FAQs) dated April 3, 2024, read, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint. Additionally, the licensee must ensure the bed rail is securely attached to the bed frame per manufacturer guidelines. This includes consideration of any identified contradictions of use such as height/weight restrictions, age, mattress, bed frame set up, etc." In addition, the document read, "Even when bed rails are used according to manufacturer's guidelines, they can present a hazard. The licensee must ensure the resident and/or resident's responsible party has been educated on the risk for injury up to and including death due to entrapment." In addition, the Minnesota Department of Health (MDH) document titled Resources & Frequently - Asked Questions (FAQs) dated April 3, 2024, read "If any aspect of patient care is not documented, it is viewed as not having been completed." The licensee's undated Side Rails Policy indicated when a resident was using side rails on	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37379	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/26/2024
NAME OF PROVIDER OR SUPPLIER NEW HOPE HEALTH CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3721 104TH AVENUE NORTH BROOKLYN CENTER, MN 55443			
(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
02310	Continued From page 47 a bed, they would assess the use, educate the resident, and when appropriate, the responsible person regarding the risks and benefits of side rails. The licensee would verify that the side rail in use is safe and consistent with the manufacturer's directions. In addition, the policy read, "2. Assessment Procedure: - o An RN must conduct an assessment to identify the intended purpose of the side rail and assess any risks associated with its use. If the side rail is acting as a restraint, appropriate action should be taken. 3. Verification of Safety: - o The agency staff will determine if the side rail is safe, which includes ensuring it is used according to manufacturer's directions, installed securely, maintained in good condition, and meets FDA's 2006 recommended dimensional measurements to reduce entrapment. 4. Education: - o The resident, and when appropriate, the resident's representative, shall be informed of the risks and benefits regarding the use of side rails. This education will be documented in the resident's record." No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	02310			



Minnesota Department of Health

3333 Division St #212
St. Cloud
320 223-7300

Type: Full
Date: 09/23/24
Time: 10:30:00
Report: 1051241120

Food and Beverage Establishment Inspection Report

Page 1

Location:

New Hope Health Care Llc
3721 104th Avenue North
Brooklyn Park, MN55443
Hennepin County, 27

Establishment Info:

ID #: 0037978
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7634006350
ID #:

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

The following orders were issued during this inspection.

4-300 Equipment Numbers and Capacities

4-302.12B **** Priority 2 ****

MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.

AT TIME OF INSPECTION, THERE IS NO THIN-TIPPED THERMOMETER.

Comply By: 09/24/24

2-100 Supervision

2-102.12DMN

MN Rule 4626.0033D Post the certified food protection manager certificate.

AT TIME OF INSPECTION, CFPM WAS NOT POSTED.

Comply By: 09/25/24

4-500 Equipment Maintenance and Operation

4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

AT TIME OF INSPECTION, THE NSF 184 DISHWASHER IS NOT FUNCTIONING. EQUIPMENT IS SCHEDULED FOR A REPLACEMENT THIS WEEK OR NEXT WEEK. SEE GENERAL COMMENT SECTION.

Comply By: 10/04/24

Type: Full
Date: 09/23/24
Time: 10:30:00
Report: 1051241120
New Hope Health Care Llc

Food and Beverage Establishment Inspection Report

Page 2

Food and Equipment Temperatures

Process/Item: Upright Cooler
Temperature: 39 Degrees Fahrenheit - Location: MILK
Violation Issued: No

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

MET WITH NURSE EVALUATOR, ASHLEY CREWS.

DISCUSSED THE FOLLOWING WITH THE OWNER, MUNTAHA:

EMPLOYEE ILLNESS LOG
VOMIT -CLEAN UP PROCEDURES
REPORTABLE ILLNESSES AND SYMPTOMS

THE KITCHEN HAS A NSF 184 DISHWASHER, SMOOTH TEXTURE CEILING, LAMINATE COUNTERTOPS WITH HOLLOW BASES, & MDF WOODEN CABINETS.

UNTIL THE DISHWASHER IS REPLACED, FILL A CONTAINER WITH SANITIZER AND MANUALLY WASH DISHES USING THE WASH, RINSE, SANITIZE STEPS.

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 1051241120 of 09/23/24.

Certified Food Protection Manager: Muntaha Yusuf Issa

Certification Number: FM121465 Expires: 02/17/27

Inspection report reviewed with person in charge and emailed.

Signed: _____
Muntaha Issa
Owner

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