Electronically Delivered

November 14, 2025

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

RE: Project Number(s) SL33208016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on November 4, 2025, 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.

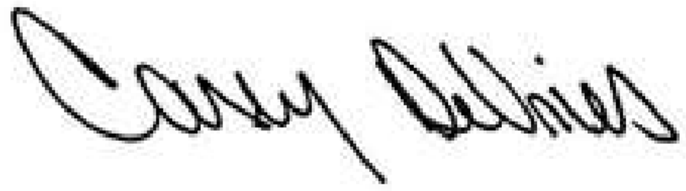
To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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,



Casey DeVries, Supervisor
State Evaluation Team
Email: Casey.DeVries@state.mn.us
Telephone: 651-201-5917 Fax: 1-866-890-9290

CLN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33208	A. BUILDING: _____ B. WING _____	11/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A HELPING HAND SENIOR CARE SER	2446 15TH AVENUE SOUTH MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL33208016-0 On November 3, 2025, through November 4, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were four residents; four receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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.	
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma	0 630		

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0 630	Continued From page 1 (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 was admitted June 6, 2024, to receive assisted living services. R2's diagnosis included human immunodeficiency virus, alcohol induced mood	0 630		

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0 630	Continued From page 2 disorder, chronic viral hepatitis C, cocaine abuse, essential hypertension, and type 2 diabetes mellitus with diabetic nephropathy. R2's service plan dated June 24, 2025, indicated R2 received assisted living services to include medication administration, medication reminders, vital signs, shopping assistance, blood glucose monitoring, and transportation assistance. R2's IAPP dated November 1, 2025, lacked documentation of an assessment of the resident's risk of abusing other vulnerable adults or minors. On November 4, 2025, 12:37 p.m., clinical nurse supervisor (CNS)-F stated they were aware the IAPP needed to contain the information and thought it had been documented in R2's assessment. CNS-F stated R2's susceptibility to abusing other vulnerable adults or minors was likely omitted in error. The licensee's Vulnerable Adult policy dated August 1, 2021, indicated the resident's risk of abusing other vulnerable adults within the residence shall be assessed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
01290 SS=D	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section	01290		

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01290	Continued From page 3 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a background study (BGS) was submitted and a clearance received in affiliation with the assisted living licensee's current health facility identification number (HFID) for one of four employees (unlicensed personnel (ULP-G)). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The licensee's HFID was #33208. ULP-G	01290		

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01290	Continued From page 4 The licensee's employee roster indicated ULP-G had a hire date of July 13, 2025. The licensee's background study roster for HFID #33208 lacked the inclusion of ULP-G. Licensed assisted living director (LALD)-A was able to produce a background study for ULP-G dated July 2, 2025, on a separate roster for a facility under the same umbrella of ownership with HFID #33206. ULP-G's record lacked evidence to indicate the licensee had submitted a background study that was affiliated with the licensee's HFID number prior to the start of the survey. The licensee's employee schedule dated October 31- November 13, 2025, indicated ULP-G had worked from 9:00 a.m. to 10:00 p.m., on Saturday November 2, 2025, and Sunday November 3, 2025, and was scheduled to work from 9:00 a.m. to 10:00 p.m., on Saturday November 8, 2025, and Sunday November 9, 2025. On November 4, 2025, at 2:00 p.m., LALD-A stated they were responsible for running background checks on staff. LALD-A stated they have had ongoing issues with running background studies and having the study be affiliated under their other facilities HFIDs. The licensee's undated Background Studies policy indicated the licensee required background screening to be completed on all final candidates for employment. Additionally, employees would not be able to start working with clients until the background check clearance has been received by the agency.	01290		

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01290	Continued From page 5 No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan 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. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part	01620		

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01620	Continued From page 6 of the resident's reassessment. (e) 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. (f) 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 interview and record review, the licensee failed to ensure the RN conducted ongoing resident assessment and reassessment, not to exceed 90 calendar days from the last date of the assessment for one of two residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include:	01620		

