Electronically Delivered

January 14, 2025

Licensee
Mission Hill Group Home Services
2722 North 4th Street
Minneapolis, MN 55411

RE: Project Number(s) SL34758015

Dear Licensee:

On December 20, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the September 25, 2024, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Renee L. Anderson

Renee Anderson, Supervisor
State Evaluation Team
Email: renee.anderson@state.mn.us
Telephone: 651-201-5871 Fax: 1-866-890-9290

JMD

Electronically Delivered

October 23, 2024

Licensee
MISSION HILL GROUP HOME SERVICES L.L.C.
2722 North 4th Street
Minneapolis, MN 55411

RE: Project Number(s) SL34758015

Dear Licensee:

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

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

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

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

In accordance with Minn. Stat. § 144G.31, Subd. 4(a)(5), MDH may impose fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. MDH may impose a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or

financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. MDH also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

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

St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - $3,000.00

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

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

The correction order documentation should include the following:

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

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

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

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a

hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. to submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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

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

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

If you have any questions, please contact me.

Sincerely,

Renee L. Anderson

Renee L. Anderson, Supervisor
State Evaluation Team
Email: Renee.L.Anderson@state.mn.us
Telephone: 651-201-5871 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34758	A. BUILDING: _____ B. WING _____	09/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSION HILL GROUP HOME SRVS	2722 NORTH 4TH STREET MINNEAPOLIS, MN 55411

(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 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been 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: SL34758015-0 On September 23, 2024, through September 25, 2024, the Minnesota Department of Health conducted an initial survey at the above provider, and the following correction orders are issued. At the time of the survey, there were three (3) residents, all of whom received services under the provider's Assisted Living license. An immediate correction order was issued September 24, 2024, for SL34758015-0 correction tag 1290. The licensee submitted an acceptable plan of correction; the scope and severity remain at level 3, widespread.	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 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This 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 September 24, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control	0 660		

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0 660	Continued From page 2 program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included baseline testing for one of two employee's (unlicensed personnel (ULP)-D). 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: The facility TB risk assessment dated July 11, 2023, indicated the facility was a low risk setting for TB transmission.	0 660		

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0 660	Continued From page 3 ULP-D was hired May 31, 2024, and provided direct cares for residents of the facility. ULP-D's employee record included a TB history and symptom screening form completed, May 30, 2024; however, lacked documentation of baseline TB skin or blood testing results. On September 24, 2024, at 1:55 p.m., clinical nurse supervisor (CNS)-A provided a TB testing document for ULP-D, dated March 7, 2023. CNS-A stated ULP-D had a TB skin test on March 7, 2024, however, ULP-D had not returned to have the result read. CNS-A further stated he had accepted a negative chest x-ray result from ULP-D dated May 31, 2024, however, never confirmed baseline TB skin test or blood test results. The Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013 noted training was required at the time of hire and included: pathogenesis, signs symptoms, and the licensee's infection control plan. In addition, baseline screening for all health care workers (HCW) included a history and symptom screen and testing for the presence of TB infection. The regulations noted a blood test should include the date of the test. According to the regulations, if a HCW had documentation for latent TB, that documentation could be substituted for documentation of a previous positive TST or blood test. The licensee's Tuberculosis Screening/Prevention policy, dated August 1, 2021, indicated the licensee would observe the recommended precautions related to TB prevention as identified by the CDC and the	0 660		

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0 660	Continued From page 4 Minnesota Department of Health (MDH). Furthermore, the policy indicated screening would be conducted as follows: 1. New staff would be screened for active signs of TB using the Baseline TB Screening Tool for HCWs. 2. New staff would have an IGRA blood test or a two-step Mantoux conducted with results documented on the Baseline TB Screening Tool for HCWs. 3. No staff would be permitted to begin work where the work involves sharing the air space with residents until the negative results of the first Mantoux were read and documented or a negative IGRA blood test result was received and documented. 4. Staff TB screening results would be kept in each employee medical file. 5. Staff with a documented history of prior treatment for Latent Tuberculosis Bacterium Infection (LTBI) or active TB would be screened for signs and symptoms on an annual basis. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency;	0 680		

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0 680	Continued From page 5 (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness (EP) plan with all the required content. 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 EP plan dated May 14, 2024, lacked the following requirements:	0 680		

