DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

November 18, 2025

Licensee
Point-One Home Health LLC
4500 East 46th Street
Minneapolis, MN 55406

RE: Project Number(s) SL37592016

Dear Licensee:

On November 11, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on August 14, 2025. 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,

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

CLN

Electronically Delivered

October 2, 2025

Licensee
Point-One Home Health LLC
4500 East 46th Street
Minneapolis, MN 55406

RE: Project Number(s) SL37592016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 14, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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;
Level 3: a fine of $1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 4: a fine of $3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 5: a fine of $5,000 per violation, 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:

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $1,000.00
St - 0 - 0810 - 144g.45 Subd. 2 (b-F) - Fire Protection And Physical Environment - $1,000.00
St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required $1,000.00

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,

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

CLN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37592	A. BUILDING: _____ B. WING _____	08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POINT-ONE HOME HEALTH LLC	4500 EAST 46TH STREET MINNEAPOLIS, MN 55406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL#37592016 On August 11, 2025, through August 14, 2025, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 2 residents; 2 receiving services under the Assisted Living license. On August 11, 2025, an immediate correction order was issue for tag identification 1290. During the course of the survey, the licensee took action to mitigate the imminent risk. Noncompliance remained and the scope and level remain unchanged.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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0 480	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A,	0 480		

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0 480	Continued From page 2 existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated August 12, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24	0 480		

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0 480	Continued From page 3 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program that complies with accepted health care, medical and nursing standards for infection control. The deficient practice had the potential to affect residents, employees, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the	0 510		

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0 510	Continued From page 4 situation has occurred only occasionally). The findings include: On August 11, 2025, at approximately 11:30 a.m., during a tour of the facility, the surveyor observed an oxygen concentrator device in the living room with oxygen tubing connected. The oxygen tubing ran along the living room wall baseboard through the hallway and into a resident's (R3) room. The end of the oxygen tubing was stored coiled up next to a television stand with the nasal cannula resting on the floor and parts of the oxygen tubing in R3's room was covered with cigarette ash. On August 11, 2025, at approximately 11:35 a.m., R3 stated the oxygen tubing was used twice in the last three days due to the air quality outside. On August 11, 2025, at approximately 11:40 a.m., licensed assisted living director/clinic nursing supervisor (LALD/CNS)-A stated licensee can't recall the last time the oxygen tubing was cleaned or replaced but it was probably replaced once a month. The licensee's 8.01 Infection Control policy dated November 2, 2021, indicated the licensee has a system for preventing, identifying, and controlling infections for the health and safety for residents, staff, and guests. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		

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0 580	Continued From page 5	0 580		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to implement and maintain a quality management program (QMP) appropriate to the size of the facility and relevant to the type of services provided. This had the potential to affect all 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 August 11, 2025, at approximately 10:15 a.m.,	0 580		

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0 580	Continued From page 6 during the entrance conference, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated ongoing QMP areas were identified, but no meeting minutes, tracking, or specific improvement projects would be documented. The licensee's 2.31 Quality Management Project policy dated November 1, 2021, indicated a QMP would be implemented, and documentation would be provided upon request. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 580		
0 650 SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living	0 650		

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0 650	Continued From page 7 services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records contained the required content for two of two employees (licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A, owner/unlicensed personnel (O/ULP)-B). 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: LALD/CNS-A LALD/CNS-A had a hire date of October 17, 2020. LALD/CNS-A's employee record did not contain a performance evaluation for 2021, 2022, 2023, and 2024. O/ULP-B O/ULP-B had a hire date of January 10, 2023. O/ULP-B's employee record did not contain a	0 650		

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0 650	Continued From page 8 performance evaluation for 2023 and 2024. O/ULP-B's employee record also did not contain evidence of demonstrated competency in the required 22 areas. On August 11, 2025, at 3:00 p.m., LALD/CNS-A stated no annual performance reviews were completed for LALD/CNS-A and O/ULP-B and was unaware of this requirement. LALD/CNS-A also stated O/ULP-B's competencies were demonstrated to LALD/CNS-A but was unable to locate the completed competency evaluation documents. The licensee's 5.10 Training Records dated November 1, 2021, indicated the licensee's employee records would include documentation of the completed competency evaluation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor;	0 680		

