Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

January 6, 2025

Licensee
Hope Rest Homes Inc
7553 University Avenue Northeast
Fridley, MN 55432

RE: Project Number(s) SL34882015

Dear Licensee:

On November 26, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the September 25, 2024, survey were corrected. 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,

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

HHH

Electronically Delivered

October 24, 2024

Licensee
Hope Rest Homes Inc.
7553 University Avenue Northeast
Fridley, MN 55432

RE: Project Number(s) SL34882015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on September 25, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

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

1290 - 144g.60 Subdivision 1 - Background Studies Required - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

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

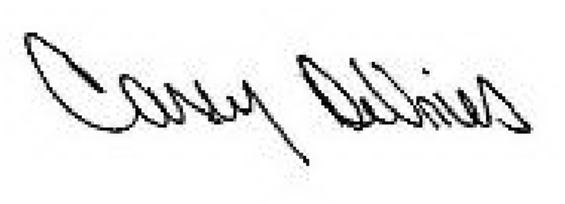
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms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

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

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

If you have any questions, please contact me.

Sincerely,



Casey DeVries, Supervisor
State Evaluation Team
Email: casey.devries@state.mn.us
Telephone: 651-201-5917 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
	34882	A. BUILDING: _____ B. WING _____	09/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPE REST HOMES INC	7553 UNIVERSITY AVENUE NE FRIDLEY, MN 55432

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL34882015-0 On September 24, 2024, through September 25, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction are issued. At the time of the survey there were three residents residing at the facility, all three residents were receiving assisted living services. 1290: An immediate correction order was issued to the provider on September 24, 2024, via draft email indicated the violation was a level 2/Widespread. The violation has been corrected and reflects the appropriate scope and level of Level 3/Widespread (l). The provider took steps to correct the deficiency; however, the scope and level remains at a level 3/Widespread (l).	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.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (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 had the potential to affect all residents of the assisted living facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated September 24, 2024, for the specific Minnesota Food Code deficiencies. The Inspection Report was provided to the licensee on September 25, 2024. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness	0 680		

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0 680	Continued From page 2 (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 observation, interview, and record review, the licensee failed to develop a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when	0 680		

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0 680	Continued From page 3 problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On September 24, 2024, at 12:51 p.m., the surveyor reviewed the licensee's Assisted Living Emergency Preparedness Manual, dated as reviewed on September 17, 2024, which lacked the following required information: - quarterly review of the missing resident plan; - a process for cooperation and collaboration with local, tribal, regional, State and Federal EP to maintain integrated response; - designation of a qualified person, who is authorized in writing, to act in the absence of the administrator; - identification of which staff would assume specific roles in another's absence through succession planning and delegation of authority; - evacuation location and agreements; - evacuation transportation plan; - arrangements and agreements with facilities receiving their residents in the even of evacuation; - shelter in place needs; - resident evacuation priority level of assistance; - development of P/P (policy/procedure) for at minimum food, water and pharmaceutical supplies; - development of P/P for sewage and waste disposal; - development of P/P for system to track the location of on-duty staff and sheltered residents; - development of P/P for if on-duty staff and sheltered residents are relocated, how the licensee must document the specific name/location of the receiving facility or other location;	0 680		

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0 680	Continued From page 4 - development of P/P for a system of medical documentation that preserves resident information, protects confidentiality, and secures/maintains availability of records; - development of P/P to address: use of volunteers, including the process/role for integration; - development of P/P to address role of facility under a waiver declared by the Secretary in accordance with section 1135 of the Act; - development of a communication plan to include all the following names/contact information: staff, entities providing services under agreement, residents' physicians, other facilities, volunteers; - development of a communication plan to include all of the following: method for sharing information from the emergency plan, that the facility has determined appropriate, with residents and their families/representatives; and - development of a communication plan which included: - method for sharing information and medical documentation for residents under the facility's care, as necessary, with other HCPs to maintain continuity of care -means, in event of evacuation, to release resident information as permitted under 45 CFR 164.510(b)(1)(ii) -means of providing information about general condition/ location of residents under the facility's care as permitted under 45 CFR 164.510(b)(4) On September 24, 2024, at 12:05 p.m., licensed assisted living director (LALD)-D stated they did not have an evacuation location in their EPP but would take them to one of their sister facilities; however, they stated they did not have a formal agreement with the other facilities. LALD-D stated they did not have a transportation plan or contract	0 680		

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0 680	Continued From page 5 in their EPP, but they would contact Metro Mobility (transport company) to get assistance. LALD-D stated they did not have an evacuation priority level of assistance in the EPP. LALD-D stated their EPP needed to be reviewed and updated. The licensee's Emergency Preparedness* updated August 1, 2021, indicated: "[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 plan considers the organization's commitment to provide services while ensuring the safety of its employees and residents. [Licensee] will implement the Emergency Management program* as soon as the agency becomes aware of the existence of an emergency." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
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	0 780		

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0 780	Continued From page 6 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 keep the facility in compliance with the Minnesota Fire Code. The deficient condition has the ability to affect all staff and residents. 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 facility tour with licensed assisted living director (LALD)-D on September 24, 2024, between 10:45 a.m. and 12:30 p.m. the following deficient condition was observed:	0 780		

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0 780	Continued From page 7 ELECTRICAL: The surveyor observed that the electrical receptacle outside by the back deck was broken and the weatherproof cover was missing. The surveyor explained to LALD-D that all the electrical receptacles shall be maintained and a weatherproof cover provided. The deficient condition was visually verified by LALD-D accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 800		

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0 800	Continued From page 8 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 facility tour with licensed assisted living director (LALD)-D on September 24, 2024, between 10:45 a.m. and 12:30 p.m. the following deficient conditions were observed: FRONT RAMP: The surveyor observed a loose board on the front ramp. BACK DECK: The surveyor observed loose railing on the back deck. BATHROOM FANS: The surveyor observed the fan in the lower-level bathroom was loose and not operating and the fan in the upper level did not operate. The surveyor explained to LALD-D that the facility shall be kept in good repair and that all the items noted above shall be fixed. The deficient conditions were visually verified by LALD-D accompanying on the tour. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 800		

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0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	0 810		

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0 810	Continued From page 10 review, the licensee failed to develop the fire safety and evacuation plan with the 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: A record review and interview were conducted on September 24, 2024, at approximately12:00 p.m. with licensed assisted living director (LALD)-D on the fire safety and evacuation plan for the facility. FIRE/EVACUATION PLAN: During record review LALD-D stated they do not have a signed contract with a transportation company to move residents to another one of their facilities if the facility needs to be evacuated. Also, the fire safety and evacuation plan were kept in a locked cabinet, was missing important telephone numbers, resident evacuation capabilities and the facility diagram. The surveyor explained to LALD-D that a written signed agreement shall be in place with a transportation company and shall be updated annually. The fire safety and evacuation plan shall be always available and accessible within the facility and that the telephone numbers, resident evacuation capabilities and diagram shall	0 810		

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0 810	Continued From page 11 be added. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01290 SS=I	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. (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 they received a background study (BGS) clearance from NETStudy 2.0 (web-based system use to submit BGS requests to the Department of Human Services (DHS)) in affiliation with the assisted living licensee's health facility identification number (HFID) for one of seven employees (unlicensed personnel (ULP)-B). Further, the licensee failed to re-run a COVID-19 expired BGS for one of one employee (ULP-C) with an expired COVID-19 BGS.	01290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34882	A. BUILDING: _____ B. WING _____	09/25/2024

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01290	Continued From page 12 This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's HFID was 34882. ULP-B ULP-B was hired on June 1, 2021, to provide direct cares to residents. The licensee's Employee List form dated September 24, 2024, indicated ULP-B was a current employee for the licensee. The licensee's posted Staffing Schedule form, with unspecified dates, indicated ULP-B worked the overnight shift on Monday through Friday every week. ULP-B's employee record and facility NETStudy 2.0 report lacked evidence a BGS was completed. ULP-C ULP-C was hired on July 20, 2021, to provide direct cares to residents. The licensee's Employee List form dated September 24, 2024, indicated ULP-C was a current employee with the licensee. The licensee's posted Staffing Schedule form, with unspecified dates, indicated ULP-C worked	01290		

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01290	Continued From page 13 the day shift on Saturday and Sunday every week. ULP-C's employee record and facility NETStudy 2.0 report lacked evidence a BGS was completed after their waived COVID-19 BGS expired on December 31, 2022. On September 24, 2024, at 9:53 a.m., the surveyor observed the licensee's NETStudy 2.0 form, completed today (September 4, 2024), with licensed assisted living director (LALD)-D which indicated ULP-B did not have a completed BGS. It further indicated the licensee did not re-run a BGS on ULP-C after their waived COVID-19 BGS expired on December 31, 2022. LALD-D stated they did not complete a BGS for ULP-B when they were hired. LALD-D stated both ULP-B and ULP-C were current employees who were currently working with residents independently. LALD-D stated they did not know what a COVID-19 expired BGS was; the surveyor had to explain it to them. They stated they were in charge of completing BGSs for staff. On September 24, 2024, at 1:03 p.m., LALD-D stated they think ULP-B's BGS was run under their old home care license prior to the new regulations which started on August 1, 2021. LALD-D stated they contacted NETStudy and were told their home care license information was no longer available in NETStudy 2.0. LALD-D stated unfortunately they did not have any documentation of ULP-B's BGS. On September 24, 2024, the Minnesota Department of Human Services website indicated the following: Emergency studies completed during the COVID-19 pandemic were no longer valid.	01290		

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01290	Continued From page 14 Individuals who only had an emergency study must have a fully compliant, fingerprint-based background study. Roster maintenance - Individuals with a completed emergency study will remain on the entity's roster unless the entity removes the individual. Entities should remove individuals with emergency studies that are no longer affiliated; - If the individual should no longer be affiliated and has a new fully compliant background study, the entity should wait until the individual is separated and then remove both the emergency study and fully compliant study from their roster at the same time; - All entities are responsible for maintaining their rosters regularly and removing study subjects from their roster when they are no longer affiliated; and - Entities are responsible for identifying who needs to submit a new background study. For help identifying which study subjects still have an emergency study and need a fully compliant study, entities should refer to the instructional guide, "Identifying Emergency Studies" in the help section of NETStudy 2.0. The licensee's Recruitment and Hiring policy dated August 1, 2021, indicated: "The Criminal Background Check will be submitted to Minnesota Department of Human Services (DHS) following the step-by-step procedure established by DHS: i. The director or designee is responsible for initiating the criminal background study for new employees ii. NetStudy 2.0 (or current version) will be used for the background check iii. The employee will be directed to locations established by DHS to obtain fingerprint scans	01290		

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01290	Continued From page 15 iv. Employees will be instructed that photographic identification will be required." No further information was provided. TIME PERIOD FOR CORRECTION: Immediate The provider took steps to correct the deficiency at the time of survey; however, the scope and level remain unchanged at I.	01290		
01610 SS=D	144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan 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. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed an initial comprehensive nursing assessment on, or	01610		

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01610	Continued From page 16 before, the date of admission for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: R2 was admitted to the licensee on October 25, 2022. R2's Service Plan dated October 25, 2022, indicated R2 received services for housekeeping, laundry, medication administration, meal assistance, shopping and safety checks. R2's Admission Assessment dated October 28, 2022, was completed three days after R2's admission. On September 25, 2024, at 9:07 a.m., the surveyor observed R2's medication administration and transfer from their bed to their electric wheel chair with a one-person assist and the use of R2's slide-board. On September 25, 2024, at 10:13 a.m., licensed assisted living director (LALD)-D stated R2's admission assessment was completed late. LALD-D searched through RTasks (charting software) during the interview and stated there were no further assessments completed for R2 prior to the admission assessment completed on October 28, 2022.	01610		

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01610	Continued From page 17 On September 25, 2024, at 11:03 a.m., clinical nurse supervisor (CNS)-A stated they were not employed with the licensee when R2's admission assessment was completed but stated R2's admission assessment was completed late; they were aware of the required assessment schedule for resident admissions. The licensee's Assessment and Reassessment policy dated August 1, 2021, indicated, "The initial RN assessment shall be completed prior to the date on which the prospective resident executes a contract or on the date on which the prospective resident moves in, whichever is earlier. If necessary, based on geography or urgent or unexpected circumstances, the assessment may be conducted via telecommunications based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01610		
01620 SS=E	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	01620		

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01620	Continued From page 18 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: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted a comprehensive assessment within 14 days of the initiation of services for one of two residents (R2). The licensee failed to conduct a comprehensive assessment every 90 days for two of two residents (R2, R3). Further, the licensee failed to conduct a change of condition assessment for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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).	01620		

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01620	Continued From page 19 The findings include: R2 was admitted to the licensee on October 25, 2022. R2's Service Plan dated October 25, 2022, indicated R2 received services for housekeeping, laundry, medication administration, meal assistance, shopping and safety checks. R2's Admission Assessment was completed on October 28, 2022. R2's 14-day assessment was completed on November 14, 2022; the assessment was three days past due. R2's record included a Change in Condition assessment dated December 27, 2023, a 90-day Assessment on April 1, 2024, and 90-day Assessment on July 1, 2024. The following assessments were past due for the 90 day assessment requirement: -95 days between the December 27, 2023, and April 1, 2024, or five days past due; and -91 days between the April 1, 2024, and July 1, 2024, or one day past due. On September 25, 2024, at 8:59 a.m., R2 stated they were no longer being transferred by two people with the use of a Hoyer Lift; they stated they had gotten stronger over the past few months. R2 stated they now only required one person to assist them with the use of a slide-board (used to transfer residents by sliding on a board). R2 stated they no longer required a two person assist with any of their cares. On September 25, 2024, at 9:07 a.m., the surveyor observed R2 medication administration and transfer from their bed to their electric wheelchair with a one-person assist and the use	01620		

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01620	Continued From page 20 of R2's slide-board. R2's record lacked a change of condition assessment when R2's condition improved requiring a change in the level of assistance they required. R2's April 1, 2024, and July 1, 2024, both indicated R2 was a two-person transfer and required the use of a Hoyer lift (a sling lift used to transfer residents). R3 R3 was admitted to the licensee on June 17, 2020. R3's Service Plan dated September 25, 2024, indicated R3 received services for housekeeping, laundry, meal assistance and medication administration. R3's record included a 90-Day Assessments on April 1, 2024, and July 1, 2024; there were 91 days between assessments, or one day past due. On September 25, 2024, at 10:13 a.m., licensed assisted living director (LALD)-D searched through RTasks (charting software) during the interview and stated there were no further assessments completed for R2 or R3. LALD-D some of the 90 day assessments were completed late. On September 25, 2024, at 11:03 a.m., clinical nurse supervisor (CNS)-A stated they were not employed with the licensee when most of the above mentioned assessments were completed but was aware of the required assessment frequency for R2 and R3's assessments. CNS-A	01620		

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01620	Continued From page 21 stated they should have completed a change of condition assessment for R2 when their condition improved. The licensee's Assessment and Reassessment policy dated August 1, 2021, indicated: "6. The RN will provide a reassessment visit to update the evaluation of the resident and services no more than 14 days after initiation of services. 7. Ongoing resident reassessments must be conducted by an RN and cannot exceed 90 days from the last date of assessment. 8. Ongoing resident monitoring must be conducted as needed based on changes in the needs of the resident and may be completed by other licensed nurses acting within their scope of licenses." No additional 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	01640		

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01640	Continued From page 22 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: Based on observation, interview, and record review, the licensee failed to obtain a resident, or resident representative's, signature when a change was made to services and service plan for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: R2 was admitted to the licensee on October 25, 2022. R2's record included a signed Service Plan effective October 25, 2022. R2's most recent service plan effective September 24, 2024, lacked a signature and included additional services not found on the signed Service Plan from October 25, 2022. The unsigned, Service Plan from September 24, 2024, included the following additional services not found on the	01640		