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0 680	Continued From page 6 - Policy and procedure to address subsistence needs for staff and residents; - Policy and procedure to address role of facility under a waiver declared by the Secretary in accordance with section 1135 of the Act; - Policy and procedure for use of volunteers; - Policy and procedure with arrangement agreements with other facilities/providers to receive residents in the event of limitations/cessation of operations to maintain the continuity of services to residents; - Must conduct exercises to test the EP at least twice per year, including unannounced staff drills using the EP; - Must participate in an annual full-scale exercise that is community based OR conduct an annual, individual, facility-based functional exercise OR if the facility experiences an actual emergency requiring activation of plan, facility is exempt from engaging in its next required full-scale exercise; - Conduct an additional annual exercise that may include: a second full-scale exercise that is community-based or an individual, facility based functional exercise OR mock disaster drill OR table-top exercise; and - Analyze the facility's response to and maintain documentation of all drills, tabletop exercises and emergency events & revise plan as needed. On September 23, 2024, at 12:30 p.m., clinical nurse supervisor (CNS)-A stated they were not aware of the requirements noted above. CNS-A further stated they had not scheduled a full-scale exercise, however, spoke with the owner about planning one. The licensee's Emergency Preparedness policy dated August 1, 2021, indicated, licensee would have in place an identified emergency preparedness plan, that would ensure the safety	0 680		

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0 680	Continued From page 7 and well-being of residents and staff during periods of an emergency or disaster that disrupts services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced	0 780		

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0 780	Continued From page 8 by: Based on observation and interview, the licensee failed to provide smoke alarms that complied with fire protection requirements. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On September 23, 2024, from 2:09 p.m. to 4:12 p.m., the surveyor toured the facility with clinical nurse supervisor (CNS)-A. During the tour, the surveyor made the following observations of non-compliance with the Minnesota State Fire Code: It was observed that the smoke alarm in the hallway in the immediate vicinity of main floor resident rooms was not interconnected with all other provided smoke alarms. No smoke alarm was present in the basement. Smoke alarms must be provided on each story and must be interconnected. Smoke alarm installed in resident sleeping room 4 was mounted on wall over four feet below the ceiling. Alarms should be properly installed and maintained per manufacturer instructions and Minnesota State Fire Code.	0 780		

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0 780	Continued From page 9 The placement of the headboard of a bed obstructed clear egress from emergency escape and rescue window in resident sleeping room 1. During the tour the smoke alarms were tested and CNS-A verified the hallway smoke alarm was not interconnected so activation of one alarm activates all alarms throughout the facility. CNS-A indicated that they understood requirements for interconnection. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a	0 800		

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0 800	Continued From page 10 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 September 23, 2024, from 2:09 p.m. to 4:12 p.m., the surveyor toured the facility with clinical nurse supervisor (CNS)-A. During the tour, the surveyor observed disrepair of the following: The emergency escape and rescue window assembly in resident room 1 was not maintained in proper working order and would not stay fully open on its own. The ventilation cover in resident room 3 was covered in dust and not properly maintained. The vanity was missing a light bulb in its lighting fixture leaving the electrical socket exposed in the second-floor bathroom. Doorknob was broken on egress side of door to front porch. Rear entry door screen was ripped and coming loose from door assembly. Rear entry door was degraded and door self-closer was not properly attached to door due to decay. Gutters throughout property were not properly maintained, with significant decay and holes on the undersides. Exterior access door connecting to basement stairwell would was not properly maintained and	0 800		

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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
0 800	Continued From page 11 would not open readily when attempted during survey. During the facility tour interview on September 23, 2024, CNS-A verified the above listed disrepair of physical environment observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at	0 810		

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	34758	A. BUILDING: _____ B. WING _____	09/25/2024

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0 810	Continued From page 12 least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop the fire safety and evacuation plan with required content. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On September 23, 2024, from 2:09 p.m. to 4:12 p.m. clinical nurse supervisor (CNS)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. Record review indicated the licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. CNS-A was unable to provide documentation showing adequate training provided or training scheduled for a future date for staff on the fire safety and	0 810		

