



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

April 21, 2025

Licensee
Heartfelt Care LLC
10344 Boundary Creek Terrace
Maple Grove, MN 55369

RE: Project Number(s) SL33112015

Dear Licensee:

On March 25, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on October 9, 2024. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in blue ink, appearing to read 'Jess Schoenecker'.

Jess Schoenecker, Supervisor
State Evaluation Team
Email: Jess.Schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

HHH



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

February 12, 2025

Licensee
Heartfelt Care LLC
10344 Boundary Creek Terrace
Maple Grove, MN 55369

RE: Project Number(s) SL33112015

Dear Licensee:

On January 6, 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 October 9, 2024. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the October 9, 2024 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on October 9, 2024, found not corrected at the time of the January 6, 2025, follow-up survey and/or subject to penalty assessment are as follows:

0820-Fire Protection And Physical Environment-144g.45 Subd. 2 (g)

The details of the violations noted at the time of this follow-up survey completed on January 6, 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.

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

DOCUMENTATION OF ACTION TO COMPLY

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

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.

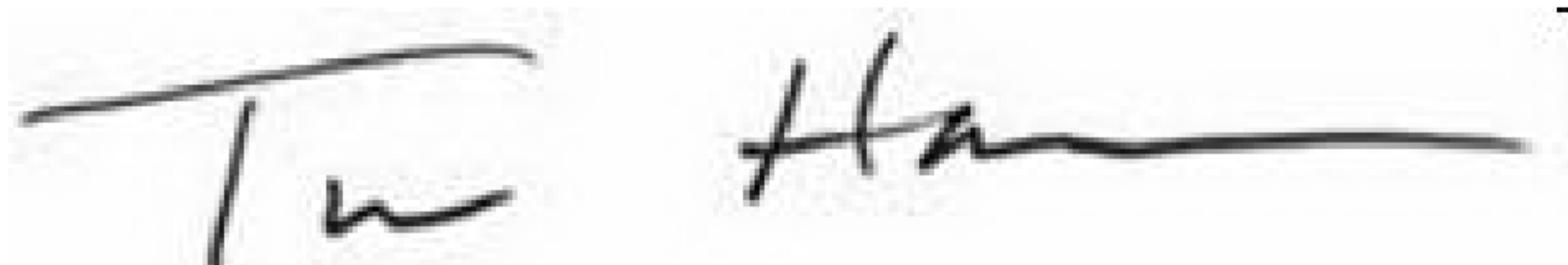
To submit a reconsideration request, please visit:

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

We urge you to review these orders carefully. If you have questions, please contact Tim Hanna at 507-208-8982.

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 "Tim Hanna", is written over a light gray rectangular background.

Tim Hanna, Supervisor
State Engineering Services Section
Email: Tim.Hanna@state.mn.us
Telephone: 507-208-8982 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33112	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 01/06/2025
NAME OF PROVIDER OR SUPPLIER HEARTFELT CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 10344 BOUNDARY CREEK TERRACE MAPLE GROVE, MN 55369			
(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, 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: SL#33112015-1 On January 6, 2025, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on October 9, 2024. At the time of the survey, there were 4 active residents; 4 receiving services under the Assisted Living license. As a result of the revisit, 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 License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
{0 110} 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

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{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.		
{0 480} 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 operation provided soiled items do not	{0 480}			

Minnesota Department of Health

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{0 480}	Continued From page 2 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}	Not reviewed during this survey.		
{0 660} SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis	{0 660}			

Minnesota Department of Health

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{0 660}	Continued From page 3 Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by:	{0 660}	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 received emergency and disaster training are	{0 680}			

Minnesota Department of Health

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{0 680}	Continued From page 4 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}	Not reviewed during this survey.		
{0 780} SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by:	{0 780}			

Minnesota Department of Health

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{0 780}	Continued From page 5	{0 780}	Not reviewed during this survey.		
{0 820} SS=D	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure physical facility elements did not constitute a distinct hazard to life. The licensee failed to provide resident bedrooms with the minimum window opening meeting the minimum state standard for egress. This had the potential to affect some 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 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).	{0 820}			

