Electronically Delivered

January 15, 2025

Licensee
Heaven Homes Inc.
1139 15th Avenue Southeast
Minneapolis, MN 55414

RE: Project Number(s) SL36736015

Dear Licensee:

On December 31, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the September 13, 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,

Kelly Thorson

Kelly Thorson, Supervisor
State Evaluation Team
Email: kelly.thorson@state.mn.us
Telephone: 320-223-7336 Fax: 1-866-890-9290

JMD

Electronically Delivered

October 15, 2024

Licensee
Heaven Homes Inc
1139 15th Avenue Southeast
Minneapolis, MN 55414

RE: Project Number(s) SL36736015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on September 13, 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,

Casey DeVrie, Supervisor
State Evaluation Team
Email: Casey.DeVries@state.mn.us
Telephone: 651-201-5917 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
	36736	A. BUILDING: _____ B. WING _____	09/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEAVEN HOMES INC	1139 15TH AVENUE SE MINNEAPOLIS, MN 55414

(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: SL36736015-0 On September 9, 2024, through September 13, 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 four residents, all of whom received services under the Assisted Living license. On September 9, 2024, an immediate correction order was issued for tag identification 1290. During the survey, the licensee took action to mitigate the immediate risk. Noncompliance remained, and the scope and level remain unchanged.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 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 September 10, 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.	0 480		
0 660 SS=F	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	0 660		

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0 660	Continued From page 2 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 maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included a two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test completed no more than 90 days prior to hire for two of three employees (unlicensed personnel (ULP)-C, ULP-F). 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: ULP-C	0 660		

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0 660	Continued From page 3 ULP- C was hired on January 1, 2021, to provide direct cares and services to residents. ULP-C's employee recorded included a negative TB Gold QuantiFERON Plus result completed on June 11, 2019, eighteen months prior to ULP-C's hired date. ULP-F ULP- F was hired on January 1, 2021, to provide direct cares and services to residents. ULP-F's employee recorded included a negative TB Gold QuantiFERON Plus result completed on March 4, 2020, nine months prior to ULP-C's hired date. On September 10, 2024, at 10:25 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-E stated they were not aware that the TB screening result completed prior to 90 days of hire was not acceptable. The licensee's 8.16 Tuberculosis Screening policy dated January 1, 2023, indicated the licensee would observe the recommended precautions related to TB prevention as identified by the CDC and the Minnesota Department of Health (MDH). The MDH Assisted living Resources and Frequently - Asked Questions (FAQs) dated September 9, 2024, indicated a previous TST or interferon- gamma release assay (IGRAs) was acceptable if completed 90 days or less prior to date of hire. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 660		

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0 660	Continued From page 4 (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; (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 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.	0 680		

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0 680	Continued From page 5 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 January 2024, lacked evidence of the required content of policies and procedures for volunteers. On September 10, 2024, at 11:30 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-E stated they did not have volunteers and their interpretation of the statute was that they needed the volunteer policy only if they had volunteers. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
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;	0 810		

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0 810	Continued From page 6 (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training and 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) and was issued at a	0 810		

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0 810	Continued From page 7 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 11, 2024, licensed assisted living director/clinical nurse supervisor (LALD/CNS-C) provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP, titled "9.06 Fire Policy", dated August 1, 2021, failed to include the following: 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 plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate) but the plan was designed for a building with life safety systems such as fire doors and smoke compartments. The policy had not been updated to provide complete actions for employees to take in the event of a fire or similar emergency at the licensed facility which did not have life safety systems or a fire-resistant construction type. The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency.	0 810		

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0 810	Continued From page 8 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 of residents. The plan included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation nor did it include instructions for staff to follow in case of relocation. On September 11, 2024, at 11:50 a.m., LALD/CNS-C stated they understood the areas of their policy that were incomplete and would work on bringing them into compliance. The policy reviewed was an unedited policy purchased from a third-party provider that was not specific to the facility. TRAINING: The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. LALD/CNS-C lacked documentation showing any training was offered or training was scheduled for a future date for staff on the fire safety and evacuation plan. On September 11, 2024, at 11:50 a.m., LALD/CNS-C stated they were doing training at the same time as the evacuation drills. LALD/CNS-C stated they understood the requirements for training residents and staff and would implement a training program that was compliant with statute requirements. DRILLS: The licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. Record review of licensee's evacuation drill log,	0 810		

