



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

November 3, 2025

Licensee
Kindheart Homes Inc.
2400 Chicago Avenue
Minneapolis, MN 55404

RE: Project Number(s) SL36885016

Dear Licensee:

On October 13, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on February 6, 2025, and the follow-up surveys completed on May 13, 2025, and July 29, 2025. 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,

A handwritten signature in black ink, appearing to read 'Tim Hanna'.

Tim Hanna, Supervisor
State Engineering Services Section
Health Regulation Division
Email: Tim.Hanna@state.mn.us
Telephone: 507-208-8982 Fax: 1-866-890-9290



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

September 30, 2025

Licensee
Kindheart Homes Inc
2400 Chicago Avenue
Minneapolis, MN 55404

RE: Project Number(s) SL36885016

Dear Licensee:

On July 29, 2025, 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 February 6, 2025. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the February 6, 2025 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on February 6, 2025, found not corrected at the time of the July 29, 2025, follow-up survey and/or subject to penalty assessment are as follows:

0775-Fire Protection And Physical Environment-144g.45 Subd. 2. (a) - \$500.00
0780-Fire Protection And Physical Environment-144g.45 Subd. 2 (a) (1) - \$500.00
0800-Fire Protection And Physical Environment-144g.45 Subd. 2 (a) (4) - \$500.00

The details of the violations noted at the time of this follow-up survey completed on July 29, 2025 (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.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$1,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

IMPOSITION OF FINES

In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be imposed immediately with no opportunity to correct the violation first as follows:

- Level 1: no fines or enforcement;
- Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;
- Level 3: a fine of \$1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

Level 4: a fine of \$3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

Level 5: a fine of \$5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

To submit a hearing request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration or a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

We urge you to review these orders carefully. **If you have questions, please contact Ben Zwart at 651-201-3715.**

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,



Benjamin J. Zwart, Supervisor
State Engineering Services Section
Email: Benjamin.Zwart@state.mn.us
Telephone: 651-201-3715 Fax: 1-866-890-9290

CLN

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36885	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 07/29/2025
NAME OF PROVIDER OR SUPPLIER KINDHEART HOMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2400 CHICAGO AVENUE 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 FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS SL36885016-2 On July 30, 2025, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on May 13, 2025. At the time of the survey, there were three residents; three receiving services under the Assisted Living license. As a result of the follow-up survey, the following orders were reissued.	{0 000}			
{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	{0 480}			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36885	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 07/29/2025
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{0 480}	Continued From page 1 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; (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:	{0 480}	Not reviewed during this survey.		

Minnesota Department of Health

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{0 510}	Continued From page 2	{0 510}			
{0 510} SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by:	{0 510}			
{0 775} SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the requirements of the Minnesota State Fire Code. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a	{0 775}	Not reviewed during this survey.		

Minnesota Department of Health

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{0 775}	Continued From page 3 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). Findings include: On a facility tour on July 30, 2025, from 11:00 a.m. to 12:00 p.m., with owner/ agent (O/A)-A, the following observations were made of non-compliance with the requirements of the Minnesota State Fire Code (MSFC) in Minnesota Rules Chapter 7511: ELECTRICAL EXTENSION CORDS There was a microwave, air conditioner and refrigerator plugged into one power strip in resident sleeping room one. There were also multiple appliances plugged into an unprotected light duty multi plug adapter in resident sleeping room one. Electrical extension cords are required to be used for temporary use only. Only one appliance shall be powered by a compliant electrical power strip. Power strips are required to be overcurrent protected. Appliances powered by temporary extension cords and power strips shall comply with MSFC in Minnesota Rules Chapter 7511. DISCARDED SMOKING MATERIALS There was used cigarette butts discarded on the ground around the front porch. There was an appropriate used cigarette butt dispenser provided on the front porch. Used cigarette butts are required to be disposed	{0 775}			

Minnesota Department of Health

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{0 775}	Continued From page 4 of in an appropriate container in accordance with the MSFC in Minnesota Rules Chapter 7511 and the facility smoking policy. During the tour O/A-A, verified the improper use of extension cords in resident room one and improper discarding of cigarette butts on the ground around the front porch.	{0 775}			
{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}			

Minnesota Department of Health

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{0 780}	Continued From page 5 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms inside all sleeping rooms, outside in immediate vicinity of all sleeping rooms, on each level of dwelling unit, and interconnected smoke alarms throughout the facility. 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 the potential to affect a large portion or all of the residents). Findings include: On a facility tour on July 30, 2025, from 11:00 a.m. to 12:00 p.m., with owner/ agent (O/A)-A, it was observed that smoke alarms were not interconnected so activation of one alarm activates all alarms throughout the dwelling unit. INTERCONNECTION OF SMOKE ALARMS During the tour the smoke alarm test buttons were activated by O/A-A, on the first floor, second floor, third floor and basement. It was observed the smoke alarms were not interconnected so activation of one alarm activates all alarms on the second and third floor. It was also observed the third-floor smoke alarm	{0 780}			

Minnesota Department of Health

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{0 780}	Continued From page 6 did not operate and did not have a battery installed when tested by O/A-A. All dwelling units required to have multiple smoke alarms are required to have interconnected alarms so activation of one alarm activates all alarms on every floor and throughout the dwelling unit. During the tour O/A-A, verified the smoke alarms were not interconnected so activation of one alarm activates all alarms on the second and third floors and throughout the dwelling unit. SMOKE ALARMS OUTSIDE OF SLEEPING ROOMS AND ON ALL LEVELS During the tour it was also observed that smoke alarms were not provided outside in the immediate vicinity of resident sleeping room one. Smoke alarms are required to be installed outside in the immediate vicinity of all sleeping rooms and on all levels within the dwelling unit. During the tour O/A-A, verified smoke alarms were not installed outside in the immediate vicinity of resident room one.	{0 780}			
{0 800} SS=E	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including 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.	{0 800}			

Minnesota Department of Health

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{0 800}	Continued From page 7 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On a facility tour on July 30, 2025, from 11:00 a.m. to 12:00 p.m., with owner/ agent (O/A)-A, the surveyor made the following observations of facility disrepair: WINDOW MAINTENANCE The interior pane of glass was broken exposing sharp edges of glass on the second floor in the room containing the bed. The window screens were torn on the exterior of the windows in resident sleeping room one and	{0 800}			

Minnesota Department of Health

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{0 800}	Continued From page 8 three. During the tour O/A-A, verified the window screens were torn on the exterior of resident sleeping room one and three. O/A-A also verified the inside window pane was broken in the second floor room with the bed in it labeled storage on the floor plan.	{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) 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	{0 810}			

Minnesota Department of Health
STATE FORM

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36885	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 07/29/2025
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{01880}	Continued From page 10 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:	{01880}	Not reviewed during this survey.		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

July 1, 2025

Licensee
Kindheart Homes Inc
2400 Chicago Avenue
Minneapolis, MN 55404

RE: Project Number(s) SL36885016

Dear Licensee:

On May 13, 2025, 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 February 6, 2025. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the February 6, 2025 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on February 6, 2025, found not corrected at the time of the May 13, 2025, follow-up survey and/or subject to penalty assessment are as follows:

0775-Fire Protection And Physical Environment-144g.45 Subd. 2. (a) - \$500.00
0780-Fire Protection And Physical Environment-144g.45 Subd. 2 (a) (1) - \$500.00
0790-Fire Protection And Physical Environment-144g.45 Subd. 2 (a) (2-3) - \$500.00
0800-Fire Protection And Physical Environment-144g.45 Subd. 2 (a) (4) - \$500.00
0810-Fire Protection And Physical Environment-144g.45 Subd. 2 (b-F) - \$500.00
0830-Local Laws Apply-144g.45 Subd. 3

The details of the violations noted at the time of this follow-up survey completed on May 13, 2025 (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.

