Electronically Delivered

July 3, 2024

Licensee
Heliopolis Home Healthcare LLC
1610 East 26th Street
Minneapolis, MN 55404

RE: Project Number(s) SL34768015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 6, 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.

MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

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

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

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

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the

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

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

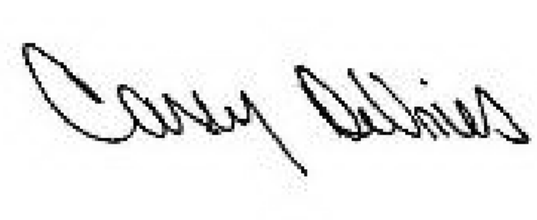
To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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

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

If you have any questions, please contact me.

Sincerely,



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
	34768	A. BUILDING: _____ B. WING _____	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELIOPOLIS HOME HEALTHCARE LLC	1610 EAST 26TH STREET MINNEAPOLIS, MN 55404

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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: SL34768015-0 On June 3, 2024, through June 6, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were three residents, all of whom received services under the Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480		

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0 480	Continued From page 1 following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated June 4, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must	0 650		

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0 650	Continued From page 2 include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records included all required content for one of three employees (clinical nurse supervisor (CNS)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include:	0 650		

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0 650	Continued From page 3 CNS-C was hired on January 1, 2018, to provide supervision and oversite to unlicensed personnel and to provide direct services to residents. CNS-C's employee record lacked documentation of annual performance reviews identifying areas of improvement needed and training needs. On June 5, 2024, at 9:40 a.m., licensed assisted living director/owner (LALD/O)-D stated they did not think they needed to do performance reviews for the CNS-C as CNS was a supervisory position. The licensee's Employee Records policy dated February 1, 2021, read, "1. Employee records for each person will include: o Evidence of current professional licensure, registration or certificate, if required o Records of all training and in-service education required and/or provided including record of competency testing as required o Current signed job description, which includes qualifications, responsibilities, and identification of supervisors, if any o Documentation of annual performance reviews that identify areas of improvement needed and training needs o For individuals providing Assisted Living services, verification that required health screenings for Tuberculosis (TB) have taken place and the dates of those screenings. (recommended to keep medical information in a separate employee medical file) o Documentation of a competed criminal background study o Evidence that a reference check has been completed o Verification of completed orientation and	0 650		

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0 650	Continued From page 4 annual training and competency testing as required" No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by:	0 680		

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0 680	Continued From page 5 Based on interview and record review, the licensee failed to maintain an emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's Emergency Preparedness Plan reviewed on January 12, 2024, lacked evidence that the licensee reviewed the missing resident plan quarterly. On June 5, 2024, at 9:44 a.m., licensed assisted living director/owner (LALD/O)-D stated they were not aware they had to review the missing resident plan quarterly. The licensee's Missing Resident policy dated February 10, 2021, indicated the missing resident procedure will be reviewed by the assisted living director and clinical nurse supervisor at least quarterly and changes to the plan will be documented. Minnesota Administrative Rule 4659.0110, Subpart 4 dated August 11, 2021, indicated the assisted living director and clinical nurse supervisor must review the missing person plan at least quarterly and document any changes to	0 680		

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0 680	Continued From page 6 the plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the	0 730		

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0 730	Continued From page 7 resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the residents record included documentation of all services provided for two of two residents (R1 and R2) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1's signed service plan form, dated December 9, 2023, indicated R1 received assistance with medication administration, housekeeping,	0 730		

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0 730	Continued From page 8 laundry, meals assistant, behavior management, and safety checks. R1's Service Recap Summary form May 1, 2024, through May 31, 2024, lacked the following documentation for services provided during multiple shifts: Morning shift -2 of 14 scheduled services for housekeeping-heavy; -2 of 14 scheduled services for laundry; -2 of 31 scheduled services for behaviors - agitation; -2 of 31 scheduled services for behaviors - anxiety; -2 of 31 scheduled services for behaviors - physical aggression; -2 of 31 scheduled services for behaviors - repetitive; -2 of 31 scheduled services for behaviors - orientation; -2 of 31 scheduled services for behaviors - verbal aggression; -2 of 31 scheduled services for behaviors - self injurious; -2 of 31 scheduled services for symptoms-wandering; -2 of 31 scheduled services for meal assistance; and -2 of 31 scheduled services for socialization. Midday shift -2 of 31 scheduled services for housekeeping-light; -2 of 31 scheduled services for meal assistance; and -5 of 9 scheduled services for transportation assistance. Afternoon shift -2 of 9 scheduled services for linen change; -8 of 31 scheduled services for behaviors -	0 730		