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0 810	Continued From page 13 evacuation plan. Documentation showed only one annual training for each staff member. Posted evacuation maps were not accurate to facility layout. The second-floor bathroom was indicated to be a resident room. Resident rooms were unlabeled in the provided documents, with no number affixed to the unit door. Posted maps displayed fire extinguisher in different locations than they are actually mounted in the facility; map displays fire extinguisher in dining room, which is not accurate. 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. Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. CNS-A provided documentation indicating that drills were completed on 1/30/24, and 7/23/24. CNS-A indicated that two aforementioned drills were all that had occurred for this year and that staff from all shifts were involved in these drills. During an interview on September 23, 2024, at 2:09 p.m., survey staff explained the requirements for frequency of drills. CNS-A stated they understood the requirements. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 820 SS=E	144G.45 Subd. 2 (g) Fire protection and physical environment	0 820		

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0 820	Continued From page 14 (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide facilities that were not a distinct hazard to life. This had the potential to directly affect one resident and all staff. 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On September 23, 2024, from 2:09 p.m. to 4:12 p.m., surveyor toured the facility with clinical nurse supervisor (CNS)-A. The emergency escape and rescue windows in resident bedrooms were opened by CNS-A and measured	0 820		

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0 820	Continued From page 15 by the surveyor. During the tour it was observed that compliant emergency escape and rescue openings were not provided in resident sleeping room 4. The noncompliant egress window measurements were as follows: Unoccupied resident sleeping room 4 windows measured 26.5 inches clear width, 16.5 inches clear height, and 437.25 square inches open area. The egress windows in resident sleeping room 4 did not meet the minimum requirements for clear opening height and clear opening total square inch area. Existing emergency escape and rescue openings are required to meet a minimum clear opening area of 648 square inches and have a minimum dimension of 20 inches in height and a minimum dimension of 20 inches in width. The windowsill height from the floor to the clear opening shall be not more than 48 inches. The main exit door had a double cylinder lock requiring a key to open from the egress side of the door. Egress door must be openable without use of a key or tool, and without any special knowledge or special effort. Basement door was equipped with a slide bolt lock which is not openable from the egress side. This type of lock is not approved as supplied on basement door; the door is required to be openable from the egress side. Several burnt cigarettes were observed in the yard near rear entry door, including in areas of dry vegetative material against the facility building. Approved containers for disposal were	0 820		

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0 820	Continued From page 16 present in the yard of the facility but were not consistently utilized for disposal. Burnt cigarettes were also observed near the front entry stairs. Containers for the disposal of smoking materials must be properly sized, stored in a location away from combustible materials, and utilized appropriately to dispose of burnt cigarettes. Inappropriate disposal of smoking materials creates a fire hazard. On September 23, 2024, CNS-A stated they understood the exit doors could not have lock requiring key, special knowledge, or special effort and that supplied slide bolt lock on basement door is required to be openable from the egress side. TIME PERIOD FOR CORRECTION: Two (2) days	0 820		
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction	01290		

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01290	Continued From page 17 does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure employees had a current, cleared Minnesota Department of Human Services (DHS) background study prior to providing direct contact services, for two of three employees (unlicensed personnel (ULP)-C and owner (O)-E). This resulted in an immediate correction order issued September 24, 2024. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-C ULP-C had a hire date of January 4, 2021, and began providing Assisted Living services starting August 1, 2021. On September 24, 2024, at 9:20 a.m., the surveyor observed ULP-C assist R1 with medication administration. ULP-C's employee record lacked a cleared DHS background study affiliated with licensee's health facility identification number (HFID) 34758. The DHS NETStudy 2.0 database, accessed	01290		

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01290	Continued From page 18 September 24, 2024, indicated ULP-C had a background study, which was affiliated with a license previously held by the licensee for HFID 33318. That study was completed under a COVID-19 waiver, which expired December 31, 2022. O-E O-E had a hire date of April 15, 2019, and began providing Assisted Living services starting August 1, 2021. O-E's employee record included a background study affiliated with licensee's current HFID 34758, dated July 15, 2021, however, the DHS NETStudy 2.0 database, accessed September 24, 2024, indicated O-E's background study was completed under a COVID-19 waiver, which expired on December 31, 2022. On September 24, 2024, at 11:00 a.m., O-E stated, via phone, that ULP-C lacked a background study with HFID 34758 and the only background study completed for ULP-C was affiliated with their prior, expired license, associated with HFID 33318. O-A stated she had never thought about ensuring ULP-C was affiliated with the correct HFID. -at 11:44 a.m., O-E stated it had never crossed her mind to ensure employee's COVID-19 studies had not expired. O-E stated she was fingerprinted but had not followed up to ensure fingerprinting had been completed. The licensee's Recruitment and Hiring policy dated August 1, 2021, indicated licensee would ensure all persons would have equal employment opportunities and would be appropriately screened prior to employment. Furthermore, the director or designee would be responsible for	01290		

