Electronically Delivered

December 12, 2024

Licensee
Belong Health Care LLC
7017 88th Avenue North
Brooklyn Park, MN 55445

RE: Project Number(s) SL40326015

Dear Licensee:

This is your **official notice** that you have been **granted your assisted living facility license.** Your license effective and expiration dates remain the same as on your provisional license. Your updated status will be listed on the license certificate at renewal and **this letter serves as proof** in the meantime. If you have not received a letter from us with information regarding renewing your license within 60 days prior to your expiration date, please contact us at (651) 201-5273 or by email at Health.assistedliving@state.mn.us.

The Minnesota Department of Health completed an initial survey on November 7, 2024, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

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.

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. The Department of Health documents state correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Home Care 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 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

Per 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 residents/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 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 the Department of Health 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40326	A. BUILDING: _____ B. WING _____	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELONG HEALTH CARE LLC	7017 88TH AVENUE NORTH BROOKLYN PARK, MN 55445

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments 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: SL40326015-0 On November 4, 2024, through November 7, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were two resident receiving services under the provisional Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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.	
0 460 SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request	0 460		

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0 460	Continued From page 1 assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a means for residents to request assistance for health and safety needs 24 hours a day, seven days a week. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a client'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 the residents). The findings include:	0 460		

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0 460	Continued From page 2 On November 4, 2024, at 11:05 a.m., during the facility tour, the surveyor did not observe a call light system for residents. On November 4, 2024, at 10:13 a.m., during the entrance conference, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated the licensee did not have a call light system in the facility as it was an oversight, and they did not feel this was a need for their residents. LALD/CNS-C stated they would get a system in place. The licensee's undated and untitled policy regarding call light systems indicated the licensee would ensure the safe, prompt, and efficient response to patient (resident) needs by maintaining accessible, operational call light systems for all patients (residents). No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 460		
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	0 480		

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0 480	Continued From page 3 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 November 4, 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		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about	0 550		

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0 550	Continued From page 4 the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post the licensee's grievance procedure along with the required contact information. This had the potential to affect all the licensee's current 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: On November 4, 2024, at 11:05 a.m., during a facility tour, the surveyor did not observe a posting of the licensee's grievance procedure. On November 4, 2024, at 11:28 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated the licensee had the grievance posting that included the required information, however they did not have this posted at the facility due to an oversight. The licensee's 2.10 Complaint/Grievance Posting policy dated July 15, 2021, indicated the licensee would post, in a conspicuous place, information	0 550		

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0 550	Continued From page 5 about their complaint/ grievance procedure; and the posting would include the contact information for the person handling resident complaints/grievances, Offices of Ombudsman for Long-Term Care (OOLTC), Mental Health and Developmental Disabilities (OOMHDD), and Minnesota Adult Abuse Reporting Center (MAARC). No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 590 SS=C	144G.42 Subd. 3 Facility restrictions (a) This subdivision does not apply to licensees that are Minnesota counties or other units of government. (b) A facility or staff person may not: (1) accept a power-of-attorney from residents for any purpose, and may not accept appointments as guardians or conservators of residents; or (2) borrow a resident's funds or personal or real property, nor in any way convert a resident's property to the possession of the facility or staff person. (c) A facility may not serve as a resident's legal, designated, or other representative. (d) Nothing in this subdivision precludes a facility or staff person from accepting gifts of minimal value or precludes acceptance of donations or bequests made to a facility that are exempt from section 501(c)(3) of the Internal Revenue Code. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to follow facility restrictions by	0 590		

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0 590	Continued From page 6 obtaining resident authorization to obtain court appointed conservator or guardianship in the event the resident became incapacitated or unable to properly care for themselves and the resident did not indicate a designated person. This had the potential to affect all residents. 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 the residents). The findings include: On November 4, 2024, at 11:51 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C provided the licensee's blank assisted living contract and indicated the contract was used for all residents. The licensee undated Assisted Living Contract read on page eight the following: In the event resident becomes incapacitated or is unable to properly care for him/herself, and in the event, resident has not designated a person or [licensee] to serve as resident's guardian or conservator, resident hereby grants authority to [licensee] to apply to a court of competent jurisdiction for the appointment of a conservator or guardian to act on behalf of resident. On November 4, 2024, at 1:42 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C confirmed the licensee had not been appointed guardian or conservator for any residents. LALD/CNS-C stated they did not know	0 590		