Also, at the time of this follow-up survey completed on May 13, 2025, we identified the following violation(s):

0510-Infection Control Program-144g.41 Subd. 3 - \$500.00
1760-Documentation Of Administration Of Medication-144g.71 Subd. 8
1880-Storage Of Medications-144g.71 Subd. 19

The details of the violation(s) noted at the time of this follow-up survey are delineated on the attached State Form. Only the ID Prefix Tag in the left hand column without brackets will identify these state correction orders. It is not necessary to develop a plan of correction.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are**

assessed is \$3,000.00. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

IMPOSITION OF FINES:

Level 1: no fines or enforcement.

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in §144G.20 for widespread violations;

Level 3: a fine of \$3,000 per violation per incident, in addition to any enforcement mechanism authorized in §144G.20.

Level 4: a fine of \$5,000 per incident, in addition to any enforcement mechanism authorized in §144G.20.

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

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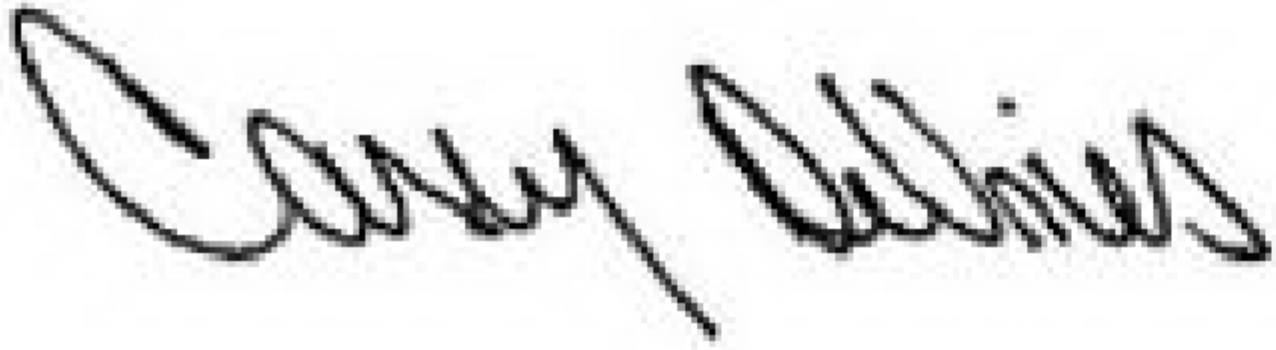
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration or a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

We urge you to review these orders carefully. If you have questions, please contact Casey DeVries at

651-201-5917.

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,

A handwritten signature in black ink, appearing to read "Casey DeVries". The signature is written in a cursive, flowing style.

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

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36885	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 05/13/2025
NAME OF PROVIDER OR SUPPLIER KINDHEART HOMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2400 CHICAGO AVENUE 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 FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS SL36885016-1 On May 12, 2025, through May 13, 2025, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on February 6, 2025. At the time of the survey, there were four residents; four receiving services under the Assisted Living License. As a result of the follow-up survey, the following orders were reissued and/ or issued.	{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.		
{0 480} SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	{0 480}			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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{0 480}	Continued From page 1 (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; (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	{0 480}			

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{0 480}	Continued From page 2 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:	{0 480}			
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program to comply with accepted health care, medical, and	0 510	not reviewed during this survey		

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0 510	Continued From page 3 nursing standards for infection control. 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 of the residents). The findings include: On May 12, 2025, at 7:56 a.m., on the main level of the four-story assisted living facility (ALF), the surveyor observed a bathroom with no hand soap. On May 13, 2025, at 7:23 a.m., the surveyor observed R3 open the bathroom door and leave the bathroom. There was no soap in the bathroom. On May 13, 2025, at 7:24 a.m., unlicensed personnel (ULP)-F stated the bathroom was used by residents, staff, and visitors. ULP-F stated they checked the bathroom all the time to ensure there was hand soap. ULP-F stated they check the bathroom at the beginning of their shift and their shift started at 6:00 a.m. ULP-F stated they were going to place soap in the bathroom now. On May 13, 2025, at 9:35 a.m., clinical nurse supervisor (CNS)-C stated they were responsible for the infection control practices. CNS-C stated ULP's were trained to check the bathroom each shift to ensure there was hand soap. CNS-C stated they thought there was hand soap in the bathroom.	0 510			

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0 510	Continued From page 4 The licensee's Infection Control policy dated June 2022, indicated licensee would have policies and procedures to prevent infection and keep residents safe. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510			
{0 775} SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the requirements of the Minnesota State Fire Code. 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 the potential to affect a large portion or all of the residents). Findings include: On a facility tour on May 12, 2025, from 10:45 a.m. to 12:30 p.m., with clinical nurse supervisor (CNS)-C, and unlicensed personnel (ULP)-H, the following observations were made of	{0 775}			

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{0 775}	Continued From page 5 non-compliance with the requirements of the Minnesota State Fire Code (MSFC) in Minnesota Rules Chapter 7511: ELECTRICAL EXTENSION CORDS There were several electrical extension cords daisy chained (plugged into multiple cords in a series) and plugged into non-compliant power splitters powering multiple appliances in resident sleeping room one, and on second floor near room with bed on the floor. Electrical extension cords are required to be used for temporary use only. Only one appliance shall be powered by a compliant electrical power strip. Power strips shall not be daisy chained from one to another. Appliances powered by temporary extension cords and power strips shall comply with MSFC in Minnesota Rules Chapter 7511. EMERGENCY ESCAPE WINDOW OBSTRUCTIONS During the tour there was a six-foot high by three foot wide fully loaded shelving unit blocking access and obstructing view of the emergency escape and rescue window in resident sleeping room three. Emergency escape and rescue windows are required to be clear of obstructions that prevent immediate use of the window for emergency escape in the event of a fire or similar emergency. STORAGE OF FUEL POWERED EQUIPMENT AND FUEL There was gasoline powered equipment (gas	{0 775}			

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{0 775}	Continued From page 6 powered snow blower) stored in the basement. Fuel (gasoline) powered equipment shall not be stored within buildings and near exit routes in accordance with MSFC in Minnesota Rules Chapter 7511. DISCARDED SMOKING MATERIALS There was used cigarette butts discarded on the ground around the front porch, on the porch and on the metal ramp leading up to the porch. There was an appropriate used cigarette butt dispenser provided on the front porch. Used cigarette butts are required to be disposed of in an appropriate container in accordance with the MSFC in Minnesota Rules Chapter 7511 and the facility smoking policy. EXIT PATH OBSTRUCTIONS There were several items stored in the basement obstructing the exit path from all spaces within the basement. Exit paths and exit stairways are required to be kept clear of obstructions that prevent the full and immediate use for exiting in the event of a fire or similar emergency. EXIT DOOR HARDWARE There was a storage room on the second floor with no latch handle installed and locking hardware that was not operable from the inside in order to exit the room. During the tour on May 12, 2025, at 11:45 a.m., ULP-H, closed the door so a photo could be taken of the non-compliant locking hardware on the outside with CNS-C, and ULP-H,	{0 775}			

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{0 775}	Continued From page 7 inside the room and they were locked into the room because of the non-compliant locking hardware. A tool was required to open the door from the outside of the room to allow CNS-C, and ULP-H, to exit the room. The exterior exit door in the back entry from the kitchen that is marked as the exit for the second floor had three separate locking devices and no interior door latch handle to operate and open the door from the inside. Exit doors from dwelling unit shall not be provided with more than two locking devices to release the door to exit in the event of a fire or similar emergency. All rooms and spaces are required to be provided with hardware that is operable without the use of keys, tools or special knowledge from the inside for the purpose of exiting in the event of a fire or similar emergency. EXTERIOR LANDING AT EXIT DOOR The exterior exit door in the back entry from the kitchen that is marked as the exit for the second floor did not have an exterior landing providing a flat surface to exit in accordance with MSFC in Minnesota Rules Chapter 7511. It was explained a compliant landing is required at the exterior of all marked exit doors to provide a flat landing surface in order to exit in the event of a fire or similar emergency. ELECTRICAL SYSTEM COVERS There was electrical outlet box covers missing, exposing electrical wires on light fixture and outlet on second floor in the bathroom near front stairway.	{0 775}			

