Electronically Delivered

April 3, 2025

Licensee
Heartfelt Care LLC
7717 Georgia Avenue North
Brooklyn Park, MN 55445

RE: Project Number(s) SL35941015

Dear Licensee:

On March 5, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the September 6, 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,

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

HHH

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

January 29, 2025

Licensee
Heartfelt Care LLC
7717 Georgia Avenue North
Brooklyn Park, MN 55445

RE: Project Number(s) SL35941015

Dear Licensee:

On December 3, 2024, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on September 6, 2024. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the September 6, 2024 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on September 6, 2024, found not corrected at the time of the December 3, 2024, follow-up survey and/or subject to penalty assessment are as follows:

0820 - Fire Protection And Physical Environment - 144g.45 Subd. 2 (g)

The details of the violations noted at the time of this follow-up survey completed on December 3, 2024 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

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 outlined on the state form; however, plans of correction are not required to be submitted for approval.

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

INFORMAL CONFERENCE

In accordance with Minn. Stat. § 144A.475, Subd. 8 OR Minn. Stat. § 144G.20, Subd. 20, the Commissioner of Health is authorized to hold a conference to exchange information, clarify issues, or resolve issues. The Department of Health staff would like to schedule a conference call with Heartfelt Care LLC. Please contact Bob Dehler at 651-201-3710 on or before Monday, February 3, 2025 to schedule the conference call.

We urge you to review these orders carefully. If you have questions, please contact Jess Schoenecker at 651-201-3789.

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

Sincerely,

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

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35941	A. BUILDING: _____ B. WING _____	R 12/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTFELT CARE LLC	7717 GEORGIA AVENUE NORTH BROOKLYN PARK, MN 55445

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL#35941015-1 On December 3, 2024, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on September 6, 2024. At the time of the survey, there were 4 active residents; 4 receiving services under the Assisted Living license. As a result of the revisit, the following orders were reissued and/or issued. **AMENDED** On February 21, 2025, tag identification number 0820 was amended to reflect the correct individual interviewed on December 3, 2024, at 10:40 a.m.	{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.	
{0 110} SS=C	144G.10 Subdivision 1a Assisted living director license required	{0 110}		

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{0 110}	Continued From page 1 Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by:	{0 110}	Not reviewed during this survey.	
{0 470} SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and	{0 470}		

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{0 470}	Continued From page 2 (v) capable of following directions; This MN Requirement is not met as evidenced by:	{0 470}	Not reviewed during this survey.	
{0 570} SS=C	144G.42 Subdivision 1 Display of license The original current license must be displayed at the main entrance of each assisted living facility. The facility must provide a copy of the license to any person who requests it. This MN Requirement is not met as evidenced by:	{0 570}	Not reviewed during this survey.	
{0 650} SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health	{0 650}		

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{0 650}	Continued From page 3 screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by:	{0 650}	Not reviewed during this survey.	
{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	{0 680}		

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{0 680}	Continued From page 4 by:	{0 680}	Not reviewed during this survey.	
{0 780} SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment 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 by:	{0 780}	Not reviewed during this survey.	
{0 800} SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including	{0 800}		

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{0 800}	Continued From page 5 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:	{0 800}	Not reviewed during this survey.	
{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) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The	{0 810}		

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{0 810}	Continued From page 6 training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by:	{0 810}	Not reviewed during this survey.	
{0 820} SS=E	144G.45 Subd. 2 (g) Fire protection and physical environment (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 ensure physical facility elements did not constitute a distinct hazard to life. The licensee failed to provide resident bedrooms with the minimum window opening meeting the minimum	{0 820}		

