Electronically Delivered

January 6, 2025

Licensee
Healing Homes Living Services
83 Cook Avenue West
Saint Paul, MN 55117

RE: Project Number(s) SL36561016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on December 2, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

The correction order documentation should include the following:

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

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

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

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

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

If you have any questions, please contact me.

Sincerely,

Renee L. Anderson

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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36561	A. BUILDING: _____ B. WING _____	12/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALING HOMES LIVING SERVICES	83 COOK AVENUE WEST SAINT PAUL, MN 55117

(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 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: SL36561016-0 On November 18, 2024, through December 2, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were two residents; two receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Licensing 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 pursuant to 144G.31 Subd. 1, 2 and 3.	
0 110 SS=C	144G.10 Subdivision 1a Assisted living director license required Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services	0 110		

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0 110	Continued From page 1 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 on the Board of Executives for Long-Term Services and Support (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 of the residents). The findings include: LALD-D had a Shared Assisted Living Director license effective through October 31, 2025. LALD-D's license lacked documentation the LALD was listed as the Director of Record with BELTSS for the licensee. On December 2, 2024, at 2:00 p.m., owner (O)-A stated she would ensure the LALD was added to the BELTSS website for the licensee. The licensee's Assisted Living Director policy, dated August 1, 2022, indicated the licensee will comply with all requirements set forth by the Board of Executives for Long Term Services and Supports (BELTSS) as a licensed professional to remain in good standing.	0 110		

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0 110	Continued From page 2 No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage;	0 480		

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0 480	Continued From page 3 (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. 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, but was not likely to cause serious injury, impairment, or death), and is 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:	0 480		

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0 480	Continued From page 4 Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated November 18, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to implement and maintain a quality management program appropriate to the size of the facility and relevant to the type of services provided. This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 580		

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0 580	Continued From page 5 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 November 18, 2024, at 10:00 a.m., owner (O)-A stated they had initiated a quality management program and would provide documentation of the program. No further information was provided. The licensee's Quality Management Project policy, dated August 1, 2022, indicated the licensee "will have at least one documented quality management project in place at all times, and retain records of such projects for at least two years." TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 580		
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 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	0 660		

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0 660	Continued From page 6 volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included: a current TB blood test for one of two employees (clinical nurse supervisor (CNS)-B); TB history and symptom screening for two of two employees (CNS-B and unlicensed personnel (ULP)-C). In addition, the licensee lacked documentation a TB facility risk assessment was completed, as required. 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 is 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: A November 22, 2024, at 9:52 a.m., owner (O)-A stated, via email, they were unable to locate the current TB facility risk assessment. CNS-B CNS-B was hired on June 29, 2024, and provided supervisory and direct care assisted living	0 660		

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0 660	Continued From page 7 services to residents. CNS-B's employee record included a negative Quantiferon-TB Gold blood test, dated October 14, 2020 (greater than 90 days prior to hire). The record also lacked documentation a history and symptom screening was completed upon hire. ULP-C ULP-C was hired on July 21, 2024, and provided direct care assisted living services to licensee residents. ULP-C's employee record included a negative Quantiferon-TB Gold blood test, dated July 18, 2024. The record lacked documentation a history and symptom screening was completed. On November 18, 2024, at 10:00 a.m., O-A stated she was unable to locate the current TB Facility Risk Assessment, and would continue to attempt to locate the form. O-A stated she would ensure CNS-B completed TB testing and CNS-B and ULP-C completed a history and symptom screening. The licensee's Tuberculosis Screening policy, dated August 1, 2022, verified "the facility will maintain a current community TB risk assessment." In addition, the policy indicated "new staff will be screened for active signs of TB using the Baseline TB Screening Tool." and will have a blood test or two-step Mantoux completed prior to working with licensee's residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness	0 680		

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0 680	Continued From page 8 (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 have a written emergency preparedness plan with all the required content as defined in the Centers for Medicare and Medicaid Services (CMS) Appendix Z. This had the potential to affect all residents, staff and visitors at the assisted living facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 680		

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0 680	Continued From page 9 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 the residents). The findings include: The licensee's Emergency Preparedness binder lacked the following required content: -a Hazard Vulnerability Assessment -a written emergency disaster plan to include 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; -have a written policy and procedure regarding missing residents. -emergency and disaster training annually available to all residents. On December 2, 2024, at 2:00 p.m., owner (O)-A verified the above was missing from the emergency plan, and stated she had been unable to locate all content of the emergency plan. The licensee's Disaster Planning and Emergency Preparedness policy, dated August 1, 2022, verified the licensee will have in place a general emergency preparedness plan, that is in alignment with facility's requirement to also comply with CMS Appendix Z. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		

