Electronically Delivered

November 21, 2023

Licensee
Hope Residential Homes, LLC
4008 129th Street
Savage, MN 55378

RE: Project Number(s) SL36880015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on November 1, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the 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. The MDH documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

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

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

The correction order documentation should include the following:

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

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

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

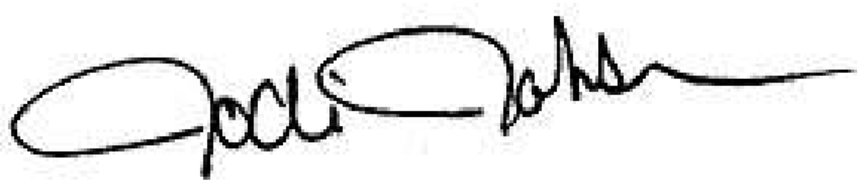
Please address your cover letter for reconsideration requests to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
HRD 3A, 3rd Floor
P.O. Box 64900
625 Robert Street North
St. Paul, MN 55164

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,



Jodi Johnson, Supervisor
State Evaluation Team
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36880	A. BUILDING: _____ B. WING _____	11/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPE RESIDENTIAL HOMES LLC	4008 129TH STREET SAVAGE, MN 55378

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL36880015 On October 30, 2023, through November 1, 2023, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were two active residents; two receiving services under the Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 110 SS=C	144G.10 Subdivision 1a Assisted living director license required Each assisted living facility must employ an	0 110		

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0 110	Continued From page 1 assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports.? This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure licensed assisted living director/registered nurse (LALD/RN)-A was listed as the Director of Record for the licensee. This had the potential to affect all the licensee's residents, staff, and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On October 27, 2023, at 2:30 p.m., the Minnesota Board of Executives for Long-Term Services and Support (BELTSS) website indicated LALD/RN-A currently held a LALD license effective through October 31, 2024; however, LALD/RN-A's license lacked an organization listed as the Director of Record for the licensee. On October 31, 2023, at 2:49 p.m. LALD/RN-A reviewed the BELTSS website with the surveyor and stated she was not listed as the director of record and further stated she hadn't realized she needed to add that. No further information was provided.	0 110		

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0 110	Continued From page 2 TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated October 31, 2023, 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		

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0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post the required information related to the grievance procedure as well as the required information related to the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. 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 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that	0 550		

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0 550	Continued From page 4 has affected or has the potential to affect a large portion or all of the residents). The findings include: On October 30, 2023, at 12:03 p.m. the surveyor toured the facility with clinical nurse supervisor (CNS)-B. There was no evidence the grievance procedure or contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities was posted in a conspicuous place. CNS-B stated the grievance form that residents could complete was posted but not the above content. The licensee's Grievance policy dated April 4, 2022, indicated: 2. A copy of the grievance procedure is conspicuously posted in the residence with the following information: Name, phone number and email contact information for the individuals who are responsible for handling resident complaints Contact information for the state and any regional Office of Ombudsman for Long-Term Care Contact information for the Office of Ombudsman for Mental Health and Developmental Disabilities Contact information for the Minnesota Adult Abuse Reporting Center No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management	0 580		

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0 580	Continued From page 5 appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to engage in and maintain documentation of ongoing quality management activities relevant to the size and services provided by the assisted living provider. 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 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on October 30, 2023, at 11:05 a.m., the surveyor requested the licensee's quality management plan and meeting minutes. Clinical nurse supervisor (CNS)-B	0 580		