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{0 820}	Continued From page 7 state standard for egress. This had the potential to affect some 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 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 December 3, 2024, surveyor conducted a revisit to follow-up on orders issued pursuant to a survey completed on September 6, 2024. On December 3, 2024, at 10:35 a.m., survey staff toured the facility with licensed practical nurse (LPN)-G. During the tour, survey staff asked LPN-G to open the windows in the resident bedrooms for measurement. The noncompliant measurements were as follows: Occupied Sleeping Rooms: Bedroom 1: window measured 23 inches clear width, 16 inches clear height, and 368 square inches total open area. Bedroom 2: window measured 23 inches clear width, 16 inches clear height, and 368 square inches total open area. Unoccupied Sleeping Rooms: Bedroom 3: window measured 23 inches clear width, 16 inches clear height, and 368 square inches total open area.	{0 820}		

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{0 820}	Continued From page 8 The windows in bedrooms 1, 2, and 3 did not meet the minimum requirements for clear height and total openable area. On December 3, 2024, at 10:40 a.m., phone interview with an individual who identified themself as the director stated the windows in bedrooms 1, 2, and 3 had not been replaced, and the new windows had been paid for, but the contractor is behind schedule to install the windows. On December 3, 2024, at 10:45 a.m. LPN-G provided documentation of an active fire watch performed by the licensee. Survey staff explained to LPN-G that at least one window in each bedroom in a state-licensed facility must meet the minimum state fire code standard for an egress window to be a complying bedroom for resident occupancy. LPN-G verbally confirmed the findings. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. No further information was provided.	{0 820}		
{01060} SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member.	{01060}		

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{01060}	Continued From page 9 An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by:	{01060}		

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{01060}	Continued From page 10	{01060}	Not reviewed during this survey.	
{01620} SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by:	{01620}	Not reviewed during this survey.	
{01880} SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments	{01880}		

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{01880}	Continued From page 11 according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by:	{01880}	Not reviewed during this survey.	
{02310} SS=F	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by:	{02310}	Not reviewed during this survey.	
{02430} SS=F	144G.91 Subd. 15 Confidentiality of records (a) Residents have the right to have personal, financial, health, and medical information kept private, to approve or refuse release of information to any outside party, and to be advised of the assisted living facility's policies and procedures regarding disclosure of the information. Residents must be notified when personal records are requested by any outside party. (b) Residents have the right to access their own records. This MN Requirement is not met as evidenced by:	{02430}	Not reviewed during this survey.	

Electronically Delivered

October 11, 2024

Licensee
Heartfelt Care LLC
7717 Georgia Avenue North
Brooklyn Park, MN 55445

RE: Project Number(s) SL35941015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on September 6, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

The correction order documentation should include the following:

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

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

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

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

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

If you have any questions, please contact me.

Sincerely,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: Jess.Schoenecker@state.mn.us
Telephone: 651-201-3789 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
	35941	A. BUILDING: _____ B. WING _____	09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTFELT CARE LLC	7717 GEORGIA AVENUE NORTH BROOKLYN PARK, MN 55445

(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: SL35941015-0 On September 3, 2024, through September 6, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were four residents receiving services under the Assisted Living license. An immediate order for tag identification was issued on September 6, 2024. The immediacy of the order was removed on September 9, 2024, but 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 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 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 evaluators ' 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.	
0 110 SS=C	144G.10 Subdivision 1a Assisted living director license required	0 110		

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0 110	Continued From page 1 Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensed assisted living director (LALD) was listed as the Director of Record for the licensee through the Board of Executives for Long-Term Service and Supports (BELTSS) website. This had the potential to affect all the licensee's residents, staff, and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: LALD-D LALD-D was licensed on August 4, 2021. On September 3, 2024, at 1:30 p.m., the BELTSS website indicated LALD-D was licensed but was not listed as the Director of Record for any licensee. LALD-F LALD-F was licensed on January 14, 2022. On September 3, 2024, at 8:39 a.m., the BELTSS website indicated LALD-F was licensed; and	0 110		

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0 110	Continued From page 2 director of record for the licensee had expired on July 31, 2024. On September 3, 2024, at 11:10 a.m., administrator (A)-E stated LALD-F had an emergency leave and would only be working through the end of September; and the licensee hired LALD-D on September 3, 2024. On September 4, 2024, at 2:26 p.m., LALD-D stated they had been shadowing LALD-F but was hired on September 3, 2024. LALD-D stated they emailed BELTSS to be added as director of record for licensee. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the	0 470		

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0 470	Continued From page 3 requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post a 24-hour staffing schedule in a central location. 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: On September 3, 2024, at 10:16 a.m., during a facility tour, the surveyor observed a posted schedule for August 25, 2024, thru August 31, 2024. The surveyor did not observe a current schedule posted. On September 3, 2024, at 11:56 a.m., administrator (A)-E stated they were just informed	0 470		

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0 470	Continued From page 4 by staff of the schedule not being updated. A-E stated the licensee usually printed the schedule every two weeks; however, this was missed with the Labor Day holiday weekend. The licensee's undated Staffing & Scheduling policy indicated the schedule would be posted at the beginning of each work shift in a central location accessible to staff, residents, volunteers, and the public. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
0 570 SS=C	144G.42 Subdivision 1 Display of license The original current license must be displayed at the main entrance of each assisted living facility. The facility must provide a copy of the license to any person who requests it. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to display the original current license at the main entrance of the assisted living facility as required. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents).	0 570		

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0 570	Continued From page 5 The findings include: On September 3, 2024, at 10:16 a.m., during a facility tour, the surveyor observed an original license posted in the living room with an expiration date of June 4, 2024. On September 4, 2024, at 9:14 a.m., administrator (A)-E stated they had found the licensee's current license and would post it. A-E indicated this was an oversight. The licensee's undated Assisted Living License and Posting policy, indicated the original current license shall be displayed at the main entrance. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 570		
0 650 SS=F	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance	0 650		

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0 650	Continued From page 6 reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the employee record contained the required content for two of two unlicensed personnel ((ULP)-A, ULP-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: ULP-A ULP-A was hired on February 12, 2023. On September 4, 2024, at 12:13 p.m., the surveyor observed ULP-A administer medications to R3 via percutaneous endoscopic gastrostomy (PEG tube). ULP-A's employee record lacked evidence of training and competency evaluation for urinary catheter, colostomy, and gastrostomy cares.	0 650		

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0 650	Continued From page 7 On September 4, 2024, at 11:30 a.m., ULP-A stated they had been trained on urinary catheter, colostomy and gastrostomy cares by a previous nurse who was no longer employed by [licensee] and by clinical nurse supervisor (CNS)-C. ULP-B ULP-B was hired on March 11, 2019. On September 4, 2024, at 10:29 a.m., the surveyor observed ULP-B administer medications to R3 via PEG tube. ULP-B's employee record lacked evidence of training and competency evaluation for urinary catheter, colostomy, and gastrostomy cares. On September 4, 2024, at 11:09 a.m., ULP-B stated they had worked for the licensee for years; and they were trained by a doctor who had owned the facility on catheter, ostomy cares, and tube feeding. ULP-B stated the previous nurse and CNS-C also trained her and have observed her performing the cares as well. On September 4, 2024, at 11:14 a.m., administrator (A)-E stated they had talked with CNS-C; and CNS-C had reported they did not train or complete a competency evaluation on urinary catheter, colostomy, and gastrostomy cares since these were being performed prior to new ownership. A-E stated they had documentation of these trainings for other staff, but these competencies were missed for ULP-B and ULP-A in the personnel record. A-E stated they would make sure the competency evaluations got completed and placed in the personnel records. The licensee's undated Employee Records policy	0 650		

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0 650	Continued From page 8 indicated employee records would include training and competency testing documentation. Minnesota Administrative Rule 4659.0190, subpart 6 dated August 11, 2021, indicated a facility must maintain a record for each training and competency evaluation that included the following: - facility name, location, and license number; - name of the training topic or training program, and the training methodology, such as classroom style, web-based training, video, or one-to-one training; - date of the training and competency evaluation, and the total amount of time of the training and competency evaluation; - name and title of the instructor and the instructor's signature, and the name and title of the competency evaluator, if different from the instructor, and the evaluator's signature with a statement attesting that the employee successfully completed the training and competency evaluation; and - name and title of the staff person completing the training, and the staff person's signature with a statement attesting that the staff person successfully completed the training as described in the training documentation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements:	0 680		