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01620	Continued From page 7 R1 was admitted to the licensee on March 30, 2020, and began receiving assisted living services on August 1, 2021. R1's diagnoses included pancreatic steatorrhea, allergic rhinitis, anxiety, atonic bladder, chronic pain, depression, duodenal ulcer, fibromyalgia, gastroparesis, gastro esophageal reflux disease, hypertension, ileostomy, neurogenic bladder, and osteoporosis. R1's Service Plan (Waiver) - Addendum to contract dated November 1, 2025, indicated R1 received assisted living services to include activity assistance, bathing assistance, bedmaking, catheter changes, colostomy care, housekeeping, laundry, behavior management, meal assistance, medication reminders, vital signs, shopping assistance, and assistance with transportation and wheelchair use. R1's record contained a 90-day assessment dated June 5, 2025, with the next 90-day assessment having occurred on September 7, 2025. This indicated 94 days had lapsed since R1's last assessment. On November 11, 2025, at 12:56 p.m., clinical nurse supervisor (CNS)-F stated they did not believe there were any additional assessments that had been completed between June 5, 2025, and September 7, 2025. Additionally, CNS-F was able to show the surveyor there had been no additional assessments completed for R1 on their electronic medical record system R-tasks. CNS-F stated they understood assessments needed to be completed within 90-days from a resident's previous assessment and was unsure as to why	01620		

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01620	Continued From page 8 R1's assessment was completed late. The licensee's Assessment and Reassessment policy dated August 1, 2021, indicated ongoing resident reassessments must be conducted by an RN and cannot exceed 90 days from the last date of assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

A HELPING HAND SENIOR CARE SER
2446 15TH AVENUE SOUTH
Minneapolis, MN 55404
Hennepin County
Parcel:

Phone:

License Info

License: HFID 33208

Risk:
License:
Expires on:
CFPM: Anisa J. Yusuf
CFPM #: 108870; Exp: 12/23/2027

Inspection Info

Report Number: F1013251106
Inspection Type: Full - Single
Date: 11/3/2025 Time: 12:30 pm
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery:

No orders were issued for this inspection report.

Food & Beverage General Comment

The inspection was completed with the operator then reviewed with MDH Nurse Evaluator Z. Morth.

The establishment has a residential kitchen and serves food prepared that day. The kitchen has wood cabinets, vinyl plank floor, tile walls, granite counter top, and a smooth painted ceiling.

A two basin sink is located in the kitchen. One basin is designated for hand washing.

Residential dish machine is available to wash ware. The dish machine should be run on the sanitize/high temperature cycle.

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

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Metro District Office inspection report number F1013251106 from 11/3/2025

Jerry Malloy

Fatima Mohamud
Operator

Jerry Malloy,
Public Health Sanitarian Supervisor
651-201-3998
jerry.malloy@state.mn.us

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

Temperature Observations/Recordings

Establishment Info

A HELPING HAND SENIOR CARE SER
Minneapolis
County/Group: Hennepin County

Inspection Info

Report Number: F1013251106
Inspection Type: Full
Date: 11/3/2025
Time: 12:30 pm

Food Temperature: Product/Item/Unit: Chicken**; Temperature Process:** Cooking
Location: Oven at 183 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Milk**; Temperature Process:** Cold-Holding
Location: Refrigerator at 41 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Eggs**; Temperature Process:** Cold-Holding
Location: Refrigerator at 41 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Ground beef**; Temperature Process:** Cold-Holding
Location: Freezer at 29 Degrees F.
Comment:
Violation Issued?: No

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

Sanitizer Observations/Recordings

Establishment Info

A HELPING HAND SENIOR CARE SER
Minneapolis
County/Group: Hennepin County

Inspection Info

Report Number: F1013251106
Inspection Type: Full
Date: 11/3/2025
Time: 12:30 pm

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Kitchen **Equal To** 160 Degrees F.
Comment:
Violation Issued?: No