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0 780	Continued From page 10	0 780		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the current Minnesota Fire Code provisions. 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	0 780		

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0 780	Continued From page 11 resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On a facility tour with owner (O)-A, on November 20, 2024, from 2:45 p.m. to 5:00 p.m., the surveyor made the following observations of non-compliance with current Minnesota Fire Code provisions. Dryer duct was not connected to the dryer and the vent was loose near the ceiling where the duct work vented. It was observed that the required hardwired smoke alarm in the basement hallway, and on the ceiling of the 2nd floor resident room was over 10 years old. Smoke alarms are required to be replaced within 10 years of manufacture date according to current Minnesota Fire Code. On November 20, 2024, at 3:30 p.m., O-A verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Two (2) days	0 780		
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	0 810		

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0 810	Continued From page 12 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 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: 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	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36561	A. BUILDING: _____ B. WING _____	12/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALING HOMES LIVING SERVICES	83 COOK AVENUE WEST SAINT PAUL, MN 55117

(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
0 810	Continued From page 13 safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On a facility tour with owner (O)-A, on November 20, 2024, from 2:45 p.m. to 5:00 p.m., the surveyor observed the posted evacuation plans lacked identification of resident rooms. Exit plan diagrams must be correctly labeled to reduce confusion and potential obstructions to egress in a fire or similar emergency. On November 20, 2024, O-A 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 "Fire Safety", dated June 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	0 810		

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0 810	Continued From page 14 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. On November 20, 2024, at 4:30 p.m., O-A 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. O-A lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan. On November 20, 2024, at 4:30 p.m., O-A 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. No documentation was available for review. On November 20, 2024, at 4:30 p.m., O-A stated there were no additional documented drills for the facility.	0 810		

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0 810	Continued From page 15 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 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:	0 950		

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0 950	Continued From page 16 Based on interview and record review, the licensee failed to offer the resident the opportunity to identify a designated representative in writing with the required statutory language 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 potential to affect a large portion or all the residents). The findings include: R1's Assisted Living Contract was signed by R1 on October 1, 2022. R1's assisted living contract lacked the statute statement from 144.50 subd. 3 with required verbatim 'right to designate a representative for certain purposes' on a separate page in the contract, and lacked documentation R1 was provided the right to name a representative or declined to name a designated representative. On December 2, 2024, at 2:00 p.m., owner (O)-A stated she was not aware of the requirement to include the designated representative verbiage in the resident record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36561	A. BUILDING: _____ B. WING _____	12/02/2024

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01530	Continued From page 17	01530		
01530 SS=D	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 employees received the required amount of dementia care training with the required content, for two of two employees (clinical nurse supervisor (CNS)-B and unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a	01530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01530	Continued From page 18 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: CNS-B CNS-B was hired by the licensee on June 29, 2024, to provide clinical duties and oversight of unlicensed personnel. NP-B's employee record included one hour of initial dementia training completed on November 21, 2024. NP-B's record lacked evidence they completed the required eight hours of initial dementia training. ULP-C ULP-C was hired by the licensee on July 21, 2024, to provide direct care services for licensee residents. ULP-C's employee record included 6.75 hours of required dementia training. ULP-C's record lacked evidence they completed the required eight hours of initial dementia training. On December 2, 2024, at 2:00 p.m., owner (O)-A stated she was not aware ULP-C and CNS-B did not have the required dementia training and would ensure the training was completed. The licensee's Dementia Training policy, dated August 1, 2022, verified supervisors of direct care staff will complete eight hours of initial training	01530		

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01530	Continued From page 19 within 120 hours of the employment start date. The licensee's direct care employees will complete eight hours of initial training within 160 hours of the employment start date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the required posting at the main entry way of the facility, included statutory language to disclose electronic monitoring activity, potentially affecting all current residents in the assisted living facility, staff, and any visitors to the facility. This practice resulted in a level one violation (a violation that has not 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 of the residents).	03090		