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01290	Continued From page 19 initiating the criminal background study for new employees, and NetStudy 2.0 or current version would be used for the background check. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01290		
01370 SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for	01370		

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01370	Continued From page 20 the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure training and competency was completed with all required content for one of two employees (unlicensed personnel (ULP)-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: ULP-C was hired on January 4, 2021, to provide direct care services to residents of the assisted living facility. On September 24, 2024, at 9:15 a.m., ULP-C was observed assisting R1 with medication administration. ULP-C's employee record lacked documentation	01370		

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01370	Continued From page 21 of training and competency evaluations for ULPs including: - standby assistance techniques and how to perform them; - preparation of modified diets as ordered by a licensed health professional; - communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; and - awareness of commonly used health technology equipment and assistive devices. On September 24, 2024, at 2:15 p.m., clinical nurse supervisor (CNS)-A stated ULP-C's training lacked the above required content. CNS-A further stated ULP-C had training and orientation by the previous registered nurse (RN), who was utilizing outdated training materials. The licensee's Staff Competency policy dated August 1, 2021, indicated all residents would receive quality service delivered by staff who were educated and competent in the delivery of assisted living services. In addition, the policy directed ULP's would not work for licensee until they had successfully passed the written test (at 80%) and demonstrated competency via evaluation. Training and competency evaluations for all ULP providing assisted living services would include: - standby assistance techniques and how to perform them; - preparation of modified diets as ordered by a licensed health professional; - communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; and - awareness of commonly used health technology	01370		

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01370	Continued From page 22 equipment and assistive devices. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01380 SS=D	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 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 and competency was completed with all required content for one of two employees (unlicensed personnel (ULP)-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	01380		

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01380	Continued From page 23 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: ULP-C was hired on January 4, 2021, to provide direct care services to residents of the assisted living facility. On September 24, 2024, at 9:15 a.m., ULP-C was observed preparing and administering oral medications to R1. ULPCs employee record lacked documentation of the following training and competency evaluations for ULPs providing assisted living services: - reading and recording temperature, pulse, and respirations of the resident. On September 24, 2024, at 2:15 p.m., clinical nurse supervisor (CNS)-A stated ULP-C's training record lacked the above required content. CNS-A further stated ULP-C had training and orientation by the previous registered nurse (RN), who was utilizing outdated training materials. The licensee's Staff Competency policy dated August 1, 2021, indicated all residents would receive quality service delivered by staff who were educated and competent in the delivery of assisted living services. In addition, the policy directed ULP's would not work for licensee until they had successfully passed the written test (at 80%) and demonstrated competency via evaluation. Training and competency evaluations for all ULP providing assisted living services	01380		

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01380	Continued From page 24 would include: -reading and recording temperature, pulse, and respirations of the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human	01470		

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01470	Continued From page 25 Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation 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 the challenges it poses to communication; (2) 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 employees received orientation to include all required content for one of two employees (unlicensed personnel (ULP)-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	01470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34758	A. BUILDING: _____ B. WING _____	09/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSION HILL GROUP HOME SRVS	2722 NORTH 4TH STREET MINNEAPOLIS, MN 55411

(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
01470	Continued From page 26 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: ULP-C was hired January 4, 2021, and provided direct cares for residents of the facility. ULP-C's employee record lacked documentation of orientation in the following topics: - an overview of this chapter; - an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; - handling of emergencies and use of emergency services; - by the staff person; - handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; - consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and - a review of the types of assisted living services the employee will be providing and the facility's category of licensure. On September 24, 2024, at 2:15 p.m., clinical nurse supervisor (CNS)-A stated ULP-C had training and orientation by the previous registered nurse (RN). CNS-A further stated ULP-C's orientation list lacked the above required content.	01470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34758	A. BUILDING: _____ B. WING _____	09/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01470	Continued From page 27 The licensee's Staff Orientation and Education policy dated August 2021, indicated the above training topics would be included for all staff prior to providing Assisted Living services to residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		

Minnesota Department of Health
Division of Environmental Health, FPLS
PO Box 64975
Saint Paul, 55164-0975
651-201-4500

Type: Full
Date: *09/24/24*
Time: 13:59:05
Report: 1023241214

Food and Beverage Establishment Inspection Report

Location:
Mission Hill Group Home Srvs
2722 North 4th Street
Minneapolis, MN55411
Hennepin County, 27

Establishment Info:
ID #: 0038468
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6125174570
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.