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0 680	Continued From page 9 (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 observation, interview, and record review, the licensee failed to maintain a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z; failed to post the EPP prominently; and failed to post an emergency exit diagram on each floor. 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) and was issued at a widespread scope (when problems are pervasive	0 680		

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0 680	Continued From page 10 or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On September 3, 2024, at 10:16 a.m., during a facility tour, the surveyor did not observe the EPP posted prominently, or an exit diagram posted on the lower level of the facility. The licensee's undated EPP lacked evidence of the following required content: - EP program patient population; - process for EP collaboration; - subsistence needs for staff and patients; - procedures for tracking of staff and patients; - policies and procedures for medical documents; - policies and procedures for volunteers; - arrangement with other facilities; - roles under a wavier declared by secretary; - names and contact information; - primary/alternate means for communication; - methods for sharing information; - sharing information on occupancy/needs; and - LTC family notifications. On September 5, at 11:25 a.m., administrator (A)-E stated they were not aware of the missing content for the EPP; and the licensee did not have emergency supplies available for food, water or alternate sources of energy or sewage at the facility. A-E stated they did not realize the EPP was not prominently posted at this facility. On September 6, 2024, at 4:45 p.m., A-E stated they posted an exit diagram on the lower level on September 6, 2024. The licensee's Emergency Preparedness policy	0 680		

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0 680	Continued From page 11 dated August 1, 2021, indicated the licensee would have in place an emergency preparedness plan, that is in alignment with facility's requirement to also comply with CMS (Centers for Medicare and Medicaid Services) Appendix Z. No additional 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;	0 780		

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0 780	Continued From page 12 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that were interconnected so that the actuation of one alarm caused all alarms in the dwelling unit to actuate. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On September 6, 2024, from approximately 10:00 a.m., survey staff toured the facility with the Administrator (A)-E. Survey staff asked A-E to initiate a test of the smoke alarms throughout the home. Upon testing, it was found that the smoke alarms in the facility were not interconnected. These deficient conditions were visually verified by A-E accompanying on the tour. 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	0 800		

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	35941	A. BUILDING: _____ B. WING _____	09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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0 800	Continued From page 13 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 maintain the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation regarding the health, safety, comfort, and well-being of the residents. This deficient condition had the potential to affect all staff, residents, 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 (problems are pervasive or represent a systematic failure that has affected or has potential to affect a large portion or all of the clients). The findings include: On September 6, 2024, at approximately 10:00 a.m., survey staff toured the facility with the Administrator A-E. The following was observed. EGRESS WINDOWS: The egress window in bedroom 4 had vegetation growing in the egress window well. As a result the vegetation obstructed the egress window from	0 800		

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0 800	Continued From page 14 opening completely. GENERAL MAINTENANCE: The front entrance screen door was in need of repair. The bottom of the screen door was decayed and dismantling. The light fixture in the mechanical room did not work. As a result, no illumination was provided in the mechanical room. It was observed outside of bedroom 4, multiple appliances were connected to unapproved extensions cords. Appliances shall be plugged into the wall socket or an UL approved extension cord. On September 6, 2024, at approximately 10:00 a.m., A-E stated they understood the above-listed deficiencies. 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	0 810		

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0 810	Continued From page 15 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 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents).	0 810		

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0 810	Continued From page 16 The findings include: On September 6, 2024, at approximately 11:00 a.m. Administrator A-E 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, 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 failed to include procedures for how staff are to complete each step. 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 6, 2024, at approximately 11:30 a.m., A-E stated they understood the areas of their policy that were incomplete and would work on bringing them into compliance.	0 810		

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0 810	Continued From page 17 TRAINING: Record review indicated the licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. A-E was unable to provide documentation showing the required amount of training provided or training scheduled for a future date for staff on the fire safety and evacuation plan. On September 6, 2024, at approximately 11:30 a.m., A-E stated they understood the requirements for training residents and staff and would implement a training program that was compliant with statute requirements. DRILLS: 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 as evident providing documentation of drills completed that were not in the required sequence of every other month and twice per year per shift. On September 6, 2024, at approximately 11:30 a.m., A-E stated documentation was not available in the required sequence of one fire drill every other month and twice per shift per year. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 820 SS=I	144G.45 Subd. 2 (g) Fire protection and physical environment	0 820		

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0 820	Continued From page 18 (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 ensure physical facility elements did not constitute a distinct hazard to life. The licensee failed to provide a resident bedrooms with the minimum window opening meeting the minimum state standard for egress. This affected the occupied resident in bedroom 1, 2, and 3 on the main level. 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: On September 6, 2024, 2024, at 10:00 a.m., survey staff toured the facility with the	0 820		

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0 820	Continued From page 19 administrator(A)-E. During the facility tour, A-E measured the egress windows, and survey staff observed the following items: It was observed that occupied resident bedrooms 1,2,3 on the main level did not have windows that met the minimum size requirements for egress escape. The clear openable area of the opened windows measured 16 inches in height and 23 inches in width, with a total openable area of 368 square inches. The windows did not meet the minimum requirements for opening height and did not meet the minimum requirements for total openable area. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. Survey staff explained to A-E that at least one egress window in each bedroom must be provided to meet the minimum state standard for an egress window to be a complying bedroom for resident occupancy. A-E verbally confirmed the findings. On September 6, 2024, at 11:00, during the interview, survey staff explained to A-E that an immediate correction order was issued for the above finding. A-E acknowledged the above finding. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate The immediacy of the order was removed on September 9, 2024, but noncompliance remained and the scope and level remain unchanged.	0 820		

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01060	Continued From page 20	01060		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not	01060		

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01060	Continued From page 21 returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation to the resident, legal representative, and designated representative for two of two residents (R1, 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) 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 R1 was admitted to licensee on February 20, 2020, with diagnoses of end stage kidney disease with hemodialysis, history of failed kidney transplant, and seizure disorder. R1's Service Plan dated August 1, 2024, indicated R1 received services for the following: activity, ambulation, exercise, appointments, bathing, behavior management, colostomy, dressing, drinking assistance, mobility, grooming, housekeeping, laundry, meals, medication administration and set up, positioning, safety check, skin care, transfer assist, urostomy catheter care, and wound care.	01060		

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01060	Continued From page 22 R1's progress notes dated August 28, 2024, at 12:16 a.m., indicated R1 was sent to the hospital via emergency medical services (EMS) due to concern of possible respiratory distress. R1's progress notes dated August 28, 2024, at 8:17 p.m., indicated R1 returned to the facility from hospital. R1's record lacked documentation of a written notice to R1, R1's legal representative, and R1's designated representative with all the required content for an emergency relocation. R2 R2 was admitted to licensee on July 28, 2022, with diagnoses of quadriplegia, C5 to C7 incomplete spinal injury, diabetes, and neuromuscular dysfunction of bladder. R2's Service Plan dated August 1, 2024, indicated R1 received services for the following: activity, ambulation, exercise, appointments, bathing, behavior management, catheter care, dressing, drinking assistance, mobility, grooming, housekeeping, laundry, meals, medication administration and set up, positioning, safety check, skin care, support stockings, transfer assist, and wound care. R2's progress notes dated July 16, 2024, at 7:25 p.m., indicated R2 was sent to hospital via EMS due to change in resident condition. R2's progress notes dated July 20, 2024, at 12:29 p.m., indicated R2 returned to the facility from hospital. R2's record lacked documentation of a written	01060		

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01060	Continued From page 23 notice to R2, R2's legal representative, and R2's designated representative with all the required content for an emergency relocation. On September 5, 2024, at 1:57 p.m., clinical nurse supervisor (CNS)-C stated they would put a note in the electronic documentation system for emergency relocations, but the licensee had not provided residents or family with a written notice. CNS-D stated they would fax OOLTC the notice if a resident had been hospitalized longer than four days. The licensee's undated Emergency Relocation policy indicated the licensee would provide the written emergency relocation notice when a resident had an emergency relocation; and notify The Office of Ombudsman for Long-Term Care if the resident had not returned within four days. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs	01620		