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0 580	Continued From page 6 stated being unsure if quality management meetings had been conducted at this location. On October 31, 2023, at 2:49 p.m. CNS-B and licensed assisted living director/registered nurse (LALD/RN)-A stated quality management meetings/activities had not been conducted at this residence though were completed at their other location. The licensee's undated, Quality Management Program policy indicated the Quality Plan will consist of: Key Goals To conduct ongoing assessments of home care services Approach quality as a management strategy Focus on key organizational processes Look for opportunities that would improve systems of care delivery, including changes in services, staffing and/or procedures Build quality into all processes and continually work to improve services to meet client needs and manage costs Evaluating the quality of care by periodically Review client services records Review complaints made, and other issues that have occurred and determining whether changes in services, staffing or other procedures need to be made to ensure safe and competent services to clients. Client records: are audited regularly - results will be reviewed and follow up as appropriate Employee records: are audited regularly - results will be reviewed and follow up as appropriate Complete Client Satisfaction Survey annually - Data will be compiled and follow up as appropriate Complete Caregiver Survey every two years - Data will be compiled and follow up as	0 580		

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0 580	Continued From page 7 appropriate Complete annual TB Survey - TB survey annually Complaint Reports: All complaint reports are reviewed following the established procedure. Data will be analyzed and trending the data which is incorporated into the Quality Improvement program Incident Reports: will be reviewed by the Registered Nurse and/or Administrator too correct safety concerns for clients Monitor organizational trends related to safety and/or client care to address unsafe clinical practice for individual caregivers or clients Documentations of the Quality Improvement Program is maintained for at least two years and will be provided to the commissioner at the time of survey investigation or renewal as requested. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 580		
0 620 SS=D	144G.42 Subd. 6 (a) / 626.557, Subd. 3 Compliance with requirements for reporting ma (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. The requirement in Minnesota Statute section 626.557, Subd. 3 is: (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury	0 620		

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0 620	Continued From page 8 which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event	0 620		

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0 620	Continued From page 9 meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) suspected maltreatment for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included paranoid schizophrenia. R1's Service Plan dated May 5, 2022, indicated services including medication administration and psychiatric management. R1's progress note dated August 12, 2023, at 11:11 a.m. indicated R1 came downstairs at 9:18 a.m. with blood all over his clothes and body telling staff that he stabbed himself. Staff immediately notified the nurse and call 911. While waiting for the arrival of paramedics, staff applied pressure to the wound. Paramedics arrived quickly and he was later taken by EMS	0 620		

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0 620	Continued From page 10 (emergency medical services). R1's progress notes further indicated R1 was hospitalized and returned to the facility on August 29, 2023. On October 31, 2023, at 11:12 a.m. licensed assisted living director/registered nurse (LALD/RN)-A stated she did not report the above incident to MAARC as it was self-harm by R1, and staff responded appropriately. LALD/RN-A stated feeling this was not a reportable incident. The licensee's undated, Vulnerable Adult/Child Protection policy indicated all employees providing home care are mandated to report abuse and/or neglect (including suspected abuse or neglect) of the vulnerable adult/child to the appropriate county social services, local police department, county sheriff or appropriate licensing or certifying organization through the Common entry Point (CEP). No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable	0 640		

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0 640	Continued From page 11 adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to support protection and safety by not posting information and phone numbers for reporting to the Minnesota Adult Abuse Reporting Center (MAARC) and 911 emergency number as required. 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 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On October 30, 2023, at 12:03 p.m. the surveyor toured the facility with clinical nurse supervisor (CNS)-B. The facility was observed to be lacking posting of the MAARC hotline and 911 emergency number in the common areas of the facility. CNS-B confirmed the finding. The licensee's undated, Posting Information for Reporting of Crimes or Maltreatment policy indicated: Emergency service and MAARC hotline number will be posted in the following areas: 1. In common areas and near any available telephone.	0 640		

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0 640	Continued From page 12 2. Notice will be available in all languages applicable to the facilities residents and staff. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) to include an annual facility TB risk assessment. In addition, the facility failed to conduct a TB symptom screen for one of two unlicensed personnel (ULP-C). This had the potential to	0 660		

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	36880	A. BUILDING: _____ B. WING _____	11/01/2023