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0 680	Continued From page 9 and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all visitors, employees, 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 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On August 12, 2025, at approximately 2:00 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A provided a binder and stated the contents were the licensee's EPP.	0 680		

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0 680	Continued From page 10 The licensee's EPP undated, lacked an individualized plan to include all the required content below: -annual reviews; -missing resident quarterly reviews; -policies and procedures for volunteers; and -EPP testing program. On August 12, 2025, at approximately 3:00 p.m., LALD/CNS-A acknowledged the licensee's EPP lacked the above listed required content. LALD-A stated the licensee was unaware of all the required content and would update the EPP with the required information. The licensee's Emergency Preparedness policy dated May 22, 2022, indicated the licensee would have an identified plan in place to ensure the safety and well-being of residents and employees during periods of an emergency or a disaster that disrupts facility services. The licensee's Missing Resident policy dated May 22, 2022, indicated the licensee would review the missing resident procedure at least quarterly. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 775 SS=I	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:	0 775		

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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
0 775	Continued From page 11 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with Minnesota State Fire Code in Minnesota Rules chapter 7511. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level three violation (a violation that harmed a client/resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident), 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 August 12, 2025, the surveyor toured the facility with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A. The following was observed. In resident room 1 there was evidence of unsafe smoking practices. There were multiple burn marks on two different shelves of the wooden TV stand, and discarded cigarettes, and ash on the floor next to the resident bed. LALD/CNS-A stated that they are aware that the resident smokes inside of their room sometimes and that they ask the resident to smoke outside when they discover the resident smoking inside. Smoking shall be done safely, and cigarettes discarded into approved non-combustible ash trays placed on a sturdy surface. Lighted matches, cigarettes, cigars or other burning	0 775		

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	37592	A. BUILDING: _____ B. WING _____	08/14/2025

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0 775	Continued From page 12 object shall not be discarded in such a manner that could cause ignition of other combustible material. TIME PERIOD FOR CORRECTION: Two (2) days	0 775		
0 810 SS=I	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system	0 810		

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0 810	Continued From page 13 activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level three violation (a violation that harmed a client/resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) 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 August 12, 2025, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP, titled "9.06 fire policy", dated October 31, 2022, failed to include the following: The FSEP included standard employee	0 810		

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0 810	Continued From page 14 procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate) but the plan was designed for a building with life safety systems such as fire doors and smoke compartments. The policy had not been updated to provide complete actions for employees to take in the event of a fire or similar emergency at the licensed facility which did not have life safety systems or a fire-resistant construction type. The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. LALD/CNS-A stated that they could not find the policy that they had shown during the follow up survey that was completed on August 29, 2023, and that the surveyor should just write the tag. TRAINING: The licensee failed to provide evacuation training to residents at least once per year. LALD/CNS-A stated that the training for residents on the FSEP was verbal training and lacked documentation that training was offered to residents. The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. LALD/CNS-A stated that the training for staff on the FSEP was verbal training and lacked documentation that staff were trained on the FSEP at time of hire and two times per year thereafter.	0 810		

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0 810	Continued From page 15 TIME PERIOD FOR CORRECTION: Twenty-one (21) 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, except a facility with a licensed resident capacity of six or fewer is exempt from rental licensing regulations imposed by any town, municipality, or county. 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 (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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:	0 830		

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0 830	Continued From page 16 On August 11, 2025, at 11:15 a.m., during a tour of the facility, surveyor observed a designated smoking area in the facility's backyard with a metal cigarette disposal receptacle located in the vicinity. On August 11, 2025, at approximately 11:30 a.m., surveyor observed R3's room with cigarette ashes in multiple areas on the floor near R3's bed. Next to R3's bed there was a small end table that contained a soda can with the top cut off that contained multiple cigarette butts that had been burned down to the filter of the cigarette in water. Also next to R3's bed there was a windowsill and a chair that was covered with some cigarette ash. Next to R3's chair there was a television (TV) stand made of wood with two shelves that had multiple burn marks. On the second shelf of R3's TV stand there was another soda can with the top cut off that contained multiple cigarette butts that had been burned down to the filter of the cigarette in water. R3 admitted to the licensee on August 31, 2024, and resided in room one on the main level of the facility. R3's diagnoses included epigastric pain and tobacco use disorder. R3's signed Resident Contract for Assisted Living dated August 31, 2024, indicated on page six, section 11, that there was no smoking in the licensee's facility. R3's Uniform Assessment Tool form dated August 31, 2024, indicated R3 was assessed to smoke safely and independently without interventions.	0 830		