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01620	Continued From page 24 and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure reassessment and monitoring were completed no more than fourteen calendar days after initiation of services; and ongoing resident reassessment and monitoring were completed as needed based on changes in the needs of the resident but not to exceed 90 calendar days from the last date of assessment for two of two residents (R1, 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) 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 On September 4, 2024, at 7:59 a.m., the surveyor observed unlicensed personnel (ULP)-A assist R1	01620		

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01620	Continued From page 25 with medication administration. R1 was admitted to licensee on February 20, 2020, with diagnoses of end stage kidney disease with hemodialysis, history of failed kidney transplant, and seizure disorder. R1's Service Plan dated August 1, 2024, indicated R1 received services for the following: activity, ambulation, exercise, appointments, bathing, behavior management, colostomy, dressing, drinking assistance, mobility, grooming, housekeeping, laundry, meals, medication administration and set up, positioning, safety check, skin care, transfer assist, urostomy catheter care, and wound care. R1's record included 90-day nursing assessments dated February 20, 2024, July 29, 2024, and August 18, 2024. The assessment completed on July 29, 2024, indicated 158 days had passed since the previous assessment completed on July 29, 2024. R2 On September 4, 2024, at 10:29 a.m., the surveyor observed ULP-B administer R2's medications. R2 was admitted to licensee on July 28, 2022, with diagnoses of quadriplegia, C5 to C7 incomplete spinal injury, diabetes, and neuromuscular dysfunction of bladder. R2's Service Plan dated August 1, 2024, indicated R1 received services for the following: activity, ambulation, exercise, appointments, bathing, behavior management, catheter care, dressing, drinking assistance, mobility, grooming, housekeeping, laundry, meals, medication	01620		

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01620	Continued From page 26 administration and set up, positioning, safety check, skin care, support stockings, transfer assist, and wound care. R2's Assessment dated August 27, 2022, indicated the reason was a 14-day assessment. The assessment was completed thirty days after the initiation of services. Also, the 14-day assessment was completed by a medical doctor and not a registered nurse (RN). R2's record included 90-day nursing assessments dated February 6, 2024, May 7, 2024, and August 19, 2024. The assessment completed on August 19, 2024, indicated 104 days had passed since the previous assessment completed on May 7, 2024; and the assessment completed on May 7, 2024, indicated 91 days had passed since the previous assessment completed on February 6, 2024. R2's progress notes dated July 20, 2024, at 4:44 p.m. by licensed practical nurse (LPN)-G indicated R2 was discharged home from hospital with new orders for antibiotic. LPN-G indicated in the progress notes, they completed a head-to-toe assessment. R2's record lacked evidence of an assessment completed by an RN following a hospitalization. On September 6, 2024, at 4:15 p.m., clinical nurse supervisor (CNS)-C stated the licensee would make sure to have an RN complete the assessments timely going forward as this was an oversight. The licensee's undated Assessments, Reviews & Monitoring policy indicated resident reassessment and monitoring would be no more than 14 calendar days after the initiation of	01620		

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	35941	A. BUILDING: _____ B. WING _____	09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01620	Continued From page 27 services; and ongoing resident reassessment and monitoring would be as needed based on changes in the needs of the resident but cannot exceed 90 calendar days from the last date of the assessment. Also, the policy indicated the assessment must be signed by the registered nurse who conducted the assessment. Minnesota Administrative Rule 4659.0140, subpart 4, A., B. dated August 11, 2021, indicated a registered nurse shall complete nursing assessments and reassessments; and ongoing monitoring may be completed by other licensed nurses acting within the scope of their license. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were stored securely for four of four residents (R1, R2, R3, R4) with medication management services. 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	01880		

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01880	Continued From page 28 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 Current Resident Roster dated September 3, 2024, indicated R1, R2, R3, and R4 had medication managed by licensee. On September 3, 2024, at 10:30 a.m., the surveyor observed a key in the doorknob for the medication closet and noted the closet door was not locked. All medications for R1, R2, R3 and R4 were not secured. On September 4, 2024, at 7:59 a.m., the surveyor observed a key in the doorknob for the medication closet and observed unlicensed personnel (ULP)-A access the medication closet without unlocking the closet door. On September 4, 2024, at 10:29 a.m., the surveyor observed a key in the doorknob for the medication closet and observed ULP-B access the medication closet without unlocking the closet door. On September 4, 2024, at 12:13 p.m., the surveyor observed a key in the doorknob for the medication closet and observed ULP-A access the medication closet without unlocking the closet door. On September 3, 2024, at 2:29 p.m., the surveyor observed R2's room and noticed unsecured medications of R2's that included clotrimazole 1.0	01880		

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01880	Continued From page 29 percent (%) cream, triamcinolone 0.1% cream, and diclofenac sodium topical gel. On September 5, 2024, at 1:00 p.m., clinical nurse supervisor (CNS)-C stated the medications were supposed to be locked; and they were not sure if the staff had forgotten to put medications back in the closet. Also, CNS-D stated the licensee would put a procedure in place to keep the medication key more secured and to maintain a locked medication closet. The licensee's Storage/Control of Medications policy dated August 1, 2021, indicated medications managed by licensee would be securely locked and only authorized personnel would have access to the stored medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
02310 SS=F	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for two of two residents (R1, R2) with bed rails.	02310		

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02310	Continued From page 30 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: R1 On September 3, 2024, at 2:38 p.m., the surveyor observed R1 had a hospital style bed with bilateral upper bed rails. The bed rails were grabbed by the surveyor and noted to be secured and not loose. R1 was admitted to licensee on February 20, 2020, with diagnoses of end stage kidney disease with hemodialysis, history of failed kidney transplant, and seizure disorder. R1's Service Plan dated August 1, 2024, indicated R1 received services for the following: activity, ambulation, exercise, appointments, bathing, behavior management, colostomy, dressing, drinking assistance, mobility, grooming, housekeeping, laundry, meals, medication administration and set up, positioning, safety check, skin care, transfer assist, urostomy catheter care, and wound care. R1's Bed Safety Assessment dated August 19, 2024, lacked documentation of measurements of zones of entrapment. R2 On September 3, 2024, at 2:29 p.m., the surveyor	02310		

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02310	Continued From page 31 observed R2 had a hospital style bed with bilateral upper bed rails. The bed rails were grabbed by the surveyor and noted to be secured and not loose. On September 3, 2024, at 2:33 p.m., R2 stated the bed rails are helpful with repositioning in bed. R2 was admitted to licensee on July 28, 2022, with diagnoses of quadriplegia, C5 to C7 incomplete spinal injury, diabetes, and neuromuscular dysfunction of bladder. R2's Service Plan dated August 1, 2024, indicated R1 received services for the following: activity, ambulation, exercise, appointments, bathing, behavior management, catheter care, dressing, drinking assistance, mobility, grooming, housekeeping, laundry, meals, medication administration and set up, positioning, safety check, skin care, support stockings, transfer assist, and wound care. R2's Bed Safety Assessment dated August 19, 2024, lacked documentation of measurements of zones of entrapment. On September 4, 2024, at 1:15 p.m., clinical nurse supervisor (CNS)-C stated they had not measured bed rails due to not being aware of needed documentation of the bed rail measurements. The licensee's undated Side Rails policy indicated licensee would ensure rails were Food and Drug Administration (FDA) compliant, measurements were within the FDA's guidelines, and risk versus benefits would be discussed and documented in the resident's record.	02310		