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{0 775}	Continued From page 8 There were ceiling light fixtures missing covers in the main floor pantry, and several light fixtures on the ceiling of the second floor were not working. During the facility tour CNS-C, and ULP-H, verified the above listed observations while accompanying on the tour.	{0 775}			
{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}			

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{0 780}	Continued From page 9 Based on observation and interview, the licensee failed to provide smoke alarms inside all sleeping rooms, outside in immediate vicinity of all sleeping rooms, on each level of dwelling unit, and interconnected smoke alarms throughout the facility. 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 the potential to affect a large portion or all of the residents). Findings include: INTERCONNECTION OF SMOKE ALARMS On a facility tour on May 12, 2025, from 10:45 a.m. to 12:30 p.m., with clinical nurse supervisor (CNS)-C, and unlicensed personnel (ULP)-H, it was observed that smoke alarms were not interconnected so activation of one alarm activates all alarms throughout the dwelling unit. During the tour the smoke alarm test buttons were activated by ULP-H, on the first floor, second floor, third floor and basement. It was observed the smoke alarms were not interconnected so activation of one alarm activates all alarms on every floor and throughout the facility. It was also observed the third-floor smoke alarm did not operate when tested by ULP-H, and was not interconnected with the smoke alarms on every floor and throughout the facility.	{0 780}			

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{0 780}	Continued From page 10 All dwelling units required to have multiple smoke alarms are required to have interconnected alarms so activation of one alarm activates all alarms on every floor and throughout the dwelling unit. During the tour CNS-C, and ULP-H, verified the smoke alarms were not interconnected so activation of one alarm activates all alarms on every floor and throughout the dwelling unit. SMOKE ALARMS OUTSIDE OF SLEEPING ROOMS AND ON ALL LEVELS During the tour it was also observed that smoke alarms were not provided outside in the immediate vicinity of resident sleeping room one. Smoke alarms are required to be installed outside in the immediate vicinity of all sleeping rooms and on all levels within the dwelling unit. During the tour CNS-C, and ULP-H, verified smoke alarms were not installed outside in the immediate vicinity of resident room one. During the tour CNS-C, and ULP-H, also verified the smoke alarms on first floor, second floor, third floor, and the basement were not interconnected so activation of one alarm activates all alarms on floors and throughout the dwelling unit.	{0 780}			
{0 790} SS=F	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3	{0 790}			

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{0 790}	Continued From page 11 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain fire extinguishers as required throughout the facility. This deficient condition had the ability to affect all staff, visitors, 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) 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 on May 12, 2025, from 10:45 a.m. to 12:30 p.m., with clinical nurse supervisor (CNS)-C, and unlicensed personnel (ULP)-H, it was observed that the required fire extinguisher had a manufacture date of 2022 with no annual maintenance records on the second floor in the kitchen. There was no documentation available that monthly inspections of the main floor and second floor fire extinguishers were completed. It was explained that at least one fire extinguisher	{0 790}			

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{0 790}	Continued From page 12 with minimum 2-A:10-B:C rating is required to be provided, mounted, maintained, and located within 75 feet of travel throughout the facility in accordance with Minnesota State Fire Code Section 906. Fire extinguishers are required to be mounted at least 4 inches off the floor and not higher than 60 inches from the floor to the top of the extinguisher. Documentation is required to demonstrate fire extinguishers have been inspected by facility personnel monthly, and annually replaced with a new extinguisher (of current year manufacture date) or serviced by a certified technician. All fire extinguishers installed are required to be maintained in accordance with Minnesota State Fire Code in Minnesota Rules Chapter 7511. During the facility tour CNS-C, verified the above listed observations while accompanying on the tour.	{0 790}			
{0 800} SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including 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}			

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{0 800}	Continued From page 13 Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On a facility tour on May 12, 2025, from 10:45 a.m. to 12:30 p.m., with clinical nurse supervisor (CNS)-C, and unlicensed personnel (ULP)-H, the surveyor made the following observations of facility disrepair: MAINTENANCE OF EXTERIOR WALLS AND DOORS There was a missing seal on the bottom of the main front door required to prevent the intrusion of pests and weather elements. There was a hole through the wall in a wood cover under the stairs leading down to the basement exposing the interior of the building to intrusion of pests and weather elements. WINDOW MAINTENANCE The interior pane of glass was broken exposing	{0 800}			

Minnesota Department of Health

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{0 800}	Continued From page 14 sharp edges of glass on the second floor in the kitchen and on the second floor in the room containing the bed. The window screens were torn on the exterior of the windows in resident sleeping room one and three. EXTERIOR RESIDENT ACTIVITY AREA There were several items and vehicles stored in the designated exterior resident activity area creating a hazard to the residents.	{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) 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	{0 810}			

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{0 810}	Continued From page 15 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 required content, make the plan readily available, provide 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 of the residents). The findings include: On May 12, 2025, at 10:00 a.m., clinical nurse supervisor (CNS)-C, provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee provided FSEP undated, failed to	{0 810}			

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{0 810}	Continued From page 16 include the following: The evacuation floor plan posted in the hallway near resident sleeping room two was not accurate to the current use of each room on the first floor. The floor plan indicated a bedroom on the first floor across the hallway from resident room 2. CNS-C, stated this is not bedroom at this time but could be in the future. There was not an evacuation floor plan posted on the second floor for the occupants to use for direction while exiting in the event of a fire or similar emergency. During review of the documentation on May 12, 2025, at 10:15 a.m., CNS-C, provided a floor plan of the second floor. The evacuation floor plan provided for the second floor indicated and identified an exit stairway, 2 bathrooms, kitchen, closet and bedroom 4. There were six rooms and spaces not identified on the provided second floor evacuation floor plan. During a tour on May 12, 2025, with CNS-C, and unlicensed personnel (ULP)-H, it was observed the room identified on the evacuation floor plan as bedroom 4 had storage in it and did not contain a bed. The third floor of the dwelling unit was accessible by a stairway and not secured from access to residents. There was not a fire evacuation floor plan posted and identifying the use of the space on the third floor. It was explained to CNS-C, that accurate resident sleeping room numbers and room identification are required to be included on the evacuation floor plans in order to direct building occupants to an exit in the event of a fire or similar emergency.	{0 810}			

Minnesota Department of Health

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{0 810}	Continued From page 17 The available FSEP included standard resident evacuation procedures, but failed to provide specific individualized unique needs of each resident for evacuation. The FSEP failed to include evacuation status and unique needs for evacuation for each individual resident in writing and available for immediate reference in the event of a fire or similar emergency. During an interview on May 12, 2025, at 10:45 a.m., CNS-C, stated the posted evacuation floor plan was not accurate for the first, second, and third floor, the evacuation floor plan was not posted on the second floor, and third floor, and a list of each individual resident unique needs for evacuation was not available in writing for immediate use in the event of a fire or similar emergency. TRAINING Record review of the available documentation indicated the licensee failed to provide training to employees on the FSEP upon hire and at least twice per year as evident by not providing documentation employee training was completed as required and as a separate event from evacuation drills. Record review of the available documentation indicated the licensee failed to provide evacuation training to residents at least once per year as evident by not providing documentation with date the required resident training was provided annually. During an interview on May 12, 2025, at 10:50 a.m., CNS-C, stated the requested documentation for employee and resident training was not available and would be emailed to the	{0 810}			