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HOPE RESIDENTIAL HOMES LLC	4008 129TH STREET SAVAGE, MN 55378

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0 660	Continued From page 13 affect all current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on October 30, 2023, at 11:05 a.m. with clinical nurse supervisor (CNS)-B, the surveyor requested to review the facility's TB risk assessment. CNS-B provided the TB Risk Assessment following the entrance conference. The licensee's current TB Risk Assessment was dated October 7, 2021. ULP-C was hired June 1, 2022, to provide direct care services. ULP-C's employee file included a TB Symptom Screen dated June 15, 2022, with the employee's name and date of birth. No other information had been completed. On November 1, 2023, at 9:10 a.m. licensed assisted living director/registered nurse (LALD/RN)-A reviewed ULP-C employee file and stated the TB Symptom Screen had not been completed. LALD/RN-A further stated the facility TB Risk Assessment had not been completed annually as required.	0 660		

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0 660	Continued From page 14 The MN Department of Health Facility Tuberculosis (TB) Risk Assessment Instructions and Worksheet for Health Care Setting Licensed by MDH updated June 2023, indicated: Settings should perform a facility risk assessment on an annual basis. The worksheet further indicated baseline TB screening is required at the time of hire for all health care personnel in Minnesota. Baseline TB screening includes assessing for current symptoms of active TB disease and assessing TB history. The licensee's undated, Tuberculosis Prevention & Screening Plan indicated the licensee will follow the recommended precautions relate to TB prevention as identified by the Center for Disease Control and prevention (CDC) and the MN Department of Health (MDH). No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (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;	0 680		

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0 680	Continued From page 15 and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop an all-hazards emergency preparedness (EP) program and plan to include the Appendix Z required content. 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 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee provided their undated, disaster plan. The licensee's written emergency disaster plan lacked the following required content:	0 680		

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0 680	Continued From page 16 - documentation of annual review of the plan; - a description of the population served by the licensee; - process for emergency preparedness (EP) collaboration with state and local EP officials/organizations; - procedure for tracking staff and residents; - subsistence needs for staff and residents during emergency situations - development of policies/procedures to address: - evacuation plan; - the medical record documentation system to preserve resident information; - use of volunteers; - emergency staff strategies; and - the facility's role in providing care and treatment at alternative sites. - a communication plan that included: - arrangement with other facilities; - names and contact information for resident physicians; - contact information for federal, state, tribal, local EP staff, or the ombudsman; - primary and alternative means for communicating with facility staff, or federal, state, regional and local - policies and procedures to address role of facility under a waiver declared by the Secretary in accordance with section 1135 of the Act -emergency management agencies; - a method of sharing information and medical documentation for residents; - a means to provide information regarding the facility's needs, and its ability to provide assistance to include information about their occupancy; and - EP training and testing program; - EP training program for staff (including documentation of training provided); and	0 680		

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0 680	Continued From page 17 - EP testing/annual testing requirements. On November 1, 2023, at 8:40 a.m. the surveyor reviewed the required components of Appendix Z with licensed assisted living director/registered nurse (LALD/RN)-A. LALD/RN-A reviewed the licensee's emergency preparedness plan and stated it did not include the above content and was unfamiliar with the requirements. The licensee's undated, Emergency Preparedness policy indicated the licensee will have an identified plan in place to assure the safety and well-being of clients and staff during periods of an emergency or disaster that disrupts services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health	0 730		

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0 730	Continued From page 18 records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record included a discharge summary with the required content for one of one discharged resident (R3). This practice resulted in a level two violation (a	0 730		

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0 730	Continued From page 19 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: R3's record lacked a discharge summary to include: - diagnoses; - course of illness; - allergies; - treatments and therapies; - pertinent lab, radiology, and consultation results; and - a final summary of the resident's status from the latest assessment or review including baseline and current mental, behavioral, and functional status. R3 was admitted to the licensee on December 30, 2021, with diagnoses including fetal alcohol syndrome disorder, oppositional defiant disorder, and attention deficit hyperactivity disorder. R3 discharged on July 4, 2022. On October 31, 2023, at 11:12 a.m. licensed assisted living director/registered nurse (LALD/RN)-A stated R3's discharge summary did not include all required content. No further information was provided. TIME PERIOD FOR CORRECTIONS: Twenty-one (21) days	0 730		