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0 830	Continued From page 17 R3's Service Plan signed August 31, 2024, indicated R3 received assistance that included behavior management and safety checks. R3's progress notes dated August 11, 2025, at 7:00 a.m., indicated R3 was smoking in his room. On August 11, 2025, at approximately 11:40 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A and owner/unlicensed personnel (O/ULP)-B stated R3 sometimes smoked in R3's room. On August 11, 2025, at approximately 11:50 a.m., R3 stated was going to the store to buy some cigarettes. On August 11, 2025, at approximately 3:40 p.m., R3 stated "I smoked in my room sometimes." On August 12, 2025, at approximately 2:20 p.m., LALD/CNS-A and O/ULP-B stated that the licensee was aware of R3's smoking habit and R3 had been smoking indoors in R3's room at various times. LALD/CNS-A and O/ULP-B also stated when the licensee tried to talk with R3 about smoking indoors, R3 would get verbally aggressive. In addition, LALD/CNS-A confirmed the facility's designated smoking area was in facility's backyard area. The licensee's Physical Environment of the Home form located in the licensee's emergency preparedness plan (EPP), undated, indicated there is no smoking in the facility. The licensee's 4.59 Smoking/Tobacco Use policy dated November 1, 2021, indicated smoking was prohibited indoors and smoking was only allowed	0 830		

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0 830	Continued From page 18 in the designated smoking area. The 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 was 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 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	0 970		

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0 970	Continued From page 19 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). The findings include: On August 12, 2025, at approximately 10:00 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A provided a resident Assisted Living Contract and indicated the contract was used by licensee for all residents who would live in the facility. The licensee's Assisted Living Contract, undated, on page 14, included a section titled Insurance Liability and Release and read, "The resident agrees that [licensee] will not be liable to the resident for any personal injury or property damage" and "The resident hereby releases [licensee] from liability for any personal injury or property damage suffered by the resident".	0 970		

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0 970	Continued From page 20 The licensee's Assisted Living Contract, undated, on page 16, included a section titled Indemnification and read, "[Licensee] shall not be liable for any damage or injury to the resident... or to any property, occurring on the premises, or any part thereof, or in common areas thereof, and the resident agrees to hold [licensee] harmless from any claims or damages unless caused solely by negligence of [licensee]." On August 12, 2025, at approximately 3:00 p.m., LALD/CNS-A acknowledged the licensee's assisted living contract included waivers of liability for health and safety or personal property of the resident. LALD/CNS-A stated the liability waivers would need to be removed from the licensee's contracts. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		
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 a staff member in good faith reliance on information or records obtained under	01290		

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01290	Continued From page 21 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 interview and record review, the licensee failed to ensure a background study (BGS) was submitted and a clearance received in affiliation with the assisted living licensee's current health facility identification (HFID) for two of four employees (unlicensed personnel (ULP)-C, ULP-D). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) 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: ULP-C ULP-C was hired on February 20, 2023. ULP-C's employee record included a BGS clearance dated November 24, 2021, with HFID 35792. ULP-D ULP-D was hired on January 10, 2023. ULP-D's employee record included a BGS clearance dated November 1, 2021, with HFID 35792.	01290	During the course of the survey, the licensee took action to mitigate the imminent risk. Noncompliance remained and the scope and level remain unchanged.	