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0 730	Continued From page 9 agitation; -8 of 31 scheduled services for behaviors - anxiety; -8 of 31 scheduled services for behaviors - physical aggression; -8 of 31 scheduled services for behaviors - repetitive; -8 of 31 scheduled services for behaviors - orientation; -8 of 31 scheduled services for behaviors - verbal aggression; -8 of 31 scheduled services for behaviors - self injurious; -8 of 31 scheduled services for symptoms-wandering; -8 of 62 scheduled services for meal assistance; and -5 of 31 scheduled services for socialization. R2 R2's signed service plan form, dated October 1, 2023, indicated R2 received assistance with medication administration, housekeeping, bathroom hygiene goal, CPAP/BIPAP, laundry, meals assistant, behavior management, and safety checks. R2's Service Recap Summary form May 1, 2024, through May 31, 2024, lacked the following documentation for services provided during multiple shifts: Morning shift -3 of 31 scheduled services for bathroom hygiene goals; -3 of 14 scheduled services for housekeeping-heavy; -2 of 14 scheduled services for laundry; -3 of 31 scheduled services for behaviors - agitation; -3 of 31 scheduled services for behaviors -	0 730		

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0 730	Continued From page 10 anxiety; -3 of 31 scheduled services for behaviors - repetitive; -3 of 31 scheduled services for behaviors - verbal aggression; -3 of 31 scheduled services for behaviors - self injurious; -3 of 31 scheduled services for meal assistance; and -3 of 31 scheduled services for socialization. Midday shift -3 of 31 scheduled services for housekeeping-light; -3 of 31 scheduled services for meal assistance; and -8 of 13 scheduled services for transportation assistance. Afternoon shift -6 of 31 scheduled services for bathroom hygiene goals; -6 of 31 scheduled services for CPAP/BIPAP; -2 of 9 scheduled services for linen change; -9 of 31 scheduled services for behaviors - agitation; -9 of 31 scheduled services for behaviors - anxiety; -9 of 31 scheduled services for behaviors - repetitive; -9 of 31 scheduled services for behaviors - verbal aggression; -9 of 31 scheduled services for behaviors - self injurious; -10 of 62 scheduled services for meal assistance; -6 of 31 scheduled services for socialization; -1 of 4 scheduled services for record- Blood pressure; -1 of 4 scheduled services for record- oxygen saturation; -1 of 4 scheduled services for record- pulse; -1 of 4 scheduled services for record- respiration;	0 730		

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0 730	Continued From page 11 -1 of 4 scheduled services for record- temperature; and -1 of 4 scheduled services for record- weight. On June 5, 2024, at 10:23 a.m., clinical nurse supervisor (CNS)- C stated they did do documentation checks, but they were not aware of the gaps in service administration charting for the residents mentioned above and stated, "I will look into it." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and	0 780		

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0 780	Continued From page 12 (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that are interconnected so that the actuation of one alarm causes all alarms in the dwelling unit to actuate. This deficient condition had 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: During the facility tour on June 3, 2024, at 11:30 a.m. with licensed assisted living director/owner (LALD/O)-D, it was observed that the sleeping rooms equipped with smoke alarms were not interconnected upon testing, so actuation of one alarm would cause all alarms to operate. During the interview on June 3, 2024, at 11:45 a.m., LALD/O-D confirmed the smoke alarms in the facility were not interconnected and the actuation of one alarm would not cause all alarms to operate at the time of survey.	0 780		

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	34768	A. BUILDING: _____ B. WING _____	06/06/2024

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0 780	Continued From page 13 TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to perform the required annual maintenance on fire extinguishers. 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:	0 790		

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0 790	Continued From page 14 On June 3, 2024, at 11:30 a.m., survey staff toured the facility with the licensed assisted living director/owner (LALD/O) - D. During the tour, it was observed that the licensee provided the monthly visual inspections on the portable fire extinguishers but did not have a service tag showing that they had been inspected annually. It was also observed that the year 2020 was stamped on the bottom of the fire extinguishers cylinder. During the interview on June 3, 2024, at 11:45 a.m., LALD/O-D verified the facility did not perform the required annual maintenance on fire extinguishers. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
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	0 810		