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0 810	Continued From page 20	0 810		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by:	0 810		

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0 810	Continued From page 21 Based on a record review and interview, the licensee failed to develop a fire safety and evacuation plan with required elements, provide required employee and resident training on fire safety and evacuation, and conduct required evacuation drills. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (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 October 31, 2023, licensed assisted living director/registered nurse (LALD/RN-A) provided documentation on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review of the available documentation indicated the evacuation plan did not include employee actions to be taken in the event of a fire or similar emergency. The current plan used the RACE acronym which is very basic and does not show the employees actions in the event of a fire or similar emergency. Record review of the available documentation indicated the evacuation plan did not include employee actions to be taken in the event of a fire or similar emergency. The current plan used the standard RACE (Remove, Alarm, Confine and Extinguish or Evacuate) directive, however did	0 810		

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0 810	Continued From page 22 not include facility specific emergency risk situational actions for employees to execute in case of an emergency. Record review of the available documentation indicated the licensee did not provide training for employees on the fire safety and evacuation plans upon hire and at least twice per year thereafter. Record review of the available documentation indicated the licensee did not conduct evacuation drills twice per year, per shift and every other month for employees as required by statute. Documentation showed evacuation drills were done two times in 2023. During interview on October 31, 2023, at 11:45 a.m., LALD/RN-A verified that the fire safety and evacuation plan for the facility lacked these provisions. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated	01060		

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01060	Continued From page 23 and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation and failed to notify the Office of Ombudsman for Long-Term Care of the emergency relocation when the residents had not returned to the facility within four days for one of one resident (R1).	01060		

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01060	Continued From page 24 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R1's diagnoses included paranoid schizophrenia. R1's Service Plan dated May 5, 2022, indicated services including medication administration and psychiatric management. R1's After Visit Summary dated August 29, 2023, indicated R1 had been hospitalized on August 13, 2023, and discharged on August 29, 2023. R1's After Visit Summary dated October 13, 2023, indicated R1 had been hospitalized on September 19, 2023, and discharged on October 13, 2023. R1's record lacked a written notice that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the Office of Ombudsman for Long-Term Care; - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; - a statement that, if the facility refuses to provide	01060		

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01060	Continued From page 25 housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. On October 31, 2023, at 12:55 p.m. licensed assisted living director/registered nurse (LALD/RN)-A stated the licensee did not provide an emergency transfer notice to resident, legal representative, and designated representative when residents were hospitalized, nor were they notifying the ombudsman when the relocation exceeded four days. LALD/RN-A stated being unaware of the requirement. The licensee's undated, Emergency Relocation policy indicated: When emergency relocation is initiated, the following procedure is to be followed: 1. A written notice to the resident will be served in person or certified mail and will contain the following: Reason for the relocation Name and contact information for the new facility that they have been relocated to and name and contact info for the new service provider if different than the relocation destination. Contact information for the Office of the Ombudsman for Long-Term Care. If know, the date or range of dates in which the resident shall be able to return to the facility or a statement that says the return date is currently not known. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01060		

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01620	Continued From page 26	01620		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing nursing assessments not to exceed 90 days or with a change in condition for 1 of 1 resident (R1), and failed to include required areas of assessment per Assisted Living Facilities: Minnesota Rules Chapter 4659, for one of one resident (R1).	01620		

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	36880	A. BUILDING: _____ B. WING _____	11/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPE RESIDENTIAL HOMES LLC	4008 129TH STREET SAVAGE, MN 55378