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{0 820}	Continued From page 6 The findings include: On January 6, 2025, surveyor conducted a revisit to follow-up on orders issued pursuant to a survey completed on October 9, 2024. On January 6, 2025, at 9:40 a.m., per phone conversation, agent (A)-F stated bedroom 4's window has not been replaced yet. A-F also stated a new window for bedroom 4 had been delivered and should be installed within the next two weeks. On January 6, 2025, at 11:10 a.m., surveyor toured the facility with A-F. During the tour, survey staff asked A-F to open the windows in the resident bedroom 4 for measurement. The noncompliant measurements were as follows: Occupied Sleeping Room: Bedroom 4: window measured approximately 17 inches clear width, 42 inches clear height, and 714 square inches total open area. The windows in bedroom 4 did not meet the minimum requirements for clear width. On January 6, 2025, at 11:20 a.m. A-F provided documentation of an active fire watch performed by the licensee. Surveyor explained to A-F that at least one window in each bedroom in a state-licensed facility must meet the minimum state fire code standard for an egress window to be a complying bedroom for resident occupancy. A-F verbally confirmed the findings. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window.	{0 820}			

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{0 820}	Continued From page 7	{0 820}			
	No further information was provided.				
{01620} SS=F	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}			
			Not reviewed during this survey.		
{01640} SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date	{01640}			

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{01640}	Continued From page 8 that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by:	{01640}			
{01760} SS=F	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	{01760}	Not reviewed during this survey.		

Minnesota Department of Health

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{01760}	Continued From page 9 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:	{01760}	Not reviewed during this survey.		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

November 15, 2024

Licensee
Heartfelt Care LLC
10344 Boundary Creek Terrace
Maple Grove, MN 55369

RE: Project Number(s) SL33112015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on October 9, 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 . . ."

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

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

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

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

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

If you have any questions, please contact me.

Sincerely,



Jess Schoenecker, Supervisor
State Evaluation Team
Email: jess.schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

JMD

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER HEARTFELT CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 10344 BOUNDARY CREEK TERRACE MAPLE GROVE, MN 55369			
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0 000	Initial Comments 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: SL33112015-0 On October 7, 2024 through October 9, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were four (4) resident(s); 4 receiving services under the Assisted Living Facility license. On October 8, 2024, an immediate order was issued for SL33112015-0 for tag identification 0820.	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: 33112	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/09/2024
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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: Based on 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 the potential to affect a large portion or all the residents). The findings include: During the entrance conference on October 7, 2024, at approximately 10:45 a.m., administrator (ADM)-A stated they had recently hired a new LALD. On October 7, 2024, at 11:59 a.m., the Minnesota Board of Executives for Long-Term Services and Support (BELTSS) website indicated LALD-B currently held an assisted living director (ALD) license effective thorough October 31, 2024. The website did not indicate LALD-B was the Director of Record for the licensee. On October 8, 2024, at approximately 11:45 a.m.,	0 110			

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0 110	Continued From page 2 LALD-B stated they had submitted the fee to BELTSS to obtain a Shared ALD license. The surveyor observed LALD-B updating their employment record on the BELTSS website to list them as Director of Record for licensee. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110			
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	0 480			

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0 480	Continued From page 3 Beverage Establishment Inspection Report (FBEIR) dated October 7, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included baseline testing and screening for one of two employees (unlicensed personnel (ULP)-E).	0 660			

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0 660	Continued From page 4 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: The licensee's Facility TB Risk Assessment form dated January 23, 2024, indicated the facility was at a low level of TB risk. ULP-E was hired on December 8, 2023, and began providing assisted living services. ULP-E's employee record contained a TB history and screening assessment completed and signed by a registered nurse (RN) on December 9, 2023. The record also contained a negative chest x-ray result dated June 27, 2024. ULP-E's employee record lacked evidence of a two-step tuberculosis skin test (TST) or a QuantiFERON Gold test (a blood test that aids in diagnosing a tuberculosis infection) predating the chest x-ray. On October 8, 2024, at approximately 12:15 p.m., clinical nurse supervisor (CNS)-B stated most of their employees had a Bacillus Calmette-Guerin (BCG) vaccine (a vaccine to prevent tuberculosis) during childhood, so they were routinely sent for chest x-rays. CNS-B stated they were unaware a positive TST or QuantiFERON Gold test was required before proceeding to a chest x-ray. Regulations for Tuberculosis Control in Minnesota	0 660			