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0 810	Continued From page 9 titled "Emergency Drill Rotation", dated June 28, 2024, indicated evacuation drills were conducted on August 25, 2024, May 26, 2024, November 11, 2023, May 31, 2024, November 29, 2022, July 10, 2022, May 1, 2022, and November 10, 2021.3. No other documentation was provided. On September 11, 2024, at 11:50 a.m., LALD/CNS-C stated there were no additional documented drills for the facility. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 950 SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the	0 950		

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0 950	Continued From page 10 designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to include the required statutory language giving residents the right to identify a designated representative on its own separate page for one of one resident (R1). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R1's Assisted Living Contract was signed on July 22, 2022. The licensee's blank undated Assisted Living Contract form did not include the required statutory notice language about designated representative on a document separate from the contract. On September 9, 2024, at 12:28 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-E stated they were not aware of the specific statutory notice language about	0 950		

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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
0 950	Continued From page 11 designated representative. LALD/CNS-E stated the same form they used for R1 is used for all residents. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 950		
0 970 SS=B	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety, or personal property of a resident for two of four residents (R1, R2). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a 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).	0 970		

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	36736	A. BUILDING: _____ B. WING _____	09/13/2024

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0 970	Continued From page 12 The findings include: R1's Assisted Living Contract was signed on July 22, 2022. R2's assisted living contract was signed on August 1, 2021. The licensee's undated Assisted Living Contract on page 15, included language waiving the facility's liability, read: "Indemnification Resident will indemnify and hold harmless Provider, its employees and agents from and against any and all claims, actions, damages, and liability and expense in connection with loss of life, personal injury or damage to property, arising from or out of the use by Resident of the rented premises or any other part of Provider's property, or caused wholly or in part by an act or omission of Resident..." "Liability Provider is not liable to Resident ... for any injury, death or property damage occurring in the Apartment Unit or on Provider's premises unless such injury, death or property damage occurs as the result of an equipment malfunction or hazardous conditions within the building not caused by Resident..." On September 9, 2024, at 12:20 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-E stated they have new version of assisted living contract without any waivers of liability. LALD/CNS-E stated they forgot to update R1 and R2's assisted living contracts with the new version.	0 970		

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0 970	Continued From page 13 No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01290 SS=H	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study (BGS) was current and eligible on NETStudy 2.0 (web-based system for submitting background study requests to the Department of Human Services (DHS)) for four of eight employees (housing manger/unlicensed personnel (HM/ULP)-D, unlicensed personnel (ULP)-A, ULP-B, and ULP-C). 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,	01290		

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01290	Continued From page 14 or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: The licensee's staffing plan last reviewed on March 31, 2024, indicated one ULP was scheduled per shift. On September 9, 2024, at 1:30 p.m., licensed assisted director/clinical nurse supervisor (LALD/CNS)-E stated the ULPs were not always supervised, and they can work independently. ULP-A ULP- A was hired on September 1, 2021, to provide direct cares and services to residents. The licensee's staffing schedule for September 8, through September 14, 2024, indicated ULP-A was scheduled to work evening-shifts (4 p.m. to 12 a.m.) for the following dates: September 9, 11, and 13. Night-shift (12 a.m. to 8 a.m.) for the following dates: September 12 and 14. ULP-A's employee record included a background study clearance dated August 15, 2021, affiliated to the licensee's HFID #36736. However, the "eligible covid 19 study "status for background study was Expired on December 31, 2022. The licensee lacked evidence the licensee submitted a background stud for ULP-A after the covid 19 eligible status was expired. ULP-B ULP- B was hired on September 26, 2021, to provide direct cares and services to residents.	01290		

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01290	Continued From page 15 The licensee's staffing schedule for September 8, through September 14, 2024, indicated ULP- B was scheduled to work morning-shifts (8 a.m. to 4 p.m.) for the following dates: September 8, and 14. Night-shift (12 a.m. to 8 a.m.) for the following dates: September 8, and 10. ULP-B's employee record included a background study clearance dated August 15, 2021, affiliated to the licensee's HFID #36736. However, the "eligible covid 19 study "status for background study was Expired on December 31, 2022. The licensee lacked evidence the licensee submitted a background stud for ULP-B after the covid 19 eligible status was expired. ULP-C ULP- C was hired on January 1, 2021, to provide direct cares and services to residents. The licensee's staffing schedule for September 8, through September 14, 2024, indicated ULP- C was scheduled to work evening-shifts (4 p.m. to 12 a.m.) for the following dates: September 10, and 12. Night-shift (12 a.m. to 8 a.m.) for the following dates: September 10, 11, and 13. ULP-C's employee record included a background study clearance dated September 7, 2021, affiliated to the licensee's HFID #36736. However, the "eligible covid 19 study "status for background study was Expired on December 31, 2022. The licensee lacked evidence the licensee submitted a background stud for ULP-C after the covid 19 eligible status was expired. HM/ULP-D HM/ULP- D was hired on January 1, 2021, to work as a housing manager and to provide direct cares and services to residents when needed. The licensee's staffing schedule for September 8,	01290		

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01290	Continued From page 16 through September 14, 2024, did not indicate HM/ULP- D was scheduled to work assigned shift for any day of the week. HM/ULP- D's employee record included a background study clearance dated August 27, 2021, affiliated to the licensee's HFID #36736. However, the "eligible covid 19 study "status for background study was Expired on December 31, 2022. The licensee lacked evidence the licensee submitted a background stud for HM/ULP- D after the covid 19 eligible status was expired. On September 9, 2024, at 1:15 p.m., HM/ULP-D stated they knew they had to resubmit a BGS study for employees with expired "eligible covid 19 study" status and stated it was overlooked. On September 9, 2024, at 1:23 p.m., HM/ULP-D stated they worked as a housing manger and they covered ULP shifts when needed, "I do not have set schedule, but I am here all the time". On September 9, 2024, at 2:10 p.m., LALD/CNS-E stated they did not know the "eligible covid 19 study" status was expired, and they did not know they had to resubmit a background study. The licensee's 4.02 Background Studies policy undated read: "No employee may provide direct services and have independent direct contact with any residents until acceptable result of the background study have been received. Heaven Homes will not employ individuals whose results of the background study indicate disqualification for the position." On September 9, 2024, the Minnesota Department of Human Services website indicated	01290		

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01290	Continued From page 17 the following: Emergency studies completed during the COVID-19 pandemic were no longer valid. Individuals who only had an emergency study must have a fully compliant, fingerprint-based background study. Roster maintenance - Individuals with a completed emergency study will remain on the entity's roster unless the entity removes the individual. Entities should remove individuals with emergency studies that are no longer affiliated; - If the individual should no longer be affiliated and has a new fully compliant background study, the entity should wait until the individual is separated and then remove both the emergency study and fully compliant study from their roster at the same time; - All entities are responsible for maintaining their rosters regularly and removing study subjects from their roster when they are no longer affiliated; and - Entities are responsible for identifying who needs to submit a new background study. For help identifying which study subjects still have an emergency study and need a fully compliant study, entities should refer to the instructional guide, "Identifying Emergency Studies" in the help section of NETStudy 2.0. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate During the survey, the licensee took action to mitigate the immediate risk. Noncompliance remained, and the scope and level remain unchanged.	01290		

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01530	Continued From page 18	01530		
01530 SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure three of three employees (unlicensed personnel (ULP)-B, ULP-C, ULP-F) received at least eight hours of initial dementia care training within 160 working hours of their employment start date and two hours of dementia care training for each 12 months of work thereafter.	01530		

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01530	Continued From page 19 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 the potential to affect a large portion or all of the residents). The findings include: ULP-B ULP-B was hired on September 26, 2021, to provide direct care and services to residents. ULP-B's Educare (education software used by the licensee) transcript for the years 2021, 2022, and 2023, indicated a total of five hours of dementia training completed by ULP-B since the date of hire. ULP-C ULP-C was hired on January 1, 2021, to provide direct care and services to residents. ULP-C's Educare transcript for the years 2021, 2022, 2023, and 2024, indicated a total of five hours of dementia training completed by ULP-C since the date of hire. ULP-F ULP-F was hired on January 1, 2021, to provide direct care and services to residents. ULP-F's Educare transcript for the years 2021, 2022, 2023, and 2024, indicated a total of six hours of dementia training completed by ULP-F since the date of hire.	01530		

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01530	Continued From page 20 ULP-B, ULP-C, and ULP-F's employee records lacked the required eight hours of dementia training and the required two hours of annual dementia training. On September 10, 2024, at 9:42 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-E stated they believe the required initial dementia training was two hours upon hire, and two hours of dementia training every year was required. LALD/CNS-E also stated their expectation for annual training was for all employees to complete their annual training by December 31st of each year. LALD/CNS-E was not aware of the requirement for eight hours of dementia training within 160 working hours of the ULPs' start date. The licensee's undated 5.03 Dementia Training read, "POLICY: All staff of [License name] are required to complete dementia training at the time of hire and annually thereafter. PROCEDURE: 1. Supervisors of direct care staff will complete eight (8) hours of initial training within 120 hours of the employment start date. 2. Direct care employees will complete eight (8) hours of initial training within 160 hours of the employment start date. 3. Employees may not provide direct care until the training is complete unless another employee who has completed the initial training is present to provide assistance. 4. A qualified trainer or supervisor must be available for consultation with new employees until training is complete. 5. Non-direct care staff will complete four (4) hours of initial training within 160 hours of	01530		

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01530	Continued From page 21 the employment start date. 6. All staff will complete two (2) hours of additional training for each 12 months of work thereafter. 7. If an employee has written proof of completing the required training within the past 18 months this may satisfy the initial training requirements. 8. Required dementia training topics include: - An explanation of Alzheimer's disease and other dementias - Assistance with activities of daily living - Problem solving with challenging behaviors - Communication skills - Person centered planning and service delivery 9. [License name] will provide consumers a written or electronic description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01890 SS=D	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: Based on observation, interview, and record	01890		

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01890	Continued From page 22 review, the licensee failed to ensure expired medications were disposed of for one of four residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's signed service plan dated August 1, 2021, indicated R2 received assistance with medication administration, homemaking, making appointments, socialization, grooming, bathing, and mental health needs. R2's record included a medication administration summary (MAR) record for the month of September 2024, which indicated R2 had an order for the following as needed (PRN) medications: -acetaminophen 500 milligrams (mg), one tablet up to four times a day as needed for pain or fever. On September 10, 2024, at 11:54 a.m., the surveyor observed R2's acetaminophen 500 mg tablet in the medication cabinet located at the nurse station on the main floor. The pharmacy label on the acetaminophen indicated an expiration date of February 5, 2023. On September 10, 2024, at 12:12 p.m., licensed assisted living director/clinical nurse supervisor	01890		

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01890	Continued From page 23 (LALD/CNS)-E stated they usually check the medication cabinet for expired medication, and they were unsure how they missed R2's acetaminophen. LALD/CNS-E also stated the ULPs were also supposed to check the expiration dates upon medication administration. The licensee's undated 7.23 Medication Disposal policy read, "Current unused medications managed by [licensee's name] will be returned to the pharmacy for credit, or given to the resident or the resident's representative, when the resident's medications are no longer managed by the facility or the medication has been discontinued by the prescriber. - Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications	01910		

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01910	Continued From page 24 remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide documentation of disposition of medications for one of one discharged resident (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 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 licensee's undated Discharged or Deceased Resident Roster indicated R4 was admitted to the licensee on June 1, 2023, and discharged on August 2, 2023. R4's signed service plan dated June 13, 2023, indicated R4 received the following services: medication setup, manage behavior, laundry,	01910		

