Electronically Delivered

June 10, 2025

Licensee
Pleasant Assisted Living LLC
6932 Jersey Avenue North
Brooklyn Park, MN 55428

RE: Project Number(s) SL37975016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 30, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

STATE CORRECTION ORDERS

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

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 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37975	A. BUILDING: _____ B. WING _____	04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT ASSISTED LIVING LLC	6932 JERSEY AVENUE NORTH BROOKLYN PARK, MN 55428

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL37975016-0 On April 28, 2025, through April 30, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were two (2) residents receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and	0 510		

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0 510	Continued From page 1 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 infection control program that complies with accepted health care, medical and nursing standards for infection control. The deficient practice had the potential to affect residents, employees, 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 all staff, residents and visitors.) The findings include: On April 28, 2025, at 10:00 a.m., the surveyor toured the facility and observed the following unmitigated infection control concerns: - On the main level bathroom, no paper towels available for drying a person's hands after washing their hands;	0 510		

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0 510	Continued From page 2 - On the main level bathroom, a metal garbage can with a step to lift lid stored in the roll-in shower had a used brief sitting on top of the lid; - On the main level bathroom, used gloves on the floor in the shower next to previously mentioned metal garbage can; and - In the basement, three (3) red biohazard sharps containers which appeared full with used insulin needles were sitting on the floor in the common area near new clean commonly used items such as paper towels, toilet paper, gloves, masks, and briefs. On April 28, 2025, at 1:30 p.m., surveyor toured the above identified infection control concerns with clinical nurse supervisor (CNS)-C. CNS-C stated all items would need to be remedied and were outside the expected policy and procedure for the licensee. CNS-C stated staff had been trained in proper infection control techniques and each item would need to be addressed immediately. CNS-C instructed unlicensed personnel (ULP)-A to correct each identified infection control concern aside from the biohazard sharps containers. CNS-C stated the biohazard sharps containers would need to be taken to an appropriate disposal system for destruction. The licensee's Infection Control policy dated February 10, 2022, indicated licensee would observe precautions as recommended by the Center for Disease Control and Prevention (CDC) for current health care standards for the practice of infection control. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		

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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 the portable fire extinguishers. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 April 29, 2025, at approximately 12:30 p.m., the surveyor toured the facility with clinical nurse supervisor (CNS)-C. The portable fire extinguishers throughout the facility lacked records to show monthly visual inspections were complete. The affixed tags indicated the upper-level fire extinguisher was last inspectioned	0 790		

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0 790	Continued From page 4 11-2024. The lower-level fire extinguisher was last inspectioned 8-2024. Documentation is required to demonstrate fire extinguishers have been inspected by facility personnel monthly. On April 29, 2025, the surveyor explained to CNS-C that the portable fire extinguishers must be provided monthly visual inspections or "quick checks" of each extinguisher by their employees to ensure all portable extinguishers are readily available, fully charged, and operable at their designated location with no obvious physical damage or condition to the extinguisher that would prevent their operation when needed. CNS-C stated they understood the requirements. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
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	0 810		

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0 810	Continued From page 5 evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training. 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:	0 810		

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0 810	Continued From page 6 On April 29, 2025, 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's FSEP failed to include the following: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate) but the plan was designed for a building with life safety systems such as a fire alarm system. The policy had not been updated to provide complete actions for employees to take in the event of a fire or similar emergency at the licensed facility which did not have a fire alarm system. The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. TRAINING: The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. No documentation was provided at the time of survey. On April 29, 2025, CNS-C stated they understood the areas of their policy that were incomplete and	0 810		

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0 810	Continued From page 7 would work on bringing them into compliance. 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 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	01060		

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01060	Continued From page 8 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 to the resident, legal representative, or designated representative for one of one resident (R2) who had an emergency relocation. 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 all staff, residents and visitors). The findings include: R2 was admitted to the licensee on February 15, 2023. R2's untitled document identified by clinical nurse supervisor (CNS)-C as R2's progress note dated January 12, 2025, indicated R2 was transferred to a local hospital via an ambulance and paramedics. R2 returned to the licensee on January 15, 2025. Additionally, the progress	01060		

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01060	Continued From page 9 notes indicated on March 8, 2025, R2 went to an appointment with their primary care provider and was transferred to a local hospital via ambulance and subsequentially admitted to the hospital. R2 then returned to the licensee on March 11, 2025. R2's record lacked evidence R2 or R2's designated representative was provided emergency relocation notices with the required content. On April 29, 2025, at 9:10 a.m., CNS-C stated licensee was not aware of the emergency relocations notice requirements. CNS-C stated an emergency relocation notice was not provided to R2, and licensee had not developed an emergency relocation notice to be provided when required. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01620 SS=D	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	01620		

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01620	Continued From page 10 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 a registered nurse (RN) conducted an assessment with a readmission from a hospital stay for one of one resident (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 licensee on February 15, 2023. R2's untitled document identified by clinical nurse supervisor (CNS)-C as R2's progress note dated January 12, 2025, indicated R2 was transferred and admitted to a local hospital via an ambulance. R2 returned to the licensee on	01620		