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0 660	Continued From page 5 Health Care Settings dated July 2013, indicated baseline TB screening consists of three components: 1. Assessing for current symptoms of active TB disease. 2. Assessing TB history; and 3. Testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step TST (given one to three weeks apart) or single Interferon-Gamma Release Assay (IGRA), a blood test that aids in diagnosing a tuberculosis infection. The licensee's 8.16 Tuberculosis Screening policy dated August 1, 2021, indicated staff would be screened and tested for tuberculosis prior to exposure to residents. The policy also indicated staff screening would include a screen for signs of active TB and a TST or a TB blood test. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents;	0 680			

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0 680	Continued From page 6 (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a written emergency preparedness (EP) plan with all required content. This had the potential to affect all residents, employees, and visitors to 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 residents). The findings include: On October 7, 2024, at approximately 1:45 p.m., clinical nurse supervisor (CNS)-B provided a red binder labeled Emergency Preparation Plan and stated it was the EP plan for the facility. The licensee's EP plan dated June 1, 2024,	0 680			

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0 680	Continued From page 7 lacked the following required content: -documentation of quarterly review of missing resident plan; -policy and procedure to track the location of on-duty staff and sheltered residents; -policies to address a system of medical documentation that preserves resident information, protects confidentiality, and secures/maintains availability of records; and -policy and procedure addressing use of volunteers. On October 9, 2024, at approximately 2:15 p.m., administrator (ADM)-A stated they were unaware the EP plan was missing required content. ADM-A stated the missing resident plan was reviewed but was not documented and the EP plan would be updated. The licensee's Emergency Preparedness policy dated April 13, 2022, read "[licensee] will have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services". The policy referenced CMS State Operations Manual Appendix Z; Minnesota Rules 4659.0100. The licensee's Missing Resident policy dated April 13, 2022, indicated the missing resident procedure would be reviewed by the director and clinical nurse supervisor at least quarterly and changes to the plan would be documented. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			

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0 780	Continued From page 8	0 780			
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that are interconnected so that the actuation of one alarm causes all alarms in the dwelling unit to actuate and failed to keep the facility in compliance with the Minnesota Fire Code. These deficient conditions had the ability to affect all staff and residents.	0 780			

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0 780	Continued From page 9 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). Findings include: On a facility tour on October 8, 2024, between 10:00 a.m. and 11:00 a.m. with clinical nurse supervisor (CNS)-B, the surveyor observed the following deficient condition was observed: SMOKE ALARMS: The surveyor observed that the smoke alarms in the facility were not interconnected. The surveyor explained to the CNS-B that all smoke alarms in the facility shall be interconnected with the 120-volt smoke alarms. The deficient condition was visually verified by the CNS-B accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780			
0 820 SS=G	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be	0 820			

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0 820	Continued From page 10 permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide facilities that were not a distinct hazard to life. This had the potential to directly affect all of the residents and staff. 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 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). Findings include: On a facility tour on October 8, 2024, between 10:00 a.m. and 11:00 a.m. with clinical nurse supervisor (CNS)-B, the surveyor observed that compliant emergency escape and rescue openings were not provided in resident sleeping room 4 in the lower level of the facility. OCCUPIED RESIDENT ROOM: Resident sleeping room 4 emergency escape and	0 820			