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01640	Continued From page 23 signed Service Plan from October 25, 2022: -record blood glucose; -record blood pressure; -record incontinence; -supervision blood glucose; -supervision blood pressure; -supervision; -therapeutic exercises; -toileting; and -transfer assist. On September 25, 2024, at 9:07 a.m., the surveyor observed R2's medication administration and transfer from their bed to their electric wheelchair with a one-person assist and the use of R2's slide-board. On September 25, 2024, at 8:59 a.m., R2 stated they were no longer being transferred by two people with the use of a Hoyer Lift; they stated they had gotten stronger over the past few months. R2 stated they now only required one person to assist them with the use of a slide-board (used to transfer residents by sliding on a board). R2 stated they no longer required a two person assist with any of their cares. On September 25, 2024, at 11:03 a.m., clinical nurse supervisor (CNS)-A stated they were not sure how often a service plan needed to be updated, and they updated it if there were changes. CNS-A stated they should have had R2 sign the updated service plan. The licensee's Service Plan policy dated August 1, 2021, indicated: "3. The service plan must be revised, if needed, based on resident review or reassessment. 4. The initial service plan and any revisions are signed by a representative from Hope Rest	01640		

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01640	Continued From page 24 Homes and the resident or resident ' s representative, indicating agreement with the services to be provided." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the required verbatim notice was posted at the facility main entrance to disclose electronic monitoring activity. 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: On September 24, 2024, at 9:21 a.m., the	03090		

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03090	Continued From page 25 surveyor observed the main entrance of the facility which lacked the required verbatim notice to disclose electronic monitoring. On September 24, 2024, at 9:57 a.m., licensed assisted living director (LALD)-D stated they did not have the required verbatim notice since they did not have video cameras in their facility. The surveyor explained the required notice was required regardless. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090		

Minnesota Department of Health
Food, Pools, and Lodging Services
625 Robert Street North
St. Paul
6512014500

Type: Full
Date: *09/24/24*
Time: 10:40:14
Report: 1029241329

Food and Beverage Establishment Inspection Report

Location:

Hope Rest Homes Inc
7553 University Avenue Ne
Fridley, MN55432
Anoka County, 02

Establishment Info:

ID #: 0038485
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 6129787023
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.

2-300 Personal Cleanliness

2-301.14B-G ***** Priority 1 *****

MN Rule 4626.0075B-G Food employees must wash their hands after: using the toilet; coughing or sneezing; using a handkerchief or disposable tissue; using tobacco; eating or drinking; handling soiled equipment or utensils; caring for or handling service animals or fish in an aquarium, molluscan shellfish or crustacea in a display tank; as frequently as necessary during food preparation to remove soil, contamination, and to prevent cross-contamination when changing food preparation tasks; when switching between working with raw food and working with RTE food; before donning gloves for working with food; and touching bare human body parts other than clean hands and clean exposed portions of arms.

COOK TOUCHED FACE WITH GLOVES ON AND ATTEMPTED TO CONTINUE TO COOK WITHOUT HANDWASH AND GLOVE CHANGE. CORRECTED DURING INSPECTION.

Comply By: 09/24/24

7-200 Toxic Supplies and Applications

7-204.11 ***** Priority 1 *****

MN Rule 4626.1620 Discontinue using chemical sanitizers, including chemical sanitizing solutions generated on site and other chemical antimicrobials on food-contact surfaces that do not meet the requirements specified in 40 CFR part 180, section 180.940, or part 180, subpart E, section 180.2020.

CHLORINE IN SPRAY BOTTLE GREATER THAN 200 PPM. CORRECTED DURING INSPECTION TO ~150 PPM. REP INSTRUCTED TO MAINTAIN BETWEEN 50-200 PPM.

Comply By: 09/24/24

4-300 Equipment Numbers and Capacities

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

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

NO SMALL DIAMETER PROBE THERMOMETER OR OTHER THERMOMETER. REP INSTRUCTED TO OBTAIN A SMALL DIAMETER PROBE THERMOMETER.