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01620	Continued From page 27 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: R1's diagnoses included paranoid schizophrenia. R1's Service Plan dated May 5, 2022, indicated services including medication administration and psychiatric management. R1's After Visit Summary dated August 29, 2023, indicated R1 had been hospitalized on August 13, 2023, and discharged on August 29, 2023. R1's After Visit Summary dated October 13, 2023, indicated R1 had been hospitalized on September 19, 2023, and discharged on October 13, 2023. R1's last two assessments were requested. Assessments dated March 30, 2023, and June 30, 2023, were provided and reviewed by the surveyor on October 31, 2023. 92 days had passed between the two assessments and 123 days had passed since the last assessment dated June 30, 2023. R1's record did not include evidence assessments had been completed upon R1's return from hospitalization on August 29, 2023, or October 13, 2023. In addition, the assessments did not include per Assisted Living Facilities: Minnesota Rules Chapter 4659.0150 Uniform Assessment Tool, the components	01620		

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01620	Continued From page 28 required. On October 31, 2023, at 11:12 a.m. licensed assisted living director/registered nurse (LALD/RN)-A stated following R1's return from hospitalization she had updated R1's vulnerability assessment and completed a progress note, though did not complete a full comprehensive assessment. At 12:06 p.m., the surveyor reviewed R1's last two 90-day assessments titled Nurse Re-Assessment Visit #1 with LALD/RN-A. The assessments included vital signs including lung sounds, and a checklist of the body systems. The checklist had a space by each body system to either check N/C (no change) or N/A (not assessed), and a line to document notes. All body systems were checked N/C with no other documentation. The assessment also included a checklist for delegated task observation/competency, service plan/agreement review and if appropriate to client needs, and if any problems were identified and plan to address. LALD/RN-A reviewed the criteria for the Uniform Assessment Tool and stated their initial/admission assessment included all the required components, though the 90-day and change of condition assessments did not. LALD/RN-A further stated using the same assessment form for all residents. The Assisted Living Facilities: Minnesota Rules Chapter 4659.0150 Uniform Assessment Tool indicated: - Subpart 1. Definition. For purposes of this part, "Uniform Assessment Tool" means an assessment tool that meets the requirements of this part and is used by a licensee to comprehensively evaluate a resident's or prospective resident's physical, mental, and cognitive needs	01620		

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01620	Continued From page 29 - Subp. 2. Assessment tool elements. Each facility must develop a uniform assessment tool. The facility may use any acceptable form or format for the tool, such as an online or a hard-copy paper assessment tool, as long as the tool includes the elements identified in this subpart. A uniform assessment tool must address the following: A. the resident's personal lifestyle preferences, including: (1) sleep schedule, dietary and social needs, leisure activities, and any other customary routine that is important to the resident's quality of life; (2) spiritual and cultural preferences; and (3) advance health care directives and end-of-life preferences, including whether a person has or wants to seek a "do not resuscitate" order and "do not attempt resuscitation order or "physician/provider orders for life-sustaining treatment: order. B. activities of daily living, including: (1) toileting pattern, bowel, and bladder control; (2) dressing, grooming, bathing, and personal hygiene; (3) mobility, including ambulation, transfers, and assistive devices; and (4) eating, dental status oral care, and assistive devices and dentures, if applicable; C. instrumental activities of daily living, including: (1) ability to self manage medications; (2) housework and laundry; and (3) transportation; D. physical health status, including: (1) a review of relevant health history and current health conditions, including medical and nursing diagnoses; (2) allergies and sensitivities related to	01620		

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01620	Continued From page 30 medication, seasonality, environment, and food and if any of the allergies or sensitivities are life threatening; (3) infectious conditions; (4) a review of medications according to Minnesota Statues, section 144G.71, subdivision 2, including prescriptions, over-the-counter medications, and supplements, and for each: (a) the reason taken; (b) any side effects, contraindications, allergies or adverse reactions, and actions to address these issues; (c) the dosage; (d) the frequency of use; (e) the route administered or taken; (f) any difficulties the resident faces in taking the medication; (g) whether the resident self administers the medication; (h) the resident's preferences in how to take medication; (i) interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications; and (j) provide instructions to the resident ad resident's legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications; (5) a review of medical, dental, and emergency room visits in the past 12 months, including visits to a primary health care provider, hospitalizations, surgeries, an care from a post acute care facility; (6) a review of any reports from a physical therapist, occupational therapist, speech therapist, or cognitive evaluations within the last 12 months; (7) weight; and	01620		