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0 820	Continued From page 11 rescue clear window opening measurements is 17" X 42" X 37". This resident room is on the lower level of the facility. The window does not meet the 20 inches minimum requirements for width. The window was measured by the surveyor with the CNS-B present. It was explained to the CNS-B that at least one compliant emergency escape and rescue opening is required within each resident sleeping room. Existing emergency escape and rescue openings are required to meet a minimum clear opening area of 648 square inches and have a minimum dimension of 20 inches in height and a minimum dimension of 20 inches in width. The windowsill height from the floor to the clear opening shall be not more than 48 inches. The deficient condition was visually verified CNS-B accompanying on the tour. The surveyor explained that an immediate correction order will be issued for the above findings. TIME PERIOD FOR CORRECTION: Immediate.	0 820			
01620 SS=F	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	01620			

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01620	Continued From page 12 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: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing client monitoring and reassessment, not to exceed 90 days for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted November 20, 2023, and began receiving assisted living services. R1's record included a Service Plan Waiver	01620			

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01620	Continued From page 13 signed November 20, 2023, indicating R1's services included medication administration, blood glucose monitoring, and behavior management. R1's record included comprehensive nursing assessments dated May 8, 2024, and August 7, 2024, indicating 91 days had passed between the assessments. R2 R2 was admitted on May 10, 2023, and began receiving assisted living services. R2's record included a Service Plan waiver signed on December 11, 2023, indicating R2's services included dressing, grooming, and bathing assistance, catheter care, and medication administration. R2's record included comprehensive nursing assessments dated November 20, 2023, and February 21, 2024, indicating 93 days had passed between the assessments. R2's record lacked any additional assessments until date of discharge on June 30, 2024, indicating 130 days had passed between R2's last assessment and discharge date. R2's record included a Resident Note dated June 30, 2024, indicating R2 was discharged from the facility at 1:04 p.m. On October 8, 2024, at approximately 12:15 p.m., clinical nurse supervisor (CNS)-B stated they were unaware that assessments could not exceed 90 days from the date of the last assessment.	01620			