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0 810	Continued From page 15 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 the interview and record review, the licensee failed to develop the fire safety and evacuation plan with the required contents. 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, 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 June 5, 2024, at 10:00 a.m., licensed assisted living director/owner (LALD/O) - D provided	0 810		

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0 810	Continued From page 16 documentation on the fire safety and evacuation plan (FSEP), fire safety and evacuation training for the facility, and fire safety and evacuation drills for the facility. The FSEP included standard employee 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 fire safety and evacuation plan was a third-party consultant provided plan, and it was not updated to meet the facility-specific layout. The fire safety and evacuation plan included the RACE (Remove, Alarm, Confine, and Extinguish or Evacuate) acronym as the fire safety procedure and instructed staff to pull the nearest fire alarm in case of fire, but the facility did not have a fire alarm system. During the interview on June 5, 2024, at 10:30 p.m., LALD/O-D verified the facility needed to update the fire safety and evacuation plan, including the facility-specific fire safety protocols. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01380 SS=F	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to	01380		

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01380	Continued From page 17 appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training was completed in all required areas for one of one employee (unlicensed personnel (ULP)-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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-A was hired on April 30, 2021, to provide direct care to residents. On June 4, 2024, at 11:00 a.m., the surveyor observed ULP-A administered oral medications to R1. ULP-A's employee record lacked the following competency evaluations: - standby assistance techniques and how to perform them.	01380		

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01380	Continued From page 18 On June 4, 2024, at 9:11 a.m., licensed assisted living director/owner (LALD/O)-D verified the standby assistance techniques competency was not on their training checklist for any employees. LALD/O-D stated Educare (training software that the licensee utilizes for training purposes) does not have the competency mentioned above and they did not know it was a requirement. On June 5, 2024, at 9:11 a.m., clinical nurse supervisor (CNS-C) stated they were not aware the above-mentioned training topic was missing and stated, "we will work on it." The licensee's Staff Orientation and Education policy dated February 1, 2024, read, " Upon hire and prior to performing any functions of their position at Heliopolis Home Healthcare, each new employee and volunteer will be oriented in accordance with State and Federal regulations, as well as company policy and procedure." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by:	01890		

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01890	Continued From page 19 Based on observation, interview, and record review, the licensee failed to ensure expired medications were disposed of for two of three residents (R2 and R4). 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: R2 R2's signed service plan form, dated October 1, 2023, indicated R2 received assistance with medication administration, housekeeping, bathroom hygiene goal, CPAP/BIPAP, laundry, meals assistant, behavior management, and safety checks. R2's record included a medication administration summary (MAR) record for the month of May 2024, which indicated R2 had an order for the following as needed (PRN) medications: -acetaminophen 500 milligrams (mg), two tablets every six hours PRN daily. On June 3, 2024, at approximately 12:00 p.m., the surveyor observed the medication cabinet, located in the basement, and observed the following expired medication for R2: - 3 bubble pack cards containing acetaminophen 500 (mg) tablets which expired on March 19, 2024.	01890		

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01890	Continued From page 20 R4 R4's signed service plan form, dated October 1, 2023, indicated R4 received assistance with medication administration, housekeeping, laundry, meals assistant, behavior management, and safety checks. R4's record included a medication administration summary (MAR) record for the month of May 2024, which indicated R4 had an order for the following PRN medications: -meloxicam 7.5mg tablets take one to two tablets by mouth daily as needed for pain; -loperamide 2mg capsule (cap) take one tablet by mouth four times a day as needed for diarrhea; -ibuprofen 200mg tablet, take one tablet by mouth every six hours as needed for fever and pain; -famotidine 40mg tablets, take 1 tablet by mouth once daily for reflux. On June 3, 2024, at approximately 12:00 p.m., the surveyor observed the medication cabinet, located in the basement, and observed the following expired medication for R4: - 2 bubble pack cards containing Meloxicam 7.5mg tablets expired on May 12, 2024; - 1 bubble pack card containing famotidine 40mg tablets, expired on May 15, 2024; - 1 bubble pack card containing loperamide 2mg cap, expired on June 18, 2023; and - 1 bubble pack card containing Ibuprofen 200mg tablet, expired on June 18, 2023. On June 5, 2024, at approximately 10:25 a.m., clinical nurse supervisor (CNS-C) stated they go by "Rx Exp" (prescription expiry date) instead of "use by date". On June 5, 2024, at 10:31a.m., the surveyor called the licensee's preferred pharmacy to clarify	01890		

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01890	Continued From page 21 which date the providers should go by for discarding medications, the pharmacist explained medication must be discarded after the use by date. The licensee's 7.08 Medication Management - Administration & Setup policy dated February 1, 2024, indicated, the licensed nurse who sets up the medications will also be observant of any problems regarding storage of medications. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
02290 SS=F	144G.91 Subd. 2 Legislative intent The rights established under this section for the benefit of residents do not limit any other rights available under law. No facility may request or require that any resident waive any of these rights at any time for any reason, including as a condition of admission to the facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee limited the rights of residents when the licensee required all residents who resided in the facility to follow certain house rules. 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	02290		

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02290	Continued From page 22 of the residents). The findings include: R1's record included the licensee's house rules entitled Home /Facility Rules dated December 9, 2023, signed by R1 and their legal guardian, and used for all residents, contained the following statements: - Residents may be subject to random Drug and Alcohol tests at any time in case of suspicion of drug use. Failure of these tests or refusal of these tests will result in immediate discharge from the home; - The Director and Staff reserve the right to perform a room search at any time it is deemed necessary to insure the serenity and security of the Home. This includes personal items. - All residents are to assist in keeping the Home and surrounding grounds neat and clean. This includes special work assignments and your own room; - All food and snack items will be eaten in the dining room. It's client's responsibility to bring the dishes downstairs if taken to their room; - We provide food and snacks to our clients, please before opening the fridge, ask our staff to get you what you need. We don't want anyone opening the fridge and taking items without us knowing; - All residents will be responsible for keeping the kitchen cleaned. Any violations of this such as dirty microwave, crumbs, spills not cleaned up, etc...will result in discharge from the home; - Residents are also expected to maintain good hygiene and personal cleanliness. This includes taking a shower daily; - Laundry is to be done during assigned times unless approved by staff. Please bring your dirty clothes to the staff and let them do the laundry for	02290		

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02290	Continued From page 23 you. We provide detergent as well as softeners to you, you are responsible of folding your clothes when cleaned; and - There will be no nude or partially nude pictures on the walls of the resident's rooms. On June 5, 2023, at approximately 9:59 a.m., licensed assisted living director/registered nurse (LALD/O)-D stated they came up with the above-mentioned rules to regulate the house, it was not intended to restrict. LALD/O-D stated nude picture were offensive to employees and the rules were to protect both residents and employees. The licensee's undated Assisted Living Bill of Rights indicated the licensee's staff may not request nor obtain from the resident any waiver of any of their rights. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02290		
02370 SS=F	144G.91 Subd. 9 Right to come and go freely Residents have the right to enter and leave the facility as they choose. This right may be restricted only as allowed by other law and consistent with a resident's service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure residents had the right to enter and leave the facility as they choose. This practice resulted in a level two violation (a	02370		

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02370	Continued From page 24 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1's record included the licensee's house rules entitled Home /Facility Rules dated December 9, 2023, signed by R1 and their legal guardian, and used for all residents, contained the following statements: -"11. House curfew is 10:00PM every night. The doors will be locked at that time. Unless approved by the staff, any resident returning after 10 will be documented and it will be reported to his legal guardian, case worker and parole/probation officer. If client comes late more than once - the client maybe discharged." -"12. All residents must use the sign in/out sheet when leaving the property. This must be done to ensure that the Staff knows where residents are at all times." -"20. Each resident is to be in his own room by 10:00 pm." On June 5, 2023, at approximately 9:59 a.m., licensed assisted living director/registered nurse (LALD/O)-D stated they came up with the above-mentioned rules to regulate the house, it was not intended to restrict. LALD/O-D stated in the future they would use words like encourage instead of must. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	02370		

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02370	Continued From page 25 days	02370		

DEPARTMENT OF HEALTH

Environmental Health
Food, Pools, and Lodging
625 Robert St. N
St. Paul
651-201-5000

Type: Full
Date: *06/04/24*
Time: 11:00:00
Report: 1031241140

Food and Beverage Establishment Inspection Report

Location:
Heliopolis Home Healthcare Llc
1610 East 26th Street
Minneapolis, MN55404
Hennepin County, 27

Establishment Info:
ID #: 0039088
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6126448696
ID #:

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

The following orders were issued during this inspection.

3-500D Microbial Control: disposition of food

3-501.18A ***** Priority 1 *****

MN Rule 4626.0405A Discard all TCS food prepared in the establishment or opened commercially packaged food when the time exceeds 7 days from the preparation or opening date or if the container or package is not marked.