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01620	Continued From page 31 (8) initial vital signs if indicated by health conditions or medications; E. emotional and mental health conditions, including; (1) review of history of and any diagnoses of mood disorders, including depression, anxiety, bipolar disorder, and thought or behavioral disorder; (2) current symptoms of mental health conditions and behavioral expressions of concerns; and (3) effective medication treatment and nonmedication interventions; F. cognition, including; (1) a review of any neurocognitive evaluations and diagnoses; and (2) current memory, orientation, confusion, and decision-making status and ability; G. communication and sensory capabilities, including; (1) hearing; (2) vision; (3) speech; (4) assistive communication and sensory devices including hearing aids; and (5) the ability to understand and be understood; H. pain, including; (1) location, frequency, intensity, and duration; and (2) effectiveness of medication and nonmedication alternatives; I. skin conditions J. nutritional and hydration status and preferences; K. list of treatments, including type, frequency, and level of assistance needed; L. nursing needs, including potential to receive nursing-delegated services; M. risk indicators, including;	01620		

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01620	Continued From page 32 (1) risk for falls including history of falls; (2) emergency evacuation ability; (3) complex medication regimen; (4) risk for dehydration, including history or urinary tract infections and current fluid intake pattern; (5) risk for emotional or psychological distress due to personal losses; (6) unsuccessful prior placements; (7) elopement risk including history or previous elopements; (8) smoking, including the ability to smoke without causing burns or injury to the resident or others or damage to property; and (9) alcohol and drug use, including the resident's alcohol use or drug use not prescribed by a physician; N. who has decision-making authority for the resident, including; (1) the presence of any advance health care directive or other legal document that establishes a substitute decision maker; and (2) the scope of decision-making authority of a substitute decision maker under subitem (1); and O. the need for follow-up referral for additional medical or cognitive care by health professionals. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01650 SS=F	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,	01650		

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01650	Continued From page 33 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 ensure the service plan included the correct required content for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when	01650		

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01650	Continued From page 34 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: R1's diagnoses included paranoid schizophrenia. R1's Service Plan dated May 5, 2022, indicated services including medication administration and psychiatric management. The service plan indicated: Resident assessment/evaluation will be completed within five days of admission. The service plan identified an incorrect schedule and method of monitoring assessments of the resident. On October 31, 2023, at 11:12 a.m. licensed assisted living director/registered nurse (LALD/RN)-A stated the above required content was incorrect in the service plan, and reflective of previous home care statutes. LALD/RN-A also said the same service plan format was utilized for all residents. The licensee's undated, Assessment - Comprehensive Services policy indicated the initial assessment will be completed within five (5) days of the initiation of services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01650		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and	01880		

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01880	Continued From page 35 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 one of one resident (R2) insulin was stored securely and according to the manufacturer's recommendations. 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: R2 began receiving assisted living services September 28, 2022. R2's diagnosis included type I diabetes and schizophrenia. R2's Service Plan dated September 28, 2022, indicated R2 received services including medication administration which included storage of medications. On October 31, 2023, at 9:18 a.m. the surveyor observed unlicensed personnel (ULP)-C administer medications to R2 which included oral medications and insulin. ULP-C obtained R2's open Novolog Kwikpen from the locked	01880		

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01880	Continued From page 36 refrigerator in the office located near the front door. ULP-C proceeded to set up and administer R2's oral medications, then prepared the Novolog KwikPen which R2 administered independently with supervision from ULP-C. Once R2 finished administering her Novolog insulin, ULP-C disposed of the needle in a sharps container then placed the Novolog KwikPen into a baggie and returned it to the locked refrigerator. On October 31, 2023, at 11:12 a.m. licensed assisted living director/RN (LALD/RN)-A and clinical nurse supervisor (CNS)-B stated they always store insulin whether opened or not, in the refrigerator. LALD/RN-A and CNS-B further stated being unaware R2's opened Novolog FlexPen should be stored at room temperature. The Novolog manufacturer's instructions dated March 2023, indicated in-use (opened) single use FlexPen should be stored at room temperature (up to 30 degrees Celsius [86 degrees Fahrenheit]) for up to 28 days (Do not refrigerate). No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for	01910		