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01620	Continued From page 14 On October 9, 2024, at approximately 2:00 p.m., administrator (ADM)-A stated R2's 90-day assessment was missed as he may have been in the hospital when the assessment became due. ADM-A stated they did not know why the assessment was not completed between R2's return to the facility and his discharge date. The licensee's 6.01 Assessments, Reviews, and Monitoring policy dated August 1, 2021, indicated resident monitoring and reviews would 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. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620			
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan.	01640			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33112	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/09/2024
NAME OF PROVIDER OR SUPPLIER HEARTFELT CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 10344 BOUNDARY CREEK TERRACE MAPLE GROVE, MN 55369			
(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
01640	Continued From page 15 (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the current service plan included a signature or other authentication by the resident and/or resident's representative to document agreement on the services to be provided 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 was admitted on November 20, 2023, and began receiving assisted living services. R1's record included a Service Plan Waiver signed on November 20, 2023, indicating R1's services included: -activity assistance by home health aide (HHA) two (2) days per week; -activity assistance by HHA four (4) times per day; -appointment reminder/assistance by HHA daily; -behavior management for agitation by HHA three (3) times per day;	01640			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33112	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/09/2024
NAME OF PROVIDER OR SUPPLIER HEARTFELT CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 10344 BOUNDARY CREEK TERRACE MAPLE GROVE, MN 55369		
(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	
01640	Continued From page 16 -behavior management for anxiety by HHA 3 times per day; -behavior management for anxiety by licensed practical nurse (LPN) daily; -behavioral management for orientation issues by HHA 4 times per day; -behavioral management for verbal aggression by HHA five (5) times per day; -housekeeping by HHA daily; -medication administration by HHA monthly; -medication administration by HHA seven (7) times per day; -medication setup by LPN weekly; -recording of blood glucose by HHA six (6) times per day; and -supervision of recording of blood glucose by LPN daily. R1's record included an unsigned Service Plan Waiver printed on October 7, 2024, indicating the following changes had been made to the service plan: -meals and snacks by HHA 3 times daily as needed had been added; -activity assistance by home health aide (HHA) two (2) days per week had been deleted; -behavior management for agitation by HHA three (3) times per day had been changed to daily; -behavior management for anxiety by HHA 3 times per day had been changed to daily; -behavioral management for orientation issues by HHA 4 times per day had been changed to daily; -behavioral management for verbal aggression by HHA five (5) times per day had been changed to daily; -medication administration by HHA seven (7) times per day had been decreased to 3 times per day; -recording of blood glucose by HHA six (6) times per day; and	01640			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33112	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/09/2024
NAME OF PROVIDER OR SUPPLIER HEARTFELT CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 10344 BOUNDARY CREEK TERRACE MAPLE GROVE, MN 55369		
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01640	Continued From page 17 R1's record lacked a current service plan with signature or authentication by the resident or resident's representative with all current services provided by the licensee after addition and revision of services on or after November 20, 2023. On October 8, 2024, at 11:04 a.m., clinical nurse supervisor (CNS)-B stated she was unaware service plans required authentication with all changes. CNS-B stated she would review all service plans and have residents sign any that include revisions. The licensee's 6.08 Service Plan policy dated August 1, 2021, indicated the service plan and any revisions shall include a signature or other authentication by [licensee] and by the resident, or resident's representative, documenting agreement on the services to be provided. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640			
01760 SS=F	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	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33112	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/09/2024
NAME OF PROVIDER OR SUPPLIER HEARTFELT CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 10344 BOUNDARY CREEK TERRACE MAPLE GROVE, MN 55369			
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01760	Continued From page 18 completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document medication administration in resident records 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) 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 number or all the residents). The findings include: R1 was admitted on November 11, 2023, and began receiving assisted living services. R1's record included a Service Plan Waiver dated November 11, 2023, indicating R1 received medication administration services. R1's record included a Medication Administration Summary dated October 2024. The Medication Administration Summary indicated the licensee failed to document administration of the following medications between October 1, 2024, through October 6, 2024: -insulin aspart: inject 10 units subcutaneously three times daily before meals. The licensee failed to document the midday medication	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33112	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/09/2024
NAME OF PROVIDER OR SUPPLIER HEARTFELT CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 10344 BOUNDARY CREEK TERRACE MAPLE GROVE, MN 55369			
(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 administration one (1) out of six (6) days. The licensee also failed to document the 8:00 p.m. medication administration 6 of 6 days. -gabapentin 600 milligrams (mg) by mouth (PO) three times daily. The licensee failed to document the 2:00 p.m. medication administration 1 of 6 days. The licensee also failed to document the 10:00 pm administration 6 of 6 days. -omeprazole 20 mg PO twice daily. The licensee failed to document the evening medication administration 1 of 6 days. -Dulera (for asthma): Inhale two (2) puffs PO twice daily. The licensee failed to document the 8:00 p.m. medication administration 6 of 6 days. -haloperidol 10 mg PO at bedtime. The licensee failed to document the 8:00 p.m. medication administration 6 of 6 days. -insulin glargine: Inject 60 units subcutaneously at bedtime. The licensee failed to document the 8:00 p.m. medication administration 6 of 6 days. -lithium carbonate extended release (ER) 300 mg. Take four (4) tablets at bedtime. The licensee failed to document the 8:00 p.m. medication administration 6 of 6 days. On October 8, 2024, at 11:00 a.m., clinical nurse supervisor (CNS)-B stated medications should be documented following administration. She was unsure of why staff failed to document on the medication administration record. CNS-B stated she would provide re-training to all staff members administering medications. The 7.22 Medication and Treatment Record - Documentation and Refusal policy dated August 1, 2021, indicated the following must be documented in the resident record after providing medication assistance: -date; -time;	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33112	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/09/2024
NAME OF PROVIDER OR SUPPLIER HEARTFELT CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 10344 BOUNDARY CREEK TERRACE MAPLE GROVE, MN 55369			
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01760	Continued From page 20 -quantity of dosage; -method of administration; and -signature and title of the authorized person who provided the assistance and/or administration of the medications/treatments/therapy. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			

Type: Full
Date: 10/07/24
Time: 11:52:15
Report: 7994241183

Food and Beverage Establishment Inspection Report

Page 1

Location:

Heartfelt Care Llc
10344 Boundary Creek Terrace
Maple Grove, MN55369
Hennepin County, 27

Establishment Info:

ID #: 0039074
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7632048125
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.