Comply By: 09/24/24

5-200C Plumbing: Maintenance, fixture location

5-205.11AB ***** Priority 2 *****

MN Rule 4626.1110AB The handwashing sink must be accessible at all times for employee use, and must be used only for handwashing.

HANDWASHING SINK USED FOR FOOD PREP. CORRECTED DURING INSPECTION. REP INSTRUCTED TO ONLY USE HANDWASHING SINK FOR HANDWASHING.

Comply By: 09/24/24

7-100 Toxic Labeling

7-102.11 ***** Priority 2 *****

MN Rule 4626.1595 Clearly label all working containers used for storing poisonous or toxic materials from bulk supplies such as sanitizers and cleaners, with the common name of the product.

CHLORINE SOLUTION NOT LABELED ON SPRAY BOTTLE. CORRECTED DURING INSPECTION.

Comply By: 09/24/24

4-600 Cleaning Equipment and Utensils

4-601.11C

MN Rule 4626.0840C Clean non-food contact surfaces of equipment and maintain free of accumulations of dust, dirt, food residue, and other debris.

ACCUMULATION OF GREASE AND GRIME ON CEILING. REP INSTRUCTED TO CLEAN AND MAINTAIN CLEAN.

Comply By: 09/24/24

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.16

MN Rule 4626.1540 Hang mops to dry after each use and do not store mops in a manner that will soil walls, equipment or supplies.

WET MOP NOT HANGED TO AIR DRY. REP INSTRUCTED TO HANG TO AIR DRY.

Comply By: 09/24/24

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.19

MN Rule 4626.1555 Keep the toilet room doors closed except during cleaning and maintenance operations.

BATHROOM DOOR OPEN. CLOSED DURING INSPECTION. REP INSTRUCTED TO KEEP CLOSED WHEN NOT BEING CLEANED OR MAINTAINED.

Comply By: 09/24/24

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Surface and Equipment Sanitizers

CHLORINE (NaOCl): = >200PPM at Degrees Fahrenheit
Location: SPRAY BOTTLE
Violation Issued: Yes

CHLORINE (NaOCl): = ~150PPM at Degrees Fahrenheit
Location: SPRAY BOTTLE
Violation Issued: No

HOT WATER: = at 166 Degrees Fahrenheit
Location: DISHWASHER
Violation Issued: No

Food and Equipment Temperatures

Process/Item: COLD HOLD/MILK
Temperature: 37 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: No

Process/Item: COLD HOLD/TOMATO SAUCE
Temperature: 40 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: No

Process/Item: COLD HOLD/MILK
Temperature: 40 Degrees Fahrenheit - Location: DOWNSTAIRS REFRIGERATOR
Violation Issued: No

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

ESTABLISHMENT HAS TILE FLOOR, WOOD/MDF CABINETRY AND DRAWERS WITH LAMINATE COVERINGS, AND SMOOTH PAINTED WALLS AND CEILING. IDENTIFIED ISSUES ADDRESSED WITH OPERATOR.

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 1029241329 of 09/24/24.

Certified Food Protection Manager: GAMI S. NASIR

Certification Number: FM113111 Expires: 10/04/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
GAMI NASIR
LALD

Signed: Trevor McCliment
Trevor McCliment
Public Health Sanitarian
Metro District Office
651-201-3957
trevor.mccliment@state.mn.us

Report #: 1029241329

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Food, Pools, and Lodging Services
625 Robert Street North
St. Paul

No. of RF/PHI Categories Out	2	Date	09/24/24
No. of Repeat RF/PHI Categories Out	0	Time In	10:40:14
Legal Authority MN Rules Chapter 4626		Time Out	

Hope Rest Homes Inc	**Address** 7553 University Avenue Ne	**City/State** Fridley, MN	**Zip Code** 55432	**Telephone** 6129787023
License/Permit # 0038485	**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 Hygenic 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 proceedures 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	X	Thermometers provided & accurate		
		Food Identification		
37		Food properly labled; 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		Warewashing facilities: installed, maintained, & used; test strips		
49	X	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	X	Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55	X	Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) **Date:** 09/25/24

Inspector (Signature) Trevor McCliment