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0 590	Continued From page 7 it was against the rules for a facility to obtain conservator or guardianship for a resident; and would further discuss with the licensee's consultant and update the contract. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) Days	0 590		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to support protection and safety by not posting information and phone numbers for reporting to the Minnesota Adult Abuse Reporting Center (MAARC) and failed to post the 911 emergency number in common areas and near telephones provided by the assisted living facility. This had the potential to affect all three residents, staff, and visitors.	0 640		

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0 640	Continued From page 8 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 4, 2024, at 11:05 a.m., during a tour of the facility, the surveyor observed the licensee failed to post 911 emergency number in common areas and near telephones provided by the Assisted Living facility; and failed to post information and the reporting number for MAARC. On November 4, 2024, at 11:29 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated they had taken it down to update something but never reposted the information. The licensee's 2.44 Vulnerable Adult Maltreatment - Prevention & Reporting policy dated July 15, 2021, indicated the licensee would post information for reporting suspected crime and maltreatment that included posting 911 emergency number in common areas and near telephones provided by the licensee; and the licensee would post information and the reporting number for MAARC to report suspected maltreatment of a vulnerable adult. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 640		

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0 640	Continued From page 9 (21) days	0 640		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to 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.	0 680		

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0 680	Continued From page 10 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: The licensee's undated EPP lacked evidence of the following required content: - documentation of annual review; - develop and maintain the emergency preparedness (EP); - process for EP collaboration; - development of communication plan; - names and contact information; - emergency officials contact information; - primary/alternate means for communication; - sharing information on occupancy/needs; and - LTC family notifications. On November 7, 2024, at 10:40 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated the licensee would work on the missing content for the licensee's EPP and would be sure to review the plan annually. The licensee's 9.01 Emergency Preparedness Plan - Appendix Z Compliance policy dated July 15, 2021, indicated the licensee's EPP would include all the required elements of appendix Z; and the plan would be reviewed annually. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		

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0 780 SS=E	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the requirements of the Minnesota State Fire Code. This had the potential to affect more than a limited number of residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 780		

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0 780	Continued From page 12 resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). Findings include: On a facility tour on November 5, 2024, from 12:15 p.m. to 1:15 p.m., with licensed assisted living director/ clinical nurse supervisor (LALD/CNS)-C, the surveyor made the following observations of non-compliance with the requirements of the Minnesota State Fire Code (MNSFC): EMERGENCY ESCAPE AND RESCUE WINDOWS The window crank handles used to open the emergency escape and rescue windows were removed in resident sleeping room 4. The window crank handles were reinstalled and secured to the window hardware while the surveyor was onsite. The surveyor explained emergency escape and rescue window crank operating handles are required to be maintained in place for instant use in the event of a fire or similar emergency in accordance with MNSFC Section 1104. ELECTRICAL OUTLET COVERS There was an electrical outlet cover missing on the exterior outlet on the back deck. The surveyor explained that electrical outlet covers are required to be maintained in place as installed at the time of construction in accordance	0 780		

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	40326	A. BUILDING: _____ B. WING _____	11/07/2024

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0 780	Continued From page 13 with MNSFC Section 604. During the facility tour LALD/CNS-C, verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Two (2) day.	0 780		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping 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	0 810		

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0 810	Continued From page 14 evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop the fire safety and evacuation plan with required content. 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 November 5, 2024, at 11:45 a.m., licensed assisted living director/ clinical nurse supervisor (LALD/CNS)-C, 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 provided FSEP dated, failed to include the following: The available FSEP included standard employee procedures, but failed to provide specific employee actions to take in the event of a fire or	0 810		

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0 810	Continued From page 15 similar emergency relative to the facility's building layout and environmental risks. The plan failed to include updated procedures for employees to take for this specific facility in the event of a fire or similar emergency. During an interview on November 5, 2024, at 12:05 p.m., LALD/CNS-C, stated updated employee procedures during a fire or similar emergency were not available and what was provided was the most current documentation. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 810		
0 830 SS=F	144G.45 Subd. 3 Local laws apply Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to follow applicable state and local laws, regulations, standards, ordinances, and codes related to smoking for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).	0 830		