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{0 810}	Continued From page 18 surveyor by May 13, 2025, at 12:00 p.m. On May 13, 2025, at 2:31 a.m., an email was received from owner/ agent (O/A)-A, and included documentation that did not indicate the requested information related to employee and resident training. DRILLS Record review of the available documentation indicated the licensee failed to conduct evacuation drills for employees every other month and at least twice per year, per shift as evident by providing documentation evacuation drills were completed 8/22/2024 p.m. shift, 6/22/2024 p.m. shift, 6/22/2024 a.m. shift, 4/23/2024 p.m. shift, 2/19/2024 medical emergency drill, and 10/22/2024 night shift only. The available documentation indicated the licensee failed to provide evacuation drills every other month for the past year and twice per shift per year. During an interview on May 12, 2025, at 10:50 a.m., CNS-C, stated documentation was not available indicating evacuation drills were completed every other month and twice per year per shift. CNS-C, also stated drills were completed February and April of 2025. No further information was provided.	{0 810}			
{0 830} SS=D	144G.45 Subd. 3 Local laws apply Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for	{0 830}			

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{0 830}	Continued From page 19 fire safety, building, and zoning requirements, except a facility with a licensed resident capacity of six or fewer is exempt from rental licensing regulations imposed by any town, municipality, or county. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with all state and local governing laws, and codes, for fire safety, building permit, and zoning requirements. This had the potential to affect a limited number of 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 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: On a facility tour on May 12, 2025, from 10:45 a.m. to 12:30 p.m., with clinical nurse supervisor (CNS)-C, and unlicensed personnel (ULP)-H, the surveyor made the following observations of facility non-compliance with all state and local governing laws and codes: During the tour it was observed a window was replaced in resident sleeping room 2 in order to comply with minimum emergency escape and rescue open size requirements.	{0 830}			

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{0 830}	Continued From page 20 During an interview on May 12, 2025, at 11:15 a.m., CNS-C, stated they thought there was a building permit from the City of Minneapolis to replace the window. During the tour CNS-C, called owner/ agent (O)-A, on the phone to verify there was a building permit to replace the window. CNS-C, stated that O-A, would email a copy of the building permit. During a facility tour and interview on May 12, 2025, at 11:20 a.m., CNS-C, stated that O-A, would email a copy of the building permit. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	{0 830}			
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	01760			

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01760	Continued From page 21 review, licensee failed to ensure medication administration documentation was completed for one of four residents (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R4 was admitted to the facility March 6, 2025, and began receiving assisted living services. R4's diagnoses included liver damage. R4's Service Plan dated March 6, 2025, indicated R4 received assistance with medication administration. R4's Medication Administration Record (MAR) dated May 1, 2025, through May 31, 2025, indicated R4 was scheduled to receive hydrochlorothiazide 25 milligram (mg) 1 tablet at 6:00 a.m., lisinopril 20 mg 1 tablet at 6:00 a.m., and mirtazapine 15 mg 1 tablet at 6:00 a.m. On May 12, 2025, at 1:21 p.m., the surveyor observed R4's MAR which lacked documentation the medications were administered or refused by R4. On May 12, 2025, at 1:14 p.m., unlicensed personnel (ULP)-H stated the reason R4 did not receive the medications that morning was R4 was	01760			

Minnesota Department of Health

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01760	Continued From page 22 sleeping. ULP-H stated they forgot to document the medications as refused as they were with the surveyor. On May 12, 2025, at 1:26 p.m., clinical nurse supervisor (CNS)-C stated staff were trained to check with residents to confirm they wanted their medications. CNS-C stated staff were trained to document refusal of medications and the situation was a medication error. The licensee's Medication/Treatment Management policy dated June 2022, indicated staff should indicate the medication was refused, and document, "R" in the MAR. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			
01880 SS=D	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 to permit only authorized personnel to have access to medications for one of four residents (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	01880			

Minnesota Department of Health

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01880	Continued From page 23 resident's health or safety) 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: On May 12, 2025, at 9:52 a.m., the surveyor observed a bubble pack containing mirtazapine 15 milligram (mg) with R4's identifiers printed on the bubble pack on a ledge in the dining area on the main level of the assisted living facility. On May 12, 2025, at 12:03 p.m., unlicensed personnel (ULP)-H stated they were trained by the clinical nurse supervisor (CNS) to secure all medications for residents in the medication cabinet. On May 12, 2025, at 12:57 p.m., CNS-C stated staff were trained to secure all medications in the medication cabinet. CNS-C stated that situation should not have occurred. The licensee's Storage/Control of Medications policy dated August 1, 2021, indicated licensee would ensure all prescription drugs were securely locked and would only allow authorized staff to have access. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

March 10, 2025

Licensee
Kindheart Homes Inc
2400 Chicago Avenue
Minneapolis, MN 55404

RE: Project Number(s) SL36885016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on February 6, 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.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;

Level 3: a fine of \$3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.

Level 4: a fine of \$5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this survey:

St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - \$3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$3,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

To submit a hearing request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at

Kindheart Homes Inc

March 10, 2025

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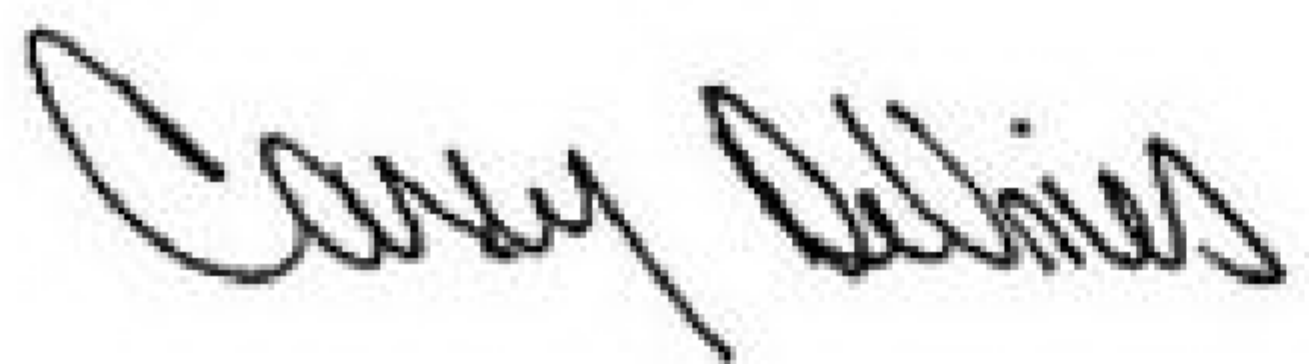
the website listed above.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: <https://forms.office.com/g/Bm5uQEPhVa>. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

A handwritten signature in black ink, appearing to read "Casey DeVries". The signature is written in a cursive, flowing style.

Casey DeVries, Supervisor

State Evaluation Team

Email: Casey.DeVries@state.mn.us

Telephone: 651-201-5917 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER KINDHEART HOMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2400 CHICAGO AVENUE MINNEAPOLIS, MN 55404		
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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: SL36885016-0 On February 3, 2025, through February 6, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were three resident(s); three receiving services under the Assisted Living Facility license. An immediate correction order was identified on February 3, 2025, issued for SL36885016-0, tag identification 1290. During the survey, the licensee took action to mitigate the immediate risk. However, noncompliance remained, and the scope and level remain unchanged. An immediate correction order was identified on February 5, 2025, issued for SL36885016-0, tag identification 0775. During the survey, the licensee took action to		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.	