3-300B Protection from Contamination: cross-contamination, eggs

3-302.11A(1) ** Priority 1 **

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

EGGS FOUND STORED OVER READY TO EAT FOODS IN THE FRIDGE. MOVE THESE AS LOW AS POSSIBLE.

Comply By: 10/07/24

4-300 Equipment Numbers and Capacities

4-302.13A ** Priority 2 **

MN Rule 4626.0710A Provide a readily accessible temperature measuring device for measuring the washing and sanitizing temperatures in manual warewashing operations.

NO TEST STRIPS WERE FOUND ON SITE FOR TESTING THE DISHWASHER. PROVIDED TEST STRIPS AND FACILITY WILL EMAIL PICTURE OF COMPLETED STRIP LATER TODAY.

Comply By: 10/07/24

6-200 Physical Facility Design and Construction

6-202.11A

MN Rule 4626.1375A Provide effective shielding, coated or shatter-resistant light bulbs for all light fixtures where there is exposed food, clean equipment, utensils and linens, or unwrapped single-service or single-use articles.

LIGHTS IN KITCHEN FOUND WITHOUT SHIELDS. REPLACE SHIELD OR PROVIDE SHATTER PROOF BULBS.

Comply By: 10/07/24

Type: Full
Date: 10/07/24
Time: 11:52:15
Report: 7994241183
Heartfelt Care Llc

Food and Beverage Establishment Inspection Report

Page 2

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

INSPECTION CONDUCTED IN THE PRESENCE OF HRD STAFF AND FINDINGS SHARED AT THE END OF INSPECTION.

WILL EMAIL SUPPORTING DOCUMENTS AND LINKS TO HRD STAFF AT THE END OF THE DAY.

KITCHEN IS RESIDENTIAL AND FOOD IS PREPARED FOR SAME DAY SERVICE.

FLOOR IS WOOD LAMINATE, CABINETS ARE WOOD WITH HALLOWED ENCLOSED BASES, gGRANITE COUNTER TOPS AND SMOOTH PAINTED CEILING. ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT ANY TIME THERE IS FOUND TO BE A RISK OF CONTAMINATION OR CONCERN THE PHYSICAL FACILITIES WILL BE REQUIRED TO BE BROUGHT UP TO CODE.

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 7994241183 of 10/07/24.

Certified Food Protection Manager Nabil F Abdullahi

Certification Number: 121463 Expires: 02/17/27

Inspection report reviewed with person in charge and emailed.

Signed: _____
Establishment Representative

Signed: 
Crystal Elva
Public Health Sanitarian 3
St Paul
651-201-3981
Crystal.Elva@state.mn.us