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0 830	Continued From page 16 The findings include: R2 was admitted to licensee on November 29, 2024, with diagnoses of bipolar disorder, schizophrenia, and chronic post-traumatic stress disorder (PTSD). R2's Service Plan dated November 29, 2023, indicated R2 received assistance with bathing, dressing, behavior management, housekeeping, laundry, medication administration, shopping assistance, and socialization services. R2's assessment dated September 19, 2024, indicated R2 smoked about two packs of cigarettes per day and needed encouragement from staff to smoke in designated area. Also, the assessment indicated R2 was not allowed to have a lighter due to safety concerns but R2 could smoke outside with staff monitoring closely at least every 15 minutes. On November 5, 2024, at 12:22 p.m., the surveyor observed R2 telling unlicensed personnel (ULP)-B that they were going to smoke in the garage. ULP-B told R2 it was ok, and they would go with them. On November 5, 2024, at 12:23 p.m., ULP-B stated R2 often smoked in the garage if it was too cold for them to smoke on the porch. Also, ULP-B noted it was raining outside. On November 5, 2024, at 12:25 p.m., the surveyor observed the interior door to the attached garage loosely closed but not completely closed. The surveyor opened the door and observed R2 smoking while sitting on cement steps going into the facility. The car garage door	0 830		

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0 830	Continued From page 17 to the outside was closed. On November 5, at 12:27 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated they could not control the resident smoking and asked the surveyor what they were to do. LALD/CNS-C stated they had residents smoking in the garage at all the facilities owned by the licensee even though they had a designated area for smoking. LALD-C stated it was not fair to punish the licensee for this. On November 5, 2024, at 1:48 p.m., the surveyor observed cigarette ashes on a rug in front of cement steps going into the facility from the garage. The surveyor also observed a fire extinguisher within arm's length by the garage door going inside the facility. The Minnesota Department of Health's Minnesota Clean Indoor Air Act (MCIAA) amendment effective on August 1, 2019, noted smoking was prohibited in health care facilities and clinics. In addition, an indoor area meant a space between a floor and a ceiling that is at least half enclosed by walls, doorways, or windows (opened or closed) around the perimeter. A wall included retractable dividers, garage doors, plastic sheeting or any other temporary or permanent physical barrier. Minnesota State Statute 144.414 Prohibitions; Subdivision 3 dated 2022, indicated under a section titled Health care facilities and clinics: (a) Smoking is prohibited in any area of a hospital, health care clinic, doctor's office, licensed residential facility for children, or other health care-related facility, except that a patient or resident in a nursing home, boarding care facility, or licensed residential facility for adults may	0 830		

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0 830	Continued From page 18 smoke in a designated separate, enclosed room maintained in accordance with applicable state and federal laws. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 830		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety, or personal property of a resident. This had the potential to affect all residents. 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 the residents).	0 970		

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0 970	Continued From page 19 The findings include: On November 4, 2024, at 11:51 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C provided the licensee's blank assisted living contract and indicated the contract was used for all residents. The licensee's undated Assisted Living Contract read on page 18, under indemnification, resident will indemnify and hold harmless provider, its employees and agents from and against any and all claims, actions, damages, and liability and expense in connection with loss of life, personal injury or damage to property, arising from or out of the use by resident of the rented premises or any other part of provider's property, or caused wholly or in part by an act or omission of resident. On November 4, 2024, at 1:42 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated they were not aware the licensee could not include a waiver of liability in the contract. LALD/CNS-C stated they would further discuss with the licensee's consultant and update the contract. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member.	01060		

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01060	Continued From page 20 An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by:	01060		

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01060	Continued From page 21 Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation to the resident, legal representative, and designated representative 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 the residents). The findings include: R1 was admitted to the licensee on April 15, 2024, with diagnoses of anemia, cardiomyopathy, and lower extremity edema. R1's Service Plan dated April 15, 2024, indicated R1 received behavior management, housekeeping, laundry, meal assistance, medication administration, shopping assistance, and socialization services. R1's After Visit Summary dated August 17, 2024, indicated R1 was hospitalized August 15, 2024, through August 17, 2024, due to confusion and weakness. R1's record lacked documentation of R1, R1's legal representative, and R1's designated representative had received a written notice with all the required content for an emergency relocation. On November 6, 2024, at 2:28 p.m., licensed assisted living director/clinical nurse supervisor	01060		