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01910	Continued From page 25 deep room cleaning, record vital signs, and appointment reminder. R4's Medication Set up Review Summary for the month of July 2023, indicated R4 took the following medications: atorvastatin 10 milligrams (mg), one tablet (tab) daily, duloxetine 30 mg three capsules (caps) daily, gabapentin 300 mg, three caps twice daily, glipizide 5 mg one tab daily, hydrochlorothiazide 12.5 mg one tab daily, losartan 50 mg one tab daily, metformin 1000 mg twice a day, calcium carbonate and vitamin D3 600/400 mg daily, and quetiapine fumarate 100 mg every evening. R4's record lacked evidence of documented disposition of medications for R4 to include: the name of the medication, strength, prescription number if applicable, quantity, to whom the medications were given, date of disposition, and the names of the staff and other individuals involved in the disposition. On September 10, 2024, at 11:45 a.m., the surveyor requested medication disposition form for R4. Licensed assisted living director/clinical nurse supervisor (LALD/CNS)-E stated they were aware of the requirement for documenting medication disposition. LALD/CNS-E stated they did not utilize medication disposition form. The licensee's undated 7.23 Medication Disposal policy read, "-Current unused medications managed by [licensee's name] will be returned to the pharmacy for credit, or given to the resident or the resident's representative, when the resident's medications are no longer managed by the facility or the medication has been discontinued by the prescriber. - Upon disposition, the facility must document in	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36736	A. BUILDING: _____ B. WING _____	09/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEAVEN HOMES INC	1139 15TH AVENUE SE MINNEAPOLIS, MN 55414

(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
01910	Continued From page 26 the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		

Minnesota Department of Health
Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975
6512014500

Type: Full
Date: *09/10/24*
Time: 10:00:00
Report: 1047241262

Food and Beverage Establishment Inspection Report

Location:

Heaven Homes Inc
1139 15th Avenue Se
Minneapolis, MN55414
Hennepin County, 27

Establishment Info:

ID #: 0037840
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6124041005
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.

7-200 Toxic Supplies and Applications

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

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

CHLORINE CONCENTRATION IN SPRAY BOTTLE WAS TOO HIGH FOR FOOD CONTACT SURFACES. CORRECTED ON SITE- WATER WAS ADDED TO BOTTLE TO DILUTE THE CONCENTRATION

Corrected on Site

4-300 Equipment Numbers and Capacities

4-301.12D

MN Rule 4626.0680D Mechanical warewashing equipment in lieu of a 3-compartment sink may be allowed as long as the warewashing equipment is large enough to accommodate the largest piece of equipment to be washed, rinsed and sanitized.

THE FACILITY IS CURRENTLY USING A TEMPORARY BASIN IN ADDITION TO THE TWO COMP SINK TO CLEAN DISHES. FACILITY MUST ACQUIRE A HIGH TEMP SANITIZING DISHWASHER OR INSTALL A THREE COMPARTMENT SINK.

Comply By: 09/10/25

Surface and Equipment Sanitizers

Chlorine: = 200 ppm at Degrees Fahrenheit
Location: Sanitizer basin
Violation Issued: No

Chlorine: = 200 ppm at Degrees Fahrenheit
Location: Upstairs spray
Violation Issued: No

Chlorine: = >200 ppm at Degrees Fahrenheit
Location: Downstairs spray
Violation Issued: Yes

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: Downstairs fridge- cheese
Violation Issued: No

Process/Item: Cold Holding
Temperature: 37 Degrees Fahrenheit - Location: Upstairs fridge- milk
Violation Issued: No

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

The inspection was completed with the operator & reviewed with MDH Nurse evaluator D. Mosissa.

The establishment has a residential kitchen & serves food that is prepared that day. There are two kitchens- one on the upper floor & one on the lower/main floor. The kitchens have wood cabinets, laminate floors, solid counter tops, painted & tiled walls, & painted ceiling.

There is a two basin sink located in each kitchen. The facility uses an additional basin for sanitizing dishes.

Discussed hand washing, ware washing, staff illness policy, temperature control, final cook temperatures, cleaning, serving highly susceptible populations, & food handling procedures.

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 1047241262 of 09/10/24.

Certified Food Protection Manager: Ahmed A Hibo

Certification Number: FM115861 Expires: 03/31/26

Inspection report reviewed with person in charge and emailed.

Signed: _____
Jama Warsame
Kitchen Operator

Signed: _____
Holly Sievers
Public Health Sanitarian 2
Metro Office
6512015946
Holly.Sievers@state.mn.us