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02310	Continued From page 32 The FDA's A Guide to Bed Safety, revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." On page 21, Table 3 Summary of FDA Hospital Bed Dimensional Limit Recommendations indicated specific measurement limits for each entrapment zone. The Minnesota Department of Health's (MDH) Assisted Living: Resources and Frequently Asked Questions (FAQs) website read under Hospital-style bed rails licensees should ensure, "measurements were completed and documented, the rails were FDA compliant, and the risk versus benefits were discussed and documented with the resident/responsible party." No further information provided. TIME PERIOD FOR CORRECTION: Two (2) days	02310		
02430 SS=F	144G.91 Subd. 15 Confidentiality of records (a) Residents have the right to have personal, financial, health, and medical information kept private, to approve or refuse release of information to any outside party, and to be advised of the assisted living facility's policies and	02430		

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02430	Continued From page 33 procedures regarding disclosure of the information. Residents must be notified when personal records are requested by any outside party. (b) Residents have the right to access their own records. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure resident's personal health and medical information were kept private. This had the potential to affect all four (4) residents residing at the 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: On September 3, 2024, at 10:16 a.m., during a facility tour, the surveyor observed staff and resident information posted on a board in the common area of the dining room. The information posted included residents' private information for medical appointments that included the name of the specialty clinic or reason for the appointments. On September 5, 2024, at 1:10 p.m., clinical nurse supervisor (CNS)-C stated this was an oversight and they would correct by putting the information into a binder for staff to use.	02430		

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02430	Continued From page 34 The licensee's undated Confidentiality policy indicated the licensee emphasized the importance of maintaining the confidentiality of personal, financial, medical, or other private information regarding residents. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02430		

Minnesota Department of Health

625 North Robert Street
Saint Paul, MN
651-201-5000

Type: Full
Date: *09/03/24*
Time: 16:00:00
Report: 8087241199

Food and Beverage Establishment Inspection Report

Location:
Heartfelt Care Llc
7717 Georgia Avenue North
Brooklyn Park, MN55445
Hennepin County, 27

Establishment Info:
ID #: 0039358
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7632087793
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.

No NEW orders were issued during this inspection.

Food and Equipment Temperatures

Process/Item: Ambient Air
Temperature: 9 Degrees Fahrenheit - Location: FREEZER
Violation Issued: No

Process/Item: Ambient Air
Temperature: 36 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: No

Process/Item: Cold Holding: MILK
Temperature: 38 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: No

Process/Item: Cold Holding: DELI MEAT
Temperature: 34 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: No

Process/Item: Cold Holding: COTTAGE CHZ
Temperature: 36 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: No

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

THIS WAS AN ANNOUNCED AND SCHEDULED FULL INSPECTION.

INSPECTION CONDUCTED IN THE PRESENCE OF NURSE EVALUATOR RHAWNIE QUINEHAN.

FLOOR IS LINOLEUM, CABINETS ARE HARDWOOD AND CEILING APPEARS TO BE DURABLE, SMOOTH IN TEXTURE AND EASILY CLEANABLE. ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT SUCH A TIME

THEY ARE FOUND TO BE A CONCERN OR RISK OF CONTAMINATION, THEY WILL BE ORDERED TO BE REPLACED AND BROUGHT UP TO CODE.

WHIRLPOOL BRAND DISHWASHER IS RESIDENTIAL BUT HAS SANITIZING RINSE CYCLE OPTION.

HOT WATER TEMPERATURE AT THE KITCHEN SINK REACHED 120 DEGREES.

NO DESIGNATED HAND WASHING SINK IN THE KITCHEN, ONLY A 2-BIN, STAINLESS STEEL RESIDENTIAL KITCHEN SINK.

INSPECTION REPORT EMAILED TO RHAWNIE QUINEHAN.

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 8087241199 of 09/03/24.

Certified Food Protection Manager: MUNTAHA ISSA

Certification Number: FM121465 Expires: 02/17/27

Inspection report reviewed with person in charge and emailed.

Signed: _____

MUNTAHA ISSA
MANAGER

Signed: _____

John Boettcher
Public Health Sanitarian 3
St. Paul, MN / Freeman
651-201-5076
john.boettcher@state.mn.us