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03090	Continued From page 20 The findings include: On November 18, 2024, at 10:00 a.m., upon entrance to the facility, the surveyor observed the licensee lacked an electronic monitoring notice with the required statutory language. On December 2, 2024, at 2:00 p.m., owner (O)-A stated she had a sign posted on the front door for electronic monitoring, and was unsure what happened to the sign. O-A stated she would ensure the sign was replaced. The licensee's Electronic Monitoring policy, dated August 1, 2022, verified "signs are installed at each facility entrance accessible to visitors that state: Electronic monitoring devices, including security cameras and audio devices, may be present to record persons or activities." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090		

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

Type: Full
Date: *11/18/24*
Time: 11:00:00
Report: 1031241346

Food and Beverage Establishment Inspection Report

Location:
Healing Homes Living Services
83 Cook Avenue West
St Paul, MN55117
Ramsey County, 62

Establishment Info:
ID #: 0037959
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6515835153
ID #:

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

The following orders were issued during this inspection.

3-500B Microbial Control: hot and cold holding

3-501.16A2 ***** Priority 1 *****

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

MILK AND HAM IN REFRIGERATOR MEASURED 44-46F.

HAD STAFF TURN DOWN REFRIGERATOR.

STAFF TO CHECK MILK TEMP TOMORROW AM AND SEND TO INSPECTOR.

MONITOR TEMPERATURES.

Corrected on Site

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.

MICROBAN SPRAY USED FOR FOOD CONTACT SURFACES MEASURED > 400 PPM.

HAD STAFF REMOVE SPRAY FROM KITCHEN.

MAKE BLEACH AND WATER SPRAY, TEST FOR CONCENTRATION, AND USE DAILY FOR KITCHEN SURFACES.

Comply By: 11/18/24

4-300 Equipment Numbers and Capacities

4-302.12B ***** Priority 2 *****

MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.

ESTABLISHMENT DOES NOT HAVE A THIN PROBE THERMOMETER.

Comply By: 11/21/24

4-300 Equipment Numbers and Capacities

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

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

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

Comply By: 11/21/24

4-300 Equipment Numbers and Capacities

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

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

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

Comply By: 11/21/24

2-100 Supervision

2-102.12AMN

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

ESTABLISHMENT DOES NOT HAVE A CERTIFIED FOOD PROTECTION MANAGER (CFPM). CFPM LINKS FOR CLASSES SENT WITH EMAIL.

COMPLETE CERTIFICATION ASAP.

Comply By: 11/19/24

4-500 Equipment Maintenance and Operation

4-501.11AB

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

GASKET ON REFRIGERATOR DAMAGED.

REPLACE GASKET.

Comply By: 12/02/24

Type: Full
Date: *11/18/24*
Time: 11:00:00
Report: 1031241346
Healing Homes Living Services

Food and Beverage Establishment Inspection Report

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.11

MN Rule 4626.1515 Maintain the physical facilities in good repair.

1. COUNTERTOP SURFACE IS DAMAGED BY MICROWAVE.
REPAIR SURFACE (MUSH BE SMOOTH, DURABLE, AND EASILY CLEANABLE) OR REPLACE COUNTERTOP.

2. LAZY SUSAN HAS RUST ON TOP AREA.
REMOVE RUST AND PAINT OR COVER WITH CONTACT PAPER.

Comply By: 12/09/24

Surface and Equipment Sanitizers

Dimethyl Ethyl Benzyl Ammo: > 400 at Degrees Fahrenheit
Location: Microban Sani Spray
Violation Issued: Yes

Hot Water: = at 166 Degrees Fahrenheit
Location: Dish Machine
Violation Issued: No

Chlorine: = 100 at Degrees Fahrenheit
Location: Sani Spray
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Hold/Milk
Temperature: 44 Degrees Fahrenheit - Location: Refrigerator
Violation Issued: Yes

Process/Item: Cold Hold/Ham 46
Temperature: 46 Degrees Fahrenheit - Location: Refrigerator
Violation Issued: Yes

Process/Item: Cold Hold/Milk
Temperature: 38 Degrees Fahrenheit - Location: Refrigerator (correction)
Violation Issued: No

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

Nurse Evaluator on site: Jolene Bertelsen

All violations discussed with Jana during the inspection.

NOTES:

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

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

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

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

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

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

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

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

I acknowledge receipt of the Environmental Health inspection report number 1031241346 of 11/18/24.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/__/____

Inspection report reviewed with person in charge and emailed.

Signed:_____
Jana Wyatt
Person in Charge

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