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01060	Continued From page 22 (LALD/CNS)-C stated they had not heard of needing to provide a written notice to a resident if they went to the hospital. LALD/CNS-C stated they had interpreted the Statue differently. The licensee's 1.23 Emergency Relocation policy dated July 20, 2021, indicated in the event of an emergency relocation of a resident, the licensee would provide a written notice that contained the reason for the relocation, the name and contact information for the location to which the resident has been relocated and any new service provider, contact information for the Office of Ombudsman for Long-Term Care, if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known, and a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01290 SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12.	01290		

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01290	Continued From page 23 (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a background study was affiliated with the licensee's assisted living health facility identification (HFID) number for seven of seven unlicensed personnel ((ULP)-A, ULP-B, ULP-D, ULP-E, ULP-G, ULP-H, ULP-I). 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: On November 4, 2024, at 2:28 p.m., the surveyor observed licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C log into NETStudy 2.0 (web-based system used to submit background study requests). The surveyor did not observe ULP-A, ULP-B, ULP-D, ULP-E, ULP-G, ULP-H and ULP-I on the licensee's roster. The surveyor requested LALD/CNS-C to print the licensee's NETStudy 2.0 roster. ULP-A ULP-A was hired on December 19, 2022, as a house manager.	01290		

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01290	Continued From page 24 ULP-B ULP-B was hired on October 5, 2023, as a resident assistant. ULP-D ULP-D was hired on October 29, 2024, as a resident assistant. ULP-E ULP-E was hired on February 14, 2024, as a resident assistant. ULP-G ULP-G was hired on March 18, 2024, as a resident assistant. ULP-H ULP-H was hired on December 12, 2023, as a resident assistant. ULP-I ULP-I was hired on June 17, 2024, as a resident assistant. The licensee's NS2 (NETStudy 2.0) Employee Roster dated on November 4, 2024, at 2:44 p.m., indicated all employees' background studies affiliated to the licensee's HFID. The roster lacked an affiliated background study for ULP-A, ULP-B, ULP-D, ULP-E, ULP-G, ULP-H and ULP-I. On November 4, 2024, at 2:35 p.m., LALD/CNS-C stated they were told if an employee was already working for owner at another licensed facility, then they did not need a new background. LALD/CNS-C stated all employees had been transferred from another facility owned by them. LALD/CNS-C stated they were not aware they needed to affiliate each	01290		

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01290	Continued From page 25 employee's background to this facility's HFID. The licensee's 4.02 Background Studies policy dated July 20, 2021, indicated licensee would complete a Minnesota Department of Human Services (DHS) background study on all employees before they provided direct care or had direct contact with any residents. Also, the policy indicated a copy of the background study would be kept in each individual employee record. No further information provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
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	01620		

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BELONG HEALTH CARE LLC	7017 88TH AVENUE NORTH BROOKLYN PARK, MN 55445

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01620	Continued From page 26 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) completed ongoing resident reassessments and monitoring not to exceed 90 calendar days from the last date of assessment for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R1 R1 was admitted to licensee on April 15, 2024, with diagnoses of anemia, cardiomyopathy, and lower extremity edema. R1's Service Plan dated April 15, 2024, indicated R1 received behavior management, housekeeping, laundry, meal assistance, medication administration, shopping assistance, and socialization services. R1's record included a 14-day nursing assessment complete on April 30, 2024, and a 90-day nursing assessment completed on August 23, 2024. The 90-day assessment completed on	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40326	A. BUILDING: _____ B. WING _____	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELONG HEALTH CARE LLC	7017 88TH AVENUE NORTH BROOKLYN PARK, MN 55445