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36885	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/06/2025
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0 000	Continued From page 1	0 000			
0 470 SS=F	mitigate the immediate risk. However, noncompliance remained, and the scope and level remain unchanged. 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 (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 develop and	0 470			

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0 470	Continued From page 2 implement a written staffing plan that included an evaluation completed by the clinical nurse supervisor (CNS) (as indicated in Minnesota Administrative Rule 4659.0180) at least twice a year. 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 February 3, 2025, at 9:47 a.m., clinical nurse supervisor (CNS)-C stated [licensee] shifts were 6:00 a.m. until 2:00 p.m., 2:00 p.m. until 10:00 p.m., and 10:00 p.m. until 6:00 a.m. and one unlicensed personnel (ULP) worked per shift. On February 3, 2025, at 10:31 a.m., during a facility tour, the surveyor observed the three-level assisted living facility and did not observe the facility's staffing plan. On February 4, 2025, at 9:38 a.m., CNS-C stated they were aware the Staffing Plan had to be signed and dated. CNS-C stated the Staffing Plan had been posted in the hallway and was unsure why they were unable to find the posting. CNS-C provided a document titled Assisted Living Home Staffing Plan. The document lacked a signature from the registered nurse and lacked a review date.	0 470			

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0 470	Continued From page 3 The licensee's undated 4.06 Staffing and Scheduling policy indicated the CNS would develop a staffing plan that provides an adequate number of qualified direct-care staff to meet the residents needs 24-hours a day, seven days a week. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470			
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	0 480			

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0 480	Continued From page 4 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; (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) and was issued at a widespread scope (when problems are pervasive	0 480			

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0 480	Continued From page 5 or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated February 3, 2025, 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			
0 680 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	0 680			

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0 680	Continued From page 6 received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's emergency disaster preparedness plan dated August 25, 2022, lacked evidence of the following required content: - annual review; - process for EPP collaboration; - subsistence needs for staff and patients; - policies and procedures for volunteers; - arrangements with other facilities; - names and contact information for entities providing services under agreement, residents physicians, other facilities and volunteers; - emergency officials contact information; - long-term care (LTC) family notifications; - emergency prep training program, and	0 680			

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0 680	Continued From page 7 - emergency prep testing requirements. On February 4, 2025, at 11:51 a.m., owner/agent (O/A)-A stated the licensee hired a consultant company to create the EPP for the assisted living facility. O/A-A stated they believed the EPP had all the required content. The licensee's undated 9.02 Disaster Planning and Emergency Preparedness policy indicated the licensee would a general emergency preparedness plan that would comply with Centers for Medicare and Medicaid Services (CMS) EPP (appendix Z). No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 700 SS=F	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure three of three resident's (R1, R2, R3) personal health and medical information was kept private.	0 700			

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0 700	Continued From page 8 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 February 3, 2025, at 10:30 a.m., during a facility tour, the surveyor observed in the hallway common area there was a documented titled Department of Health Current Resident Roster: State Evaluations [licensee]. The document contained the following information. "[R1] August 1, 2021, hypoxemic respiratory failure", "[R2] depression", and "[R3] altered mental health." The document also indicated R1, R2, and and R3 received the following services: housekeeping, laundry meals, psychotropic medications, medication administration, and medication setup. On February 4, 2025, at 11:28 a.m., licensed assisted living director (LALD)-E stated only staff should have access to medical information for residents and medical information should not be displayed in public areas. LALD-E stated the stated information should not be displayed and was unsure why that information was posted. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 700			

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0 775	Continued From page 9	0 775			
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the requirements of the Minnesota State Fire Code and provide compliant emergency escape and rescue openings. This had the potential to directly affect all residents, staff, and visitors. 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 a facility tour on February 5, 2025, from 10:10 a.m. to 12:30 p.m., with owner/ agent (O/A)-A, it was observed that compliant emergency escape and rescue openings were not provided in resident sleeping room two and of non-compliance with the requirements of the Minnesota State Fire Code (MSFC) in Minnesota Rules Chapter 7511: OCCUPIED RESIDENT SLEEPING ROOMS Resident sleeping room two emergency escape	0 775			

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0 775	Continued From page 10 and rescue clear window opening measurements were 23 inches wide, 27 inches in height and 621 square inches in openable area. The window was measured with O/A-A, and the surveyor present. The window did not meet the minimum requirements for clear opening square inch openable area. It was explained to O/A-A, that at least one compliant emergency escape and rescue opening is required within each resident sleeping room. Existing emergency escape and rescue openings are required to meet a minimum clear opening area of 648 square inches and have a minimum dimension of 20 inches in height and a minimum dimension of 20 inches in width. If the window clear opening measures the minimum of 20 inches in one direction, the other measurement will be more than 20 inches in order to achieve the total square inch area of 648 square inches. During the facility tour O/A-A, verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Immediate. Additionally, based on observation and interview, the licensee failed to comply with the requirements of the Minnesota State Fire Code (MSFC) in Minnesota Rules Chapter 7511. This had the potential to directly affect all residents, staff, and visitors. 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	0 775			

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0 775	Continued From page 11 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 on February 5, 2025, from 10:10 a.m. to 12:30 p.m., with owner/ agent (O/A)-A, the surveyor made the following observations of non-compliance with the requirements of the Minnesota State Fire Code (MSFC) in Minnesota Rules Chapter 7511: ELECTRICAL EXTENSION CORDS There were several electrical extension cords daisy chained (plugged into multiple cords in a series) and plugged into non-compliant power splitters powering multiple appliances in resident sleeping room one, in the main floor kitchen near refrigerator, in second floor kitchen behind microwave, and on second floor near room with bed on the floor. There was electrical extension cords routed through the doorway leading outside from the main floor kitchen and through the doorway in the second-floor kitchen. Electrical extension cords are required to be used for temporary use only and not routed through doorways and other building elements. Appliances powered by temporary extension cords and power strips shall comply with MSFC in Minnesota Rules Chapter 7511. EMERGENCY ESCAPE WINDOW OBSTRUCTIONS	0 775			

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0 775	Continued From page 12 There was a six-foot wide by three foot wide fully loaded shelving unit blocking access and obstructing view of the emergency escape and rescue window in resident sleeping room three. Emergency escape and rescue windows are required to be clear of obstructions that prevent immediate use of the window for emergency escape in the event of a fire or similar emergency. STORAGE OF FUEL POWERED EQUIPEMENT AND FUEL There was gasoline powered equipment, and a can of gasoline stored in the small storage closet in the exit hallway near the main floor front door. Fuel (gasoline) powered equipment shall not be stored within buildings and near exit routes in accordance with MSFC in Minnesota Rules Chapter 7511. COMPRESSED GAS PROPANE CYLINDER STORAGE There was a 20-pound compressed gas propane cylinder stored in the basement. Compressed gas propane cylinders shall not be stored in buildings in accordance with MSFC in Minnesota Rules Chapter 7511. SPACE HEATER USE There were two electric space heaters plugged in on second floor one did not have required three-foot clearance to combustible material and one was not maintained, and the side of the frame was coming apart.	0 775			

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0 775	Continued From page 13 Electric space heaters are required to be operated and maintained according to MSFC in Minnesota Rules Chapter 7511 and manufactures use manual. DISCARDED SMOKING MATERIALS There was used cigarette butts discarded on the ground around the front porch, on the porch and on the metal ramp leading up to the porch. There was an appropriate used cigarette butt dispenser provided on the front porch. Used cigarette butts are required to be disposed in an appropriate container in accordance with the MSFC in Minnesota Rules Chapter 7511 and the facility smoking policy. EXIT PATH OBSTRUCTIONS The exit stairway leading to the exterior from the second floor had several items including bicycles stored in the stairway obstructing the exit path. There were several items stored in the basement obstructing the exit path from all spaces within the basement. Exit paths and exit stairways are required to be kept clear of obstructions that prevent the full and immediate use for exiting in the event of a fire or similar emergency. DOOR HARDWARE There was a storage room on the second floor with locking hardware that was not operable from the inside in order to exit the room. All rooms and spaces are required to be provided	0 775			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 775	Continued From page 14 with hardware that is operable from the inside for the purpose of exiting in the event of a fire or similar emergency. ELECTRICAL SYSTEM COVERS There was electrical outlet box covers missing in resident sleeping room one, in the main floor dining room, in the main floor kitchen near the refrigerator, and in several locations on the second floor. There were ceiling light fixtures missing covers in the main floor pantry, and in several locations on the ceiling on the second floor. During the facility tour O/A-A, verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775			
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	0 780			