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01290	Continued From page 22 On August 11, 2025, at 11:14 a.m., the Minnesota Department of Human Services NETStudy2 website indicated ULP-C's and ULP-D's BGS affiliated with HFID 35792 were listed as "COVID 19 Study Expired" on December 31, 2022. On August 11, 2025, at approximately 2:00 p.m., licensed assisted living director/clinal nurse supervisor (LALD/CNS-A) stated ULP-C was the only staff member that worked the night shift yesterday and ULP-D was the only staff member that worked the night shift today for the licensee at this facility and provided cares for the residents. The licensee's staff schedule dated August 10, 2025, through August 18, 2025, indicated ULP-C was scheduled to work 8:00 p.m. to 6:00 a.m. Saturday and Sunday, and ULP-D was scheduled to work 7:00 p.m. to 7:00 a.m. Monday through Friday. On August 11, 2025, at approximately 2:30 p.m., LALD/CNS-A stated ULP-C and ULP-D's BGS were cleared in the past and was unaware ULP-C and ULP-D's BGS were listed as expired. LALD/CNS-A also stated the licensee would update ULP-C and ULP's BGS status in NETStudy. The licensee's 4.01 Background Studies policy dated November 1, 2021, indicated a licensee's employee may not provide direct services to residents until acceptable result of BGS have been received. The Department of Health Services (DHS) Emergency Background Studies End publication	01290		

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01290	Continued From page 23 updated July 31, 2024, read "Emergency studies are no longer valid. Individuals who only have an emergency study must have a fully compliant, fingerprint-based background study." The document indicated that emergency studies ended as of December 31, 2022. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	01290		
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's	01500		

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01500	Continued From page 24 disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an employee received at least eight hours of annual training for each 12 months of employment for two of two employees (licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A, owner/unlicensed personnel (O/ULP)-B).	01500		

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01500	Continued From page 25 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: LALD/CNS-A LALD/CNS-A had a hire date of October 17, 2020. LALD/CNS-A's training record for 2024 lacked evidence of the eight hours annual training requirement to include review of provider's policies and procedures. O/ULP-B O/ULP-B had a hire date of February 10, 2023. O/ULP-B's training record for 2024 lacked evidence of the eight hours annual training requirement to include review of provider's policies and procedures. On August 11, 2025, at 2:00 p.m., LALD/CNS-A stated the licensee forgot to include review of provider's policies and procedures to the required annual training and would ensure all the required annual training for employees would be completed. The licensee's 5.06 Annual Required Staff Training policy dated November 1, 2021,	01500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37592	A. BUILDING: _____ B. WING _____	08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POINT-ONE HOME HEALTH LLC	4500 EAST 46TH STREET MINNEAPOLIS, MN 55406

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01500	Continued From page 26 indicated review of the licensee's policies and procedures relating to the provision of assisted living services would be included in the annual training for all staff. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		
01530 SS=F	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related	01530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37592	A. BUILDING: _____ B. WING _____	08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POINT-ONE HOME HEALTH LLC	4500 EAST 46TH STREET MINNEAPOLIS, MN 55406

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01530	Continued From page 27 to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure all employees received eight hours of initial dementia care training within the first 120 working hours of employment for supervisors of direct care staff as required for one of one licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A. 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: LALD/CNS-A was hired on October 17, 2020, to	01530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37592	A. BUILDING: _____ B. WING _____	08/14/2025

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POINT-ONE HOME HEALTH LLC	4500 EAST 46TH STREET MINNEAPOLIS, MN 55406

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01530	Continued From page 28 provide direct care to residents and supervise employees. LALD/CNS-A's employee record included the following initial dementia training: -Alzheimer's Disease: What it is (1 hour) completed on November 11, 2020; -Alzheimer's Disease, Part 1 (2 hours) completed on November 25, 2020; and -Alzheimer's Disease, Part 2 (2 hours) completed on November 25, 2020. LALD/CNS-A had a total of 5 hours completed of dementia care training within 120 hours of working for the licensee. LALD/CNS-A's employee record lacked the required eight hours of dementia care training within 120 hours of working for the licensee. On August 11, 2025, at 2:00 p.m., LALD/CNS-A stated was unsure if completed the initial dementia care training and would ensure any new employee would be provided 8 hours of the initial dementia care training during orientation. The licensee's 5.03 Dementia Training policy dated November 1, 2021, indicated supervisors of direct care staff would complete at least eight hours of initial dementia training within 120 working hours of employment start date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

POINT ONE HOME HEALTH LLC

4500 EAST 46TH STREET

Minneapolis, MN 55406
Hennepin County
Parcel:

Phone:

License Info

License: HFID 37592

Risk:
License:
Expires on:
CFPM: Sabir M. Hussein Hassan
CFPM #: 32055; Exp: 06/06/2028