CHEESE STORED IN OVERFLOW REFRIGERATOR WAS NOT DATE MARKED AND HAD WHITE SUBSTANCE ON SURFACE. ***CHEESE DISCARDED.*** ENSURE ALL ITEMS REQUIRING DATE MARKING ARE PROPERLY MARKED.

Comply By: 06/04/24

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.

CHEMICAL SPRAY USED FOR FOOD CONTACT SURFACES MEASURED > 400 PPM. DISCONTINUE USING PREMADE SPRAY CHEMICALS ON FOOD CONTACT SURFACES. MAKE BLEACH AND WATER SPRAY BOTTLE, TEST CONCENTRATION WHEN PREPARING BOTTLE (50-200PPM Chlorine)

Comply By: 06/04/24

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.

ESTABLISHMENT DOES NOT HAVE A THIN PROBE THERMOMETER.

Comply By: 06/07/24

4-300 Equipment Numbers and Capacities

4-302.13B ***** Priority 2 *****

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

ESTABLISHMENT MISSING IRREVERSIBLE MEASURING DEVICE OR WAX TEST STRIPS. PROVIDE IRREVERSIBLE MEASURING DEVICE OR WAX STRIPS AND MEASURE UTENSIL TEMPERATURE (160F REQUIRED) AT REGULAR INTERVALS.

Comply By: 06/07/24

4-300 Equipment Numbers and Capacities

4-302.14 ***** Priority 2 *****

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

ESTABLISHMENT DOES NOT HAVE SANITIZER TESTING KIT ON SITE. PURCHASE KIT AND TEST SANI CONCENTRATION (50-200PPM BLEACH, 150-400PPM QUAT)

Comply By: 06/07/24

4-500 Equipment Maintenance and Operation

4-501.11AB

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

SINK FAUCET IS LOOSE. TIGHTEN FAUCET TO SINK BASIN.

Comply By: 06/18/24

Surface and Equipment Sanitizers

Quaternary Ammonia: > 400 at Degrees Fahrenheit
Location: Lyson Surface Cleaner
Violation Issued: No

Hot Water: = at 160 Degrees Fahrenheit
Location: Dish Machine
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Hold/Cheese Spread
Temperature: 40 Degrees Fahrenheit - Location: Refrigerator
Violation Issued: No

Type: Full
Date: *06/04/24*
Time: 11:00:00
Report: 1031241140
Heliopolis Home Healthcare Llc

Food and Beverage Establishment Inspection Report

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

- Establishment has a residential kitchen (4626.0506(G)(2)) Same-day service only. No saving and reheating of foods or preparation of foods the day prior to eating. Any remaining food from meals to be removed/discarded at end of day.

- Staff must prepare sanitizer squirt bottle daily. Check concentration of sanitizer with test strips (50-200ppm Chlorine) when preparing bottle.

- Establishment does not have pasteurized eggs and does not prepare eggs for consumption under 145F. Purchase pasteurized eggs if intending to serve eggs undercooked.

- Make sure to datemark any prepared and/or cold items that are kept in refrigerator.

- - Establishment needs to check dish washer utensil temperature weekly (160F required). If utensil temp not reaching 160F, use washer to wash/rinse and sink basin with sanitizer solution to sanitize dishes then air dry, as discussed during inspection.

- 2-Comp sink has left basin designated for handwashing and the right basin for product washing/prep sink.

- When preparing food, make sure to use a thin-probe thermometer to check temperatures.

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Environmental Health inspection report number 1031241140 of 06/04/24.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/__/_____

Inspection report reviewed with person in charge and emailed.

Signed:_____

Nuruldin Nur
Person in Charge

Signed:_____

Chris Foster
Public Health Sanitarian II
Freeman Office Building
651-983-8760
chris.j.foster@state.mn.us

Report #: 1031241140

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Environmental Health
Food, Pools, and Lodging
625 Robert St. N
St. Paul

No. of RF/PHI Categories Out	1
No. of Repeat RF/PHI Categories Out	0
Legal Authority MN Rules Chapter 4626	

Date 06/04/24
Time In 11:00:00
Time Out

Heliopolis Home Healthcare Llc	Address: 1610 East 26th Street	City/State: Minneapolis, MN	Zip Code: 55404	Telephone: 6126448696
License/Permit #: 0039088	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	X	Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48	X	Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
Physical Facilities				
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) **Date:** 06/04/24

Inspector (Signature)