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0 780	Continued From page 15 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 provide smoke alarms inside all sleeping rooms, outside in immediate vicinity of all sleeping rooms, on each level of dwelling unit, and interconnected smoke alarms throughout the facility. 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 the potential to affect a large portion or all of the residents). The findings include: INTERCONNECTION On a facility tour on February 5, 2025, from 10:10 a.m. to 12:30 p.m., with owner/ agent (O/A)-A, it was observed that smoke alarms were not interconnected so activation of one alarm activates all alarms throughout the second floor	0 780			

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0 780	Continued From page 16 and in the hallway on the main floor outside resident room two. During the tour the smoke alarm test button was activated by O/A-A, on the first floor. It was observed the smoke alarms on second floor and outside resident sleeping room two on the main floor were not interconnected so activation of one alarm activates all alarms throughout the facility. All dwelling units required to have multiple smoke alarms are required to have interconnected alarms so activation of one alarm activates all alarms within the dwelling unit. During the tour O/A-A, verified the smoke alarms were not interconnected so activation of one alarm activates all alarms throughout the facility. INSIDE SLEEPING ROOMS There was not a smoke alarms installed as required inside resident sleeping room two. During the tour it was observed the smoke alarm was removed from the provided mounting base on the wall in resident sleeping room two. OUTSIDE OF SLEEPING ROOMS AND ON ALL LEVELS On the same tour it was also observed that smoke alarms were not provided outside in the immediate vicinity of resident sleeping room one, in the basement level, and on the third floor accessible by a stairway. Smoke alarms are required to be installed outside in the immediate vicinity of all sleeping rooms and on all levels within the dwelling unit.	0 780			

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0 780	Continued From page 17 During the tour O/A-A, verified smoke alarms were not installed outside in the immediate vicinity of resident room one, and in the basement and on the third floor. During the tour O/A-A, also verified the smoke alarms on second floor and outside resident sleeping room two were not interconnected so activation of one alarm activates all alarms throughout the dwelling unit. TIME PERIOD FOR CORRECTION: Two (2) days	0 780			
0 790 SS=F	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain fire extinguishers as required throughout the facility. This deficient condition had the ability to affect all staff, visitors, 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	0 790			

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0 790	Continued From page 18 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 on February 5, 2025, from 10:10 a.m. to 12:30 p.m., with owner/ agent (O/A)-A, it was observed that the required fire extinguisher had a manufacture date of 2023 with no documentation of annual maintenance on the main floor in the pantry. The fire extinguisher had a manufacture date of 2022 with no annual maintenance records on the second floor in the kitchen. There was no documentation available that monthly inspections of the main floor and second floor fire extinguishers were completed. It was explained that at least one fire extinguisher with minimum 2-A:10-B:C rating is required to be provided, mounted, maintained, and located within 75 feet of travel throughout the facility in accordance with Minnesota State Fire Code Section 906. Fire extinguishers are required to be mounted at least 4 inches off the floor and not higher than 60 inches from the floor to the top of the extinguisher. Documentation is required to demonstrate fire extinguishers have been inspected by facility personnel monthly, and annually replaced with a new extinguisher (of current year manufacture date) or serviced by a certified technician.	0 790			

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0 790	Continued From page 19 During the facility tour O/A-A, verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Two (2) days	0 790			
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including 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 facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 800			

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0 800	Continued From page 20 The findings include: On a facility tour on February 5, 2025, from 10:10 a.m. to 12:30 p.m., with owner/ agent (O/A)-A, the surveyor made the following observations of facility disrepair: MAINTENANCE OF EXTERIOR WALLS AND DOORS There was a missing seal on the bottom of the main front door required to prevent the intrusion of pests and weather elements. There was a hole through the wall in a wood cover under the stairs leading down to the basement exposing the interior of the building to intrusion of pests and weather elements. Mouse droppings and a live mouse were observed in the main floor storage room previously used as resident room three and throughout second floor. WINDOW MAINTENANCE The interior pane of glass was broken exposing sharp edges of glass on the second floor in the kitchen and on the second floor in the room containing the bed. The window screens were torn on the exterior of the windows in resident sleeping room one and three. EXTERIOR RESIDENT ACTIVITY AREA There were large pieces of window glass leaning against the outside wall on the side of the house creating a hazard to the residents in the exterior	0 800			

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0 800	Continued From page 21 yard designated for resident activities. There were several items and vehicles stored in the designated exterior resident activity area creating a hazard to the residents. ELECTRICAL LIGHT FIXTURE MAINTENANCE There were several ceiling light fixtures missing covers and were not working to provide light on the second floor. There was a broken light bulb on the wall exposing the electrical power socket in the main floor storage room formerly used as resident room three. Electrical light fixtures are required to be maintained with all covers, and bulbs installed and in working condition to provide light to building occupants. During the facility tour O/A-A, verified the above listed observations while accompanying on the tour. 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) staff actions to be taken in the event of a fire or similar emergency;	0 810			

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0 810	Continued From page 22 (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 required content, make the plan readily available, provide 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	0 810			

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0 810	Continued From page 23 or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During observation on February 5, 2025, at 11:40 a.m., the surveyor observed the fire safety and evacuation plan was not located in a central location for all staff and occupants accessibility. The plan was located in the office and owner/ agent (O/A)-A, stated on February 5, 2025, at 11:40 a.m., that the office is locked occasionally preventing access to the fire safety and evacuation plan. On February 5, 2025, at 11:45 a.m., owner/ agent (O/A)-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 provided FSEP undated, failed to include the following: The evacuation floor plan posted in the hallway near resident sleeping room two was not accurate to the current use of each room in the facility. The floor plan indicated a fourth sleeping room on the second floor. O/A-A, stated the fourth room on the second floor was not currently being used as a sleeping room. There was not an evacuation floor plan posted on the second floor for the occupants to use for direction while exiting in the event of a fire or similar emergency.	0 810			

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0 810	Continued From page 24 It was explained to O/A-A, that accurate resident sleeping room numbers are required to be included on the evacuation floor plan in order to direct building occupants to an exit in the event of a fire or similar emergency. The available FSEP included standard resident evacuation procedures, but failed to provide specific individualized unique needs of each resident for evacuation. The FSEP failed to include evacuation status and unique needs for evacuation for each individual resident in writing and available for immediate reference in the event of a fire or similar emergency. During an interview on February 5, 2025, at 11:45 a.m., O/A-A, stated the posted evacuation floor plan was not accurate for the second floor, the evacuation floor plan was not posted on the second floor, and resident unique needs for evacuation was not available in writing for immediate use. TRAINING Record review of the available documentation indicated the licensee failed to provide training to employees on the FSEP upon hire and at least twice per year as evident by not providing employee training was completed as required and as a separate event from evacuation drills. Record review of the available documentation indicated the licensee failed to provide evacuation training to residents at least once per year as evident by not providing documentation the required resident training was provided annually. During an interview on February 5, 2025, at 11:50 a.m., O/A-A, stated the requested documentation	0 810			

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0 810	Continued From page 25 for employee and resident training was not available. DRILLS Record review of the available documentation indicated the licensee failed to conduct evacuation drills for employees every other month and at least twice per year, per shift as evident by providing documentation evacuation drills were completed 8/22/2024 p.m. shift, 6/22/2024 p.m. shift, 6/22/2024 a.m. shift, 4/23/2024 p.m. shift, 2/19/2024 medical emergency drill, and 10/22/2024 night shift only. The available documentation indicated the licensee failed to provide evacuation drills every other month for the past year and twice per shift per year. During an interview on February 5, 2025, at 12:00 p.m., O/A-A, stated documentation was not available indicating evacuation drills were completed every other month and twice per year per shift. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
0 830 SS=F	144G.45 Subd. 3 Local laws apply Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements, except a facility with a licensed resident capacity of six or fewer is exempt from rental licensing regulations imposed by any town, municipality, or county.	0 830			

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0 830	Continued From page 26 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to follow applicable state and local laws, regulations, standards, ordinances, and codes related to smoking for one of three 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) 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 February 3, 2025, at 9:35 a.m., the surveyor entered the three-level assisted living facility. There was a smell of cigarette smoking and THC/marijuana in the hallway. On February 3, 2025, at 10:31 a.m., during a facility tour, the surveyor observed R2's bedroom which smelled of cigarette smoke. On a small stand was a soda can that had what appeared to be cigarette ash around the top, and also surrounding the can. There were 24 one-quarter inch in length individual tobacco paper rolls with a burned end on each of them. R2 was admitted to the facility February 1, 2022, and began receiving assisted living services. R2's diagnoses included depression.	0 830			

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0 830	Continued From page 27 R2's Service Plan dated January 24, 2025, indicated R2 received assistance with medication administration, feeding, food preparation, bathing assistance, hygiene and grooming assistance, dressing assistance, personal laundry, mental health services, and mobility assistance. R2's Notes entry dated January 10, 2025, indicated, "client was in his room smoking again and I told him many times to not to smoke inside the house. He took his meds and went to sleep." R2's record lacked evidence of interventions related to smoking to prevent reoccurrences. On February 3, 2025, at 10:26 a.m., owner/agent (O/A)-A stated smoking was only allowed outside of the assisted living facility. O/A-A stated they believed R2 was no longer smoking inside the assisted living facility. O/A-A stated when staff observed smoking inside the facility, they trained to tell residents not to smoke inside. O/A-A stated they continued to provide education to R2 that there was no smoking in the facility. O/A-A stated they had not informed R2's case manager as they could not report behaviors that were not observed. The licensee's undated Smoking Policy indicated smoking was prohibited inside the assisted living facility. The Minnesota Department of Health's Minnesota Clean Indoor Air Act (MCIAA) amendment effective on August 1, 2019, noted smoking was prohibited in health care facilities and clinics. In addition, an indoor area meant a space between a floor and a ceiling that is at least half enclosed by walls, doorways, or windows (opened or closed) around the perimeter. A wall included	0 830			

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0 830	Continued From page 28 retractable dividers, garage doors, plastic sheeting or any other temporary or permanent physical barrier. MCIAA defined smoking to include carrying or using an activated electronic delivery device. Minnesota State Statute 144.414 Prohibitions; Subdivision 3 dated 2022, indicated under a section titled Health care facilities and clinics. (a) Smoking is prohibited in any area of a hospital, health care clinic, doctor's office, licensed residential facility for children, or other health care-related facility, except that a patient or resident in a nursing home, boarding care facility, or licensed residential facility for adults may smoke in a designated separate, enclosed room maintained in accordance with applicable state and federal laws. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 830			
01290 SS=G	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under	01290			

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NAME OF PROVIDER OR SUPPLIER KINDHEART HOMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2400 CHICAGO AVENUE MINNEAPOLIS, MN 55404		
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01290	Continued From page 29 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 was submitted and received in affiliation with the assisted living license for one of eight employees (unlicensed personnel (ULP)-B). 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 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: ULP-B was hired to provide direct care services on September 30, 2021. On February 3, 2025, at 2:48 p.m., owner/agent (O/A)-A provide a document printed from the NETStudy 2.0 website (a web-based system used to submit background study requests) for the licensee's HFID 36885. ULP-B was missing from the staff roster provided to the surveyor. The surveyor inquired why ULP-B was not on the NETStudy 2.0 roster. O/A-A provided a NETStudy printout for another affiliated HFID 34031 and stated ULP-B was on the roster for HFID 34031. ULP-B's background study affiliated to licensee's	01290			

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01290	Continued From page 30 former comprehensive license HFID 34031 indicated "Eligible - COVID-19 Study - Expired" with an expiration date of December 31, 2022, on the NETStudy 2.0 roster page. ULP-B did not have an affiliated background check for the licensee's HFID 36885. On February 3, 2025, at 2:24 p.m., O/A-A stated ULP-B did not have a formal timecard that were able to produce. O/A-A stated the next scheduled shifts were Friday, February 7, 2025, starting 10:00 p.m., until Saturday 2:00 p.m., and Saturday, February 8, 2025, 10:00 p.m., until Sunday 2:00 p.m. On February 3, 2025, at 3:11 p.m., the surveyor observed O/A-A using the NETStudy 2.0 website to affiliate ULP-B to the NETStudy 2.0 roster for HFID 36885. On February 3, 2025, at 3:23 p.m., O/A-A stated they and the clinical nurse supervisor were responsible for the background studies for the facility. O/A-A stated they were unaware the COVID-19 studies had expired. O/A-A stated ULP-B's background study should have been affiliated with HFID 36885 and it was oversight for not having it completed. On February 3, 2025, at 4:27 p.m., O/A-A stated ULP-B worked alone during the night shifts. On February 3, 2025, at 4:28 p.m., ULP-B stated they worked last weekend starting Friday January 31, 2025, from 10:00 p.m. until 2:00 p.m., Saturday February 1, 2025. ULP-B stated they also worked Saturday February 1 starting at 10:00 p.m., until Sunday February 2, 2025, at 2:00 p.m.	01290			

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01290	Continued From page 31 On February 3, 2025, at 4:30 p.m., O/A-A stated they did not have access to the payroll system for the facility on their laptop, and they would have to go to the facility office off-site to access that information. The Minnesota Department of Human Services website indicated the following: Emergency studies completed during the COVID-19 pandemic were no longer valid. Individuals who only had an emergency study must have a fully compliant, fingerprint-based background study. Roster maintenance - Individuals with a completed emergency study will remain on the entity's roster unless the entity removes the individual. Entities should remove individuals with emergency studies that are no longer affiliated; - If the individual should no longer be affiliated and has a new fully compliant background study, the entity should wait until the individual is separated and then remove both the emergency study and fully compliant study from their roster at the same time; - All entities are responsible for maintaining their rosters regularly and removing study subjects from their roster when they are no longer affiliated; and - Entities are responsible for identifying who needs to submit a new background study. For help identifying which study subjects still have an emergency study and need a fully compliant study, entities should refer to the instructional guide, "Identifying Emergency Studies" in the help section of NETStudy 2.0. The license's 4.02 background studies policy dated September 1, 2023, indicated the licensee would conduct a background check on each	01290			

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01290	Continued From page 32 employee and no employee can provide direct care services without acceptable background study results. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01290			
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services	01500			

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01500	Continued From page 33 and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an employee received at least eight hours of annual training for each 12 months of employment for one of three employees (unlicensed personnel (ULP)-E). 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	01500			

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01500	Continued From page 34 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: ULP-E began employment on September 1, 2022, and began to provide direct care and services to residents. ULP-E's employee record lacked the following training to be completed within the last 12 months: - reporting maltreatment of vulnerable adults or minors; - assisted living bill of rights; - infection control techniques; - effective approaches to use to problems solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; - review of provider's policies and procedures; - principles of person-centered planning/service delivery, and; - two hours of dementia training. On February 4, 2025, at 11:20 a.m., licensed assisted living director (LALD)-E stated they were providing coverage for LALD-D who was on a leave of absence. On February 4, 2025, at 11:31 a.m., licensed assisted living director (LALD)-E stated the annual training was scheduled to be completed around the employee yearly hire anniversary date. LALD-E stated the licensee used a software program called Educare to complete the required trainings for employees. LALD-E stated they were	01500			

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01500	Continued From page 35 unsure why the annual training was not completed. The licensee's undated 5.06 Annual Required Staff Training policy indicated each employee would receive eight hours of annual training for each 12 months of employment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500			
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.	01530			

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01530	Continued From page 36 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 direct-care staff received at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date for one of three employees (unlicensed personnel (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, 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: ULP-B was hired to provide direct care services on September 30, 2021. ULP-B's employee file contained five undated individual documents titled [licensee] Dementia Training. Each individual document consisted of two pages of true or false questions related to dementia. There were no completed answers for any true or false questions on any of the five documents. On three of the two-page documents, the mark, "x" was handwritten in the "pass" box. At the bottom of the second page was clinical nurse supervisor (CNS)-C's name and signature. The document lacked a signature from ULP-B.	01530			

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01530	Continued From page 37 On February 3, 2025, at 4:28 p.m., ULP-B stated they worked last weekend starting Friday January 31, 2025, from 10:00 p.m. until 2:00 p.m., Saturday February 1, 2:00 p.m. and worked Saturday February 1 starting at 10:00 p.m. until Sunday February 2, 2025. until 2:00 p.m. On February 3, 2025, at 2:48 p.m., owner/agent (O/A)-A stated ULP-B worked every weekend for the licensee. On February 5, 2025, at 9:59 a.m., O/A-A provided a timecard for ULP-B for the following dates: January 3, 2025, January 10, 2025, January 17, 2025, January 24, 2025, January 31, 2025. The timecard indicated ULP-B worked 16 hours per weekend. On February 4, 2025, at 11:20 a.m., licensed assisted living director (LALD)-E stated they were providing coverage for LALD-D who was on a leave of absence. On February 4, 2025, at 11:34 a.m., LALD-E stated the required eight hours dementia training was provided through a training program called Educare (a software program used to complete training) . LALD-E stated the dementia training should have been completed with 14 days of hire. ULP-B's employee file lacked any documentation of completed training from Educare. The licensee's undated 5.03 Dementia Training policy indicated direct care employees will complete 8 hours of initial dementia training with 160 hours of the employment start date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	01530			

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01530	Continued From page 38 (21) days	01530			
01650 SS=E	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to include required service plan content for two of three residents (R1, R3).	01650			

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01650	Continued From page 39 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: R1 R1 was admitted to the facility August 1, 2021, and began receiving assisted living services. R1's Service Plan Agreement dated December 8, 2024, indicated R1 received assistance with medication administration, food preparation, bathing reminder, hygiene reminder, dressing reminder, personal laundry, mental health services, and safety check. R1's service plan lacked the following required content: - the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency. R3 R3 was admitted to the facility February 19, 2024, and began receiving assisted living services. R3's Service Plan Agreement dated November 13, 2024, indicated R3 received assistance with medication administration, food preparation, hygiene/grooming assistance, dressing	01650			

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01650	Continued From page 40 assistance, continence and toileting assistance, personal laundry, mental health services, and assistance with mobility. R2's service plan lacked the following required content: - the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency. On February 4, 2025, at 12:07 p.m., clinical nurse supervisor (CNS)-C stated they were responsible for creating the service plans for each resident. CNS-C stated they were aware the stated information was required to be included and was unsure why it was missed. The licensee's undated 6.08 Service Plan policy indicated the Service Plan should include identification and contact information of who the resident has authorized if any, to sign for the resident in an emergency. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650			
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by:	01820			

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01820	Continued From page 41 Based on interview and record review, the licensee failed to ensure written or electronically recorded prescriptions were obtained for one of three 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 to the facility February 1, 2022, and began receiving assisted living services. R2's diagnoses included depression. R2's Service Plan dated January 24, 2025, indicated R2 received assistance with medication administration, feeding, food preparation, bathing assistance, hygiene and grooming assistance, dressing assistance, personal laundry, mental health services, and mobility assistance. R2's Medication Administration Record (MAR) dated January 1, 2025, through January 31, 2025, indicated R2 received the following medications: divalproex extended release (ER) 500 milligram (mg) take 3 tablets once daily, fluticasone 1 spray into each nostril once daily, metformin 500 mg 1 tablet once daily, olanzapine 20 mg 1 tablet once daily, vitamin D3 25 micrograms (mcg) once daily, and naloxone 1 spray into the nostril as needed.	01820			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36885	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/06/2025
NAME OF PROVIDER OR SUPPLIER KINDHEART HOMES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 2400 CHICAGO AVENUE 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
01820	Continued From page 42 R2's medical record lacked a manual or electronic signature for the following medication: naloxone. On February 4, 2025, at 11:41 a.m., clinical nurse supervisor (CNS)-C stated they believed the naloxone was discontinued by the medical prescriber but did not have a copy of the discontinuation order from the medical prescriber. CNS-C stated they were unsure why they could not find that discontinuation order and was aware the documentation was required to be available. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820			

Type: Full
Date: 02/03/25
Time: 13:00:00
Report: 1047251030

Food and Beverage Establishment Inspection Report

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Location:

Kindheart Homes Inc
2400 Chicago Avenue
Minneapolis, MN55404
Hennepin County, 27

Establishment Info:

ID #: 0038416
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6124126639
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.

4-300 Equipment Numbers and Capacities

4-302.12A **** Priority 2 ****

MN Rule 4626.0705A Provide a readily accessible food temperature measuring device to ensure attainment and maintenance of food temperatures.

NO THERMOMETER AVAILABLE IN FACILITY

Comply By: 02/10/25

3-300B Protection from Contamination: cross-contamination, eggs

3-302.11A(4)

MN Rule 4626.0235A(4) Protect food from cross-contamination by packages or covered containers.

CONTAINER OF RICE OPEN IN CABINET. DISCUSSED NEED TO KEEP FOOD IN SEALED CONTAINERS TO AVOID CONTAMINATION & AVOID PESTS.

Comply By: 02/03/25

4-600 Cleaning Equipment and Utensils

4-601.11C

MN Rule 4626.0840C Clean non-food contact surfaces of equipment and maintain free of accumulations of dust, dirt, food residue, and other debris.

FOOD DEBRIS BUILD UP THROUGH OUT KITCHEN, INCLUDING ON HANDLE OF OVEN, CUP IN CUPBOARD, INSIDE CUPBOARD, AND STOVETOP

Comply By: 02/03/25

Type: Full
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6-200 Physical Facility Design and Construction

6-202.15A

MN Rule 4626.1395A Seal holes, gaps, and other openings along floors, walls and ceilings to the outside of the building and provide self-closing, tight-fitting doors and windows for all outside openings.
LARGE GAPS LOCATED UNDER & ON SIDE OF DOORS INTO KITCHEN & FRONT OF BUILDING.
DISCUSSED NEED FOR TIGHT FITTING DOOR, ESPECIALLY TO PREVENT PESTS & DUST.

Comply By: 08/03/25

Surface and Equipment Sanitizers

Hot Water: = at 180 Degrees Fahrenheit
Location: Dishmachine
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: Refrigerator- hot dog
Violation Issued: No

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

The inspection was completed with the operator and reviewed with MDH Nurse Evaluator K. Langley.

The establishment has a residential kitchen and serves food that is prepared that day. Facility serves primarily take-out with limited cooking occurring. The kitchen has wood cabinets, wood floor, painted walls, solid counter top, and a painted ceiling.

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

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

Type: Full
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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 1047251030 of 02/03/25.

Certified Food Protection Manager Ubax Ali

Certification Number: FM107971 Expires: 10/01/27

Inspection report reviewed with person in charge and emailed.

Signed: _____

Abraham Ugas
Facility Manager

Signed: _____

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