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	Continued From page 27 August 23, 2024, indicated 115 days had passed since the previous 14-day assessment completed on April 30, 2024. R2 R2 was admitted to licensee on November 29, 2024, with diagnoses of bipolar disorder, schizophrenia, and chronic post-traumatic stress disorder (PTSD). R2's Service Plan dated November 29, 2023, indicated R2 received assistance with bathing, dressing, behavior management, housekeeping, laundry, medication administration, shopping assistance, and socialization services. R2's record included 90-day nursing assessments completed on March 6, 2024, June 9, 2024, and September 19, 2024. The 90-day assessment completed on June 9, 2024, indicated 95 days had passed since the previous 90-day assessment completed on March 6, 2024, and the 90-day assessment completed on September 19, 2024, indicated 102 days had passed since the previous 90-day assessment completed on June 9, 2024. On November 6, 2024, at 1:28 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated they had talked to RN-F who had reported the assessments were late due to resident refusals. On November 6, 2024, at 1:30 p.m., RN-F stated they had documented the residents refusing their assessments, but the assessments were not re-attempted timely. On November 6, 2024, at 1:30 p.m., LALD/CNS-C stated the residents had a right to	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40326	A. BUILDING: _____ B. WING _____	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	Continued From page 28 refuse. The surveyor then observed LALD/CNS-C tell RN-F they will need to find new ways to assess the residents, so the assessments are on time and residents don't refuse. The licensee's 6.01 Assessments, Reviews & Monitoring policy dated July 20, 2021, indicated the RN would conduct a resident reassessment and monitoring no more than fourteen calendar days after initiation of services; and ongoing resident reassessment and monitoring would be conducted as needed based on changes in the needs of the resident and could not exceed 90 calendar days from the last date of the assessment. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01620		

Minnesota Department of Health
Environmental Health, FPLS
P.O Box 64975
Saint Paul
651-201-4500

Type: Full
Date: *11/04/24*
Time: 10:55:51
Report: 1018241198

Food and Beverage Establishment Inspection Report

Location:
BELONG HEALTH CARE LLC
7017 88TH AVENUE NORTH
Brooklyn Park, MN55445
Hennepin County, 27

Establishment Info:
ID #: 0043796
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/24

Operator:

Phone #:
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.

RAW EGGS OBSERVED TO BE STORED OVER READY TO EAT ITEMS IN THE REFRIGERATOR. CORRECTED ON SITE.

Corrected on Site

3-500A Microbial Control: cooling

3-501.13ABC

MN Rule 4626.0380ABC Thaw TCS food by one of the following methods: 1. under mechanical refrigeration that maintains the food temperature at 41 degrees F (4 degrees C) or less; 2. completely submerged under running water at 70 degrees F (21 degrees C) or less with a velocity to remove loose particles on an overflow and the food is maintained at 41 degrees F (5 degrees C) or less; 3. in a microwave oven or; 4. as part of the cooking process.

FROZEN MILK OBSERVED TO BE THAWING IN SINK BASIN. DISCUSSED PROPER THAWING PROCEDURES WITH THE MANAGER.

Corrected on Site

Surface and Equipment Sanitizers

Hot Water: = at 170 Degrees Fahrenheit
Location: DISHWASHER
Violation Issued: No

Food and Equipment Temperatures

Type: Full
Date: *11/04/24*
Time: 10:55:51
Report: 1018241198
BELONG HEALTH CARE LLC

Food and Beverage Establishment Inspection Report

Process/Item: Cold Holding/ BUTTER
Temperature: 40 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: No

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

ESTABLISHMENT IS A RESIDENTIAL HOME WITH RESIDENTIAL EQUIPMENT.

ESTABLISHMENT IS DOING ALL SAME DAY SERVICE OF FOODS.

ESTABLISHMENT CURRENTLY HAS 2 RESIDENTS.

FLOORS, WALLS AND CEILINGS WERE OBSERVED TO BE IN GOOD CONDITION DURING THIS INSPECTION AND WILL BE MONITORED THROUGH THE YEARS.

KITCHEN HAS A TWO BASIN SINK WITH ONE SPECIFICALLY FOR HAND WASHING.

ESTABLISHMENT HAS A NEEDLE POINT THERMOMETER FOR CHECKING FOOD TEMPERATURES.

DISHWASHER HAS SANITIZE FUNCTION AVAILABLE.

DISCUSSED PEST CONTROL AND ILLNESS REPORTING.

VIEWED ILLNESS LOG.

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 1018241198 of 11/04/24.

Certified Food Protection Manager: FRANCES D THIAM

Certification Number: 108339 Expires: 09/30/27

Inspection report reviewed with person in charge and emailed.

Signed: _____
FRANCES D THIAM
MANAGER

Signed: _____
Rebecca Prestwood
Sanitarian 3
6512013777
rebecca.prestwood@state.mn.us