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01620	Continued From page 11 January 15, 2025. Additionally, the progress notes indicated on March 8, 2025, R2 went to an appointment with their primary care provider and was transferred to a local hospital via ambulance and subsequentially admitted to the hospital. R2 then returned to the licensee on March 11, 2025. R2's [licensee] Uniform Assessment Tool (90 Days Assessment) dated February 15, 2025, was identified by CNS-C as R2's most recent assessment. R2's [licensee] Uniform Assessment Tool (90 Days Assessment) dated November 15, 2024, was identified by CNS-C as R2's previous assessment completed. On April 28, 2025, at 2:00 p.m., CNS-C stated licensee had not completed an assessment for R2 when R2 returned from the hospital on January 15, 2025, or on March 11, 2025. CNS-C stated an assessment of R2 should have been completed when R2 returned from the hospital to ensure R2 did not require a change in services or needs to be provided by the licensee. The licensee's Nursing Assessment and Reassessment of Residents policy dated February 10, 2022, indicated the RN would conduct an assessment any time a resident returned from a hospital admission. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01620		
01710 SS=F	144G.71 Subd. 3 Individualized medication monitoring and reas	01710		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37975	A. BUILDING: _____ B. WING _____	04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT ASSISTED LIVING LLC	6932 JERSEY AVENUE NORTH BROOKLYN PARK, MN 55428

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01710	Continued From page 12 The assisted living facility must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed annual re-assessments for an individualized medication management plan (IMMP) for one of one resident (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 April 29, 2025, at 7:00 a.m., observed unlicensed personnel (ULP)-A provide medication administration to R2 including oral and subcutaneous medication administration. ULP-A obtained medications from a secured medication cart and provided the medications to R2. R2 was admitted to the licensee on February 15, 2023. R2's Individualized Medication Management Plan was dated February 15, 2023.	01710		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37975	A. BUILDING: _____ B. WING _____	04/30/2025

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01710	Continued From page 13 R2's Service Plan dated May 26, 2023, indicated R2 required the service of medication administration. R2's [licensee] Uniform Assessment Tool (90 Days Assessment) dated February 15, 2025, indicated R2 required assistance with medication administration and monitoring. On April 28, 2025, at 2:00 p.m., clinical nurse supervisor (CNS)-C stated licensee had not completed an annual IMMP assessment. CNS stated the licensee's assessment template did not include the IMMP content and would need to be added to ensure all required content would be addressed with each assessment. CNS-C stated licensee was not aware each resident's IMMP was required to be reassessed annually. The licensee's Mediation Management Services policy dated February 10, 2022, failed to indicate the frequency a resident's IMMP would be reassessed. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01710		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01970	Continued From page 14 therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain written or electronically signed treatment or therapy orders from an authorized prescriber one of one resident (R2) with treatments. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client'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 clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On April 28, 2025, at 10:00 a.m., during a tour of the facility, oxygen (O2) tanks were noted stored in R2's room with a tube running from a tank toward R2's bed. R2 was admitted to the licensee on February 15, 2023. R2's Individualized Treatment or Therapy Management Plan dated February 15, 2023, indicated R2 required treatment services for BiPAP/CPAP (a device used to help a person who suffers from sleep apnea (stopping breathing when sleeping) breath effectively), and oxygen management services. R2's Service Plan dated May 26, 2023, indicated	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01970	Continued From page 15 R2 required the service of treatment management services. R2's [licensee] Uniform Assessment Tool (90 Days Assessment) dated February 15, 2025, indicated R2 required a CPAP at night with O2. On April 28, 2025, at 2:00 p.m., clinical nurse supervisor (CNS)-C stated licensee had not obtained current signed orders for R2's CPAP and O2. CNS-C stated the orders were sent to R2's durable medical equipment (DME) distribution company who bring the items to R2. CNS-C stated licensee would need to get current authenticated orders from the DME company or would call R2's provider's office to get the orders from them. CNS-C stated they were not sure why the orders were not maintained in R2's record. The licensee's 7.20 Medication & Treatment Orders policy dated February 10, 2022, indicated current authenticated provider orders would be maintained for all treatments licensee provided to a resident. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		

St Cloud District Office
Minnesota Department of Health
4140 Thielman Lane, Suite 101
St Cloud, MN 56301
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

Pleasant Assisted Living LLC
6932 Jersey Ave N
Brooklyn Park, MN 55428
Hennepin County
Parcel:

Phone:

License Info

License: HFID 37975

Risk:
License:
Expires on:
CFPM:
CFPM #: ; Exp:

Inspection Info

Report Number: F1051251004
Inspection Type: Full - Single
Date: 4/28/2025 Time: 11:00:00 AM
Duration: 45 minutes
Announced Inspection: Yes
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

No orders were issued for this inspection report.

Food & Beverage General Comment

MET WITH NURSE EVALUATOR, BRANDON MUELLER.

DISCUSSED THE FOLLOWING WITH THE PERSON IN CHARGE, BALLAH:

EMPLOYEE ILLNESS LOG
VOMIT CLEAN-UP PROCEDURES
HANDWASHING & GLOVE USE

THE KITCHEN HAS LAMINATE CABINETS & COUNTERTOPