



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

December 18, 2023

Licensee

A Helping Hand Senior Care Services LLC
2446 15th Avenue South
Minneapolis, MN 55404

RE: Project Number(s) SL33208015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on December 5, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the 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.

The 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. The 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 the MDH within 15 calendar days of the correction order receipt date.

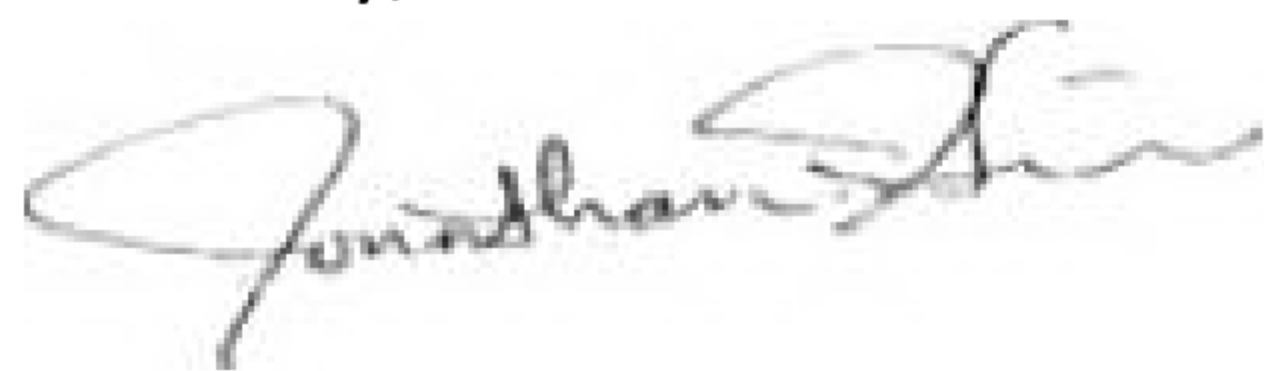
To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRD-Appeals-Form>

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,



Jonathan Hill, Supervisor

State Evaluation Team

Email: jonathan.hill@state.mn.us

Telephone: 651-201-3993 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33208	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/05/2023
NAME OF PROVIDER OR SUPPLIER A HELPING HAND SENIOR CARE SER			STREET ADDRESS, CITY, STATE, ZIP CODE 2446 15TH AVENUE SOUTH MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL33208015-0 On December 4 through December 5, 2023, 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 (3) active 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			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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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 had the potential to affect all residents of the assisted living facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report (FBEIR), dated December 4, 2023, for the specific Minnesota Food Code deficiencies. 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 program according to the most current tuberculosis infection control guidelines issued by	0 660			

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0 660	Continued From page 2 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 observation, 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 includes baseline testing, and symptom and history screening for one of two employees clinical nursing supervisor (CNS)-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). Findings include: The facility TB risk assessment was completed June 1, 2023, and indicated the facility was at a low risk for TB transmission.	0 660			

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0 660	Continued From page 3 CNS-D was hired November 10, 2023, and provided direct care services for residents. CNS-D's employee record included a negative TB blood test dated February 1, 2022, greater than 90 days prior to the November 10, 2023 hire date. CNS-D's record further lacked documentation of a TB symptom and history screening completed upon hire. On December 4, 2023, at 2:20 p.m., licensed assisted living director (LALD)-A stated CNS-D did have a TB gold, but it was not completed within 90 days before hire. LALD-A further stated he thought the blood test was "good" for at least a year. On December 4, 2023, at 3:27 p.m., CNS-D stated she filled out many forms when she was hired, and could not remember if she completed a TB history and symptom screening form. The Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, noted, "The purpose of this manual is to assist health care facilities in Minnesota to understand what is needed to be in compliance with Minnesota laws revised in 2013 regarding TB prevention and control, and to provide tools for implementing legal regulations and best practices in their settings." This included, Baseline TB screening is required for all health care workers (HCW). Baseline TB screening consists of three components: 1. Assessing for current symptoms of active TB disease; 2. Assessing TB history; 3. Testing for the presence of infection with <i>Mycobacterium tuberculosis</i> by administering either a	0 660			

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0 660	Continued From page 4 two-step TST or single IGRA; and An employee may begin working with patients after a negative TB symptom screen (i.e., no symptoms of active TB disease) and a negative IGRA or TST (i.e., first step) dated within 90 days before hire. The second TST may be performed after the HCW starts working with patients." The licensee's Tuberculosis Screening/Prevention policy, dated August 1, 2021, indicated, "[Licensee] will observe the recommended precautions related to TB prevention as identified by the Centers for Disease Control and Prevention (CDC) and the Minnesota Department of Health (MOH). The precautions include the following elements. -Risk Assessment -TB Screening -Staff Education". 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; (2) post an emergency disaster plan prominently;	0 680			

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0 680	Continued From page 5 (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 develop a written emergency preparedness (EP) plan with all the required content, and review annually. 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 included documentation indicating the plan was created and last reviewed August 1, 2021. The plan further included a	0 680			

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0 680	Continued From page 6 hazard vulnerability assessment (HVA) that was last reviewed February 20, 2022. On December 5, 2023, at 11:30 a.m., licensed assisted living director (LALD)-A stated he reviewed the EP plan regularly, but had not documented. LALD-A further stated he would document the annual review of the EP plan, including HVA, communication plan, and policies. The licensee's Emergency Preparedness Plan - Appencix Z Compliance, dated August 1, 2021, indicated, "[Licensee's] emergency preparedness plan will include all required elements of appendix Z. The plan will be in writing and reviewed annually." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680			
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	0 790			

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0 790	Continued From page 7 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to perform the required annual and monthly maintenance on fire extinguishers and failed to provide adequately rated (size) portable fire extinguishers as required for the facility. This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On December 4, 2023, at 1:00 p.m., survey staff toured the facility with licensed assisted living director (LALD)-A. During the tour, it was observed the fire extinguishers have a service tag showing they were inspected in August 2022 and had not been inspected annually since. It was also observed the portable fire extinguisher lacked records to show the required monthly visual inspections were performed. It was also observed the installed fire extinguishers on the upper level was 1-A:10-BC (size) rated and did not have at least one 2-A:10-B:C rated fire extinguisher as required. On December 4, 2023, at 1:00 p.m., LALD-A verified maintenance had not been completed as required and the facility did not have an	0 790			

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0 790	Continued From page 8 appropriate size fire extinguisher. 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 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	0 810			

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0 810	Continued From page 9 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, the plan was readily accessible in the facility and failed to provide required drills. 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 the facility tour with licensed assisted living director (LALD)-A on December 4, 2023, at 1:00 p.m., it was observed the fire safety and evacuation plans were not posted or readily available throughout the facility. This deficient condition was verified by LALD-A accompanying the tour. On December 5, 2023, LALD-A provided 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. FIRE SAFETY AND EVACUATION PLAN	0 810			

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0 810	Continued From page 10 The FSEP included the following discrepancies: - The policy indicated residents should be evacuated to the safest exit or nearest set of smoke compartment doors away from fire and smoke. This facility was a residential home and did not contain any sort of smoke compartments or smoke compartment doors to contain fire and smoke. - The policy indicated when the fire alarm is triggered, all fire doors on magnetic holders will automatically close to contain smoke and fire and residents are to remain behind these doors. The facility did not have any doors that are on magnetic door holders or doors that are rated for smoke and fire. The facility also did not have a fire alarm system that supports the use of magnetic door holders. - The policy indicated the system was wired directly to the fire station. The facility did not have a fire alarm system that supported the direct connection to the fire station. 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 FSEP was provided by a third-party consultant, and it was not updated to meet the facility-specific layout. The FSEP 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. The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs	0 810			