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.

HIGH TEMP DISH MACHINE IN USE BUT OPERATOR STATED NO WAY OF VERIFYING TEMPERATURE. ACQUIRE AND USE ONE OF THESE DEVICES TO ENSURE PATHOGEN DESTRUCTION.

Comply By: 09/24/24

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.

CHLORINE SANITIZER IN USE BUT NO TEST STRIPS AVAILABLE.

Comply By: 09/24/24

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

TO GET A CFPM YOU MUST TAKE EIGHT HOUR MANAGER CLASS, PASS TEST, AND MAIL APPLICATION IN TO MDH. YOU CAN SIGN UP FOR FOOD MANAGER COURSES AND FIND AN APPLICATION HERE:
https://fmctraining.web.health.state.mn.us/search/index.cfm

Comply By: 09/24/24

4-200 Equipment Design and Construction

4-201.11

MN Rule 4626.0505 Replace equipment or utensils that are not durable or do not retain their characteristic qualities under normal use conditions.

OPERATOR STORING BULK FOOD IN OLD CLEANING CHEMICAL CONTAINERS. REPLACE WITH CONTAINERS DESIGNED FOR FOOD.

Comply By: 09/24/24

Surface and Equipment Sanitizers

Chlorine: = at Degrees Fahrenheit
Location: CLEAN UP KIT
Violation Issued: No

Hot Water: = at Degrees Fahrenheit
Location: ANSI 184 DISH WASHER
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Hold/MILK
Temperature: 41 Degrees Fahrenheit - Location: REACH IN COOLER
Violation Issued: No

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

THIS INSPECTION WAS CONDUCTED IN CONJUNCTION WITH MDH HEALTH REGULATORY DIVISION (HRD) SURVEY. INSPECTION CONDUCTED IN PRESENCE OF THE PERSON IN CHARGE.

THIS FACILITY DOES NOT HAVE ALL COMMERCIAL GRADE ANSI EQUIPMENT. ALL FOOD MUST BE SERVED THE SAME DAY IT IS PREPARED, AND LEFTOVERS CAN NEVER BE SAVED. FOOD SERVICE IS PROVIDED BY FACILITY STAFF.

FOOD SERVICE AREA FLOORS, WALLS, CEILINGS, COUNTERTOPS, AND FINISH MATERIALS MUST BE NON-ABSORBANT, SMOOTH, DURABLE, AND EASILY CLEANABLE. CEILINGS CANNOT HAVE POPCORN TEXTURE. CABINETS CANNOT HAVE HOLLOW BASES. EXPOSED WOOD IS NOT APPROVED FOR FOOD SERVICE AREAS. WOOD IS NOT AN APPROVED FOOD CONTACT SURFACE.

THESE TOPICS WERE DISCUSSED WITH THE PERSON IN CHARGE:
- EMPLOYEE ILLNESS EXCLUSION
- HAND WASHING PROCEDURE
- NO BARE HAND CONTACT WITH RTE FOOD
- VOMIT CLEAN UP PROCEDURE
- FULLY COOKING FOOD FOR HIGH RISK POPULATIONS
- ANSI 184 DISH WASHER

TO GET A CFPM YOU MUST TAKE EIGHT HOUR MANAGER CLASS, PASS TEST, AND MAIL

Type: Full
Date: *09/24/24*
Time: 13:59:05
Report: 1023241214
Mission Hill Group Home Srvs

Food and Beverage Establishment Inspection Report

APPLICATION IN TO MDH. YOU CAN SIGN UP FOR FOOD MANAGER COURSES AND FIND AN APPLICATION HERE:
https://fmctraining.web.health.state.mn.us/search/index.cfm

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1023241214 of 09/24/24.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Inspection report reviewed with person in charge and emailed.

Signed:_____
HAWO
PERSON IN CHARGE

Signed: Gregory T Nelson
Gregory T. Nelson
Public Health Sanitarian
Freeman Building
651-201-4259
greg.nelson@state.mn.us