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01910	Continued From page 37 disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident's record the disposition of the medication including the medication's prescription number as applicable, for one of one discharged resident (R3) with record review. 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 discharge resident roster provided by the licensee, indicated R3 discharged on July 4, 2022, to another facility.	01910		

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01910	Continued From page 38 R3's List of Services to be Provided dated February 10, 2022, indicated services included medication administration. R3's Medication When Client Away From Home form dated July 4, 2022, included medications that had been sent with R3's client representative upon discharge. The document identified the medication name, strength, quantity, and signature of the nurse and client representative. The document did not include the prescription number for any of the identified medications including: Adderal (stimulant), amphetamine salts (stimulant), clonidine (hypertension), Abilify (antipsychotic), lamotrigine (mood stabilizer), metformin (diabetes), lithium (mood stabilizer), fluticasone HFA inhaler, Ventolin inhaler, olanzapine (antipsychotic), and amoxicillin (antibiotic). On October 31, 2023, at 11:12 a.m. licensed assisted living director/registered nurse (LALD/RN)-A stated being unaware the prescription number was required for the disposition of medications when sending medications with a discharging resident or when destroying resident medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to	03090		

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03090	Continued From page 39 record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the required notice was posted at the main entry way of the establishment to display statutory language to disclose electronic monitoring activity, potentially affecting all current residents, staff, and any visitors of the facility. This practice resulted in a level one violation (a violation that has not potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The finding include: On October 30, 2023, at approximately 10:50 a.m. upon arriving at the establishment, an observation outside the front entrance, or just inside the front entrance, lacked the required posting for electronic monitoring devices. On October 30, 2023, at 12:03 p.m. the surveyor toured the residence with clinical nurse supervisor (CNS)-B. CNS-B stated licensee utilized cameras in the common areas of the residence and further stated no posting was available related to the statutory language for electronic monitoring.	03090		

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03090	Continued From page 40 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	03090		

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

Type: Full
Date: *10/31/23*
Time: 10:59:33
Report: 1047231052

Food and Beverage Establishment Inspection Report

Location:
Hope Residential Homes Llc
4008 129th Street
Savage, MN55378
Scott County, 70

Establishment Info:
ID #: 0038328
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6125988681
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.

2-200 Employee Health

2-201.11C ***** Priority 1 *****

MN Rule 4626.0040C The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority.

No employee illness log available on site. Provided log with report.

Comply By: 10/31/23

4-300 Equipment Numbers and Capacities

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

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

No available method to check temperature of dishwasher. Provided information on thermometer (waterproof that captures max temperature) or thermal stickers that record temperature.

Comply By: 11/07/23

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 38 Degrees Fahrenheit - Location: Refrigerator- sliced cheese
Violation Issued: No

Type: Full
Date: *10/31/23*
Time: 10:59:33
Report: 1047231052
Hope Residential Homes Llc

Food and Beverage Establishment Inspection Report

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: Refrigerator- roast beef
Violation Issued: No

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

Inspection condcuted with operator Z. Farah and MDH nurse evaluator W. Buckholz.

The establishment has a residential kitchen and serves food that is prepared that day. Currently there are two residents at the facility. The kitchen has wood cabinets, laminate 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.

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 1047231052 of 10/31/23.

Certified Food Protection Manager Zamzam L Farah

Certification Number: FM110093 Expires: 10/25/24

Inspection report reviewed with person in charge and emailed.

Signed: _____
Zamzam Farah
PIC

Signed: _____
Holly Sievers
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