Report #: 7994241183

m

DEPARTMENT OF HEALTH

Minnesota Department of Health

625 Robert Street North
St Paul

No. of RF/PHI Categories Out

1

No. of Repeat RF/PHI Categories Out

0

Legal Authority MN Rules Chapter 4626

Date

10/07/24

Time In

11:52:15

Time Out

Heartfelt Care Llc

Address

10344 Boundary Creek Terrace

City/State

Maple Grove, MN

Zip Code

55369

Telephone

7632048125

License/Permit #

0039074

Permit Holder

Purpose of Inspection

Full

Est Type

Risk Category

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item

Mark "X" in appropriate box for COS and/or R

IN= in compliance

OUT= not in compliance

N/O= not observed

N/A= not applicable

COS=corrected on-site during inspection

R= repeat violation

Compliance Status

COS

R

Supervision

1

IN

OUT

PIC knowledgeable; duties & oversight

2

IN

OUT

N/A

Certified food protection manager, duties

Employee Health

3

IN

OUT

Mgmt/Staff;knowledge,responsibilities&reporting

4

IN

OUT

Proper use of reporting, restriction & exclusion

5

IN

OUT

Procedures for responding to vomiting & diarrheal events

Good Hygienic Practices

6

IN

OUT

N/O

Proper eating, tasting, drinking, or tobacco use

7

IN

OUT

N/O

No discharge from eyes, nose, & mouth

Preventing Contamination by Hands

8

IN

OUT

N/O

Hands clean & properly washed

9

IN

OUT

N/A

N/O

No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed

10

IN

OUT

Adequate handwashing sinks supplied/accessible

Approved Source

11

IN

OUT

Food obtained from approved source

12

IN

OUT

N/A

N/O

Food received at proper temperature

13

IN

OUT

Food in good condition, safe, & unadulterated

14

IN

OUT

N/A

N/O

Required records available; shellstock tags, parasite destruction

Protection from Contamination

15

IN

OUT

N/A

N/O

Food separated and protected

16

IN

OUT

N/A

Food contact surfaces: cleaned & sanitized

17

IN

OUT

Proper disposition of returned, previously served, reconditioned, & unsafe food

Compliance Status

COS

R

Time/Temperature Control for Safety

18

IN

OUT

N/A

N/O

Proper cooking time & temperature

19

IN

OUT

N/A

N/O

Proper reheating procedures for hot holding

20

IN

OUT

N/A

N/O

Proper cooling time & temperature

21

IN

OUT

N/A

N/O

Proper hot holding temperatures

22

IN

OUT

N/A

Proper cold holding temperatures

23

IN

OUT

N/A

N/O

Proper date marking & disposition

24

IN

OUT

N/A

N/O

Time as a public health control: procedures & records

Consumer Advisory

25

IN

OUT

N/A

Consumer advisory provided for raw/undercooked food

Highly Susceptible Populations

26

IN

OUT

N/A

Pasteurized foods used; prohibited foods not offered

Food and Color Additives and Toxic Substances

27

IN

OUT

N/A

Food additives: approved & properly used

28

IN

OUT

Toxic substances properly identified, stored, & used

Conformance with Approved Procedures

29

IN

OUT

N/A

Compliance with variance/specialized process/HACCP

Risk factors (RF) are improper practices or proceeedures identified as the most prevalent contributing factors of foodborne illness or injury. Public Health Interventions (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is not in compliance

Mark "X" in appropriate box for COS and/or R

COS=corrected on-site during inspection

R= repeat violation

COS

R

Safe Food and Water

30

IN

OUT

N/A

Pasteurized eggs used where required

31

Water & ice obtained from an approved source

32

IN

OUT

N/A

Variance obtained for specialized processing methods

Food Temperature Control

33

Proper cooling methods used; adequate equipment for temperature control

34

IN

OUT

N/A

N/O

Plant food properly cooked for hot holding

35

IN

OUT

N/A

N/O

Approved thawing methods used

36

Thermometers provided & accurate

Food Identification

37

Food properly labeled; original container

Prevention of Food Contamination

38

Insects, rodents, & animals not present

39

Contamination prevented during food prep, storage & display

40

Personal cleanliness

41

Wiping cloths: properly used & stored

42

Washing fruits & vegetables

COS

R

Proper Use of Utensils

43

In-use utensils: properly stored

44

Utensils, equipment & linens: properly stored, dried, & handled

45

Single-use/single service articles: properly stored & used

46

Gloves used properly

Utensil Equipment and Vending

47

Food & non-food contact surfaces cleanable, properly designed, constructed, & used

48

X

Warewashing facilities: installed, maintained, & used; test strips

49

Non-food contact surfaces clean

Physical Facilities

50

Hot & cold water available; adequate pressure

51

Plumbing installed; proper backflow devices

52

Sewage & waste water properly disposed

53

Toilet facilities: properly constructed, supplied, & cleaned

54

Garbage & refuse properly disposed; facilities maintained

55

Physical facilities installed, maintained, & clean

56

X

Adequate ventilation & lighting; designated areas used

57

Compliance with MCIAA

58

Compliance with licensing & plan review

Food Recalls:

Person in Charge (Signature)

Date: 10/07/24

Inspector (Signature)

Crystal Eha