Inspection Info

Report Number: F1021251096
Inspection Type: Full - Single
Date: 8/12/2025 Time: 11:23:15 AM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 3
Delivery: Emailed

New Order: 4-200 Equipment Design and Construction
4-204.112A *Priority Level: Priority 3 CFP#: 36*
MN Rule 4626.0620A Provide a temperature measuring device located in the warmest part of mechanically refrigerated units and coolest part of hot food storage units that are capable of measuring air temperature or a simulated product temperature.
COMMENT: THE MINI FRIDGE IN ROOM 1 WAS MISSING A THERMOMETER. DURING INSPECTION, STAFF PLACED A THERMOMETER IN THE WARMEST PART OF THE MINI FRIDGE. CORRECTED ON-SITE.
Comply By: 8/12/2025 Originally Issued On: 8/12/2025

New Order: 4-500 Equipment Maintenance and Operation
4-501.19AMN *Priority Level: Priority 3 CFP#: 47*
MN Rule 4626.0780A Provide a separate food preparation sink for washing or thawing food in a newly licensed food establishment.
COMMENT: THE KITCHEN ONLY HAS A ONE-COMPARTMENT SINK AND THAT SINK HAS BEEN DESIGNATED AS A HANDWASHING SINK. SINCE THE ESTABLISHMENT DOES NOT HAVE A PREPARATION SINK, THEY MUST EITHER PURCHASE PRE-WASHED PRODUCE OR REPLACE THE SINGLE SINK WITH A TWO-COMPARTMENT SINK.
Comply By: 8/12/2025 Originally Issued On: 8/12/2025

New Order: 4-600 Cleaning Equipment and Utensils
4-601.11C *Priority Level: Priority 3 CFP#: 49*
MN Rule 4626.0840C Clean non-food contact surfaces of equipment and maintain free of accumulations of dust, dirt, food residue, and other debris.
COMMENT: THE BOTTOM SHELF OF THE MINI FRIDGE IN ROOM #1 HAS A BUILDUP OF SPILLED DRIED LIQUIDS AND FOOD DEBRIS. CLEAN AND MAINTAIN CLEAN.
Comply By: 8/18/2025 Originally Issued On: 8/12/2025

Food & Beverage General Comment

All findings on this report were discussed with Certified Food Protection Manager, Sabir Hussein Hassan and Health Regulation Division Nurse Evaluator, Carl Samrock.

This establishment is a residential home. Currently, there are 2 clients with a maximum number of 4 clients.
.
Per conversation with manager, food is made for same-day service. No leftovers are kept.

The kitchen has residential equipment. Equipment and any physical facility items will be monitored at future inspections.

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Metro District Office inspection report number F1021251096 from 8/12/2025

Melissa Ramos

Sabir Hussein Hassan
Certified Food Protection Manager

Melissa Ramos,
Public Health Sanitarian 3
651-201-4495
melissa.ramos@state.mn.us

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

Temperature Observations/Recordings

Establishment Info

POINT ONE HOME HEALTH LLC

Minneapolis
County/Group: Hennepin County

Inspection Info

Report Number: F1021251096
Inspection Type: Full
Date: 8/12/2025
Time: 11:23:15 AM

Food Temperature: Product/Item/Unit: Milk **; Temperature Process:** Cold-Holding
Location: Samsung Kitchen Refrigerator at 40 Degrees F.
Comment:
Violation Issued?: No

Equipment Temperature: Product/Item/Unit: Samsung Kitchen Refrigerator**; Temperature Process:** Ambient Air
Location: Samsung Kitchen Refrigerator at 36 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Milk**; Temperature Process:** Cold-Holding
Location: Room **#**3 Mini Fridge at 41 Degrees F.
Comment:
Violation Issued?: No

Equipment Temperature: Product/Item/Unit: Room **#**3 Mini Fridge **; Temperature Process:** Ambient Air
Location: Room **#**3 Mini Fridge at 39 Degrees F.
Comment:
Violation Issued?: No

Equipment Temperature: Product/Item/Unit: Room **#**1 Mini Fridge **; Temperature Process:** Ambient Air
Location: Room **#**1 Mini Fridge at 41 Degrees F.
Comment:
Violation Issued?: No