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0 810	Continued From page 11 of residents. The plan failed to include ways to move, evacuate residents based on the facility's specific layout in the event of a fire or similar emergency. During interview on December 5, 2023, at 10:00 a.m., LALD-A stated the fire safety and evacuation plan was from a third-party provider and verified the facility needed to update the fire safety and evacuation plan, including the facility-specific fire safety protocols. DRILLS Record review of the available documentation indicated the licensee did not conduct evacuation drills twice per year per shift as required by statute. Provided documentation indicated drills were conducted for the first and second shifts, and the facility failed to provide two drills for the third shift. During interview on December 5, 2023, at 10:00 a.m., LALD-A verified there were no further documented drills for the facility and verified this deficient condition. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			

Type: Full
Date: 12/04/23
Time: 09:11:33
Report: 8058231283

Food and Beverage Establishment Inspection Report

Page 1

Location:

A Helping Hand Senior Care Ser
2446 15th Avenue South
Minneapolis, MN55404
Hennepin County, 27

Establishment Info:

ID #: 0039018
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6122553110
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.

3-500B Microbial Control: hot and cold holding

3-501.16A2 ** Priority 1 **

MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

COOLER NEEDS TO BE ADJUSTED LOWER AND FOOD ITEMS MONITORED BY USING A FOOD THERMOMETER-SEE COMMENTS

Comply By: 12/04/23

8-500A Embargo/Condemnation

8-501.03MN

MN Rule 4626.1810 The following items are condemned and shall be removed from the establishment immediately:

HOME CANNED ITEMS (2 JARS PEACHES, 1 JAR JAM) - RETURN TO RESIDENT, NOT ALLOWED IN STAFF SUPERVISED COOLER

Comply By: 12/04/23

Surface and Equipment Sanitizers

Hot Water: = --- at 180 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: DELI TURKEY
Temperature: 44 Degrees Fahrenheit - Location: COOLER
Violation Issued: Yes

Type: Full
Date: 12/04/23
Time: 09:11:33
Report: 8058231283
A Helping Hand Senior Care Ser

Food and Beverage Establishment Inspection Report

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Process/Item: CHEESE
Temperature: 45 Degrees Fahrenheit - Location: COOLER
Violation Issued: Yes

Process/Item: GRAPES
Temperature: 45 Degrees Fahrenheit - Location: COOLER
Violation Issued: Yes

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

HRD INSPECTOR RENEE ANDERSON

RESIDENTIAL KITCHEN WITH NON COMMERCIAL APPLIANCES AND FINISHES

TO BE MONITORED FOR WARE:

- FLOOR BEGINNING TO DE-LAMINATE IN SPOTS ALONG EDGES
- MICROWAVE VENTS BACK INTO ROOM AND DEPOSITING GREASE ON CABINETS
- EXPOSED PRESSED BOARD CABINET CARCASS IS BEGINNING TO SHOW SIGNS OF WATER DAMAGE UNDER SINK

THESE ITEMS WILL LIKELY NEED TO BE REPLACED IN THE NEXT TWO YEARS WITH MORE DURABLE FINISHES (DISCUSSED ON SITE)

COMMENTS:

- COOLER DISPLAY SHOWS 36 DEGREES, FOOD ITEMS INSIDE COOLER ARE TESTING ABOVE 41 (44-45) ADJUST TEMPERATURE UNTIL FOOD ITEMS ARE TESTING AT OR BELOW 41 - NO ITEMS NEED TO BE DISCARDED AT THIS TIME

-RESIDENTS ARE NOT ALLOWED TO KEEP HOME CANNED ITEMS IN COMMUNAL COOLER

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 8058231283 of 12/04/23.

Certified Food Protection Manager ANISA YUSUF

Certification Number: 108870 Expires: 12/22/24

Inspection report reviewed with person in charge and emailed.

Signed: _____
Establishment Representative

Signed: 
Inspector Number 8058
Sanitarian 3
MDH Metro Office
651 201 4500
health.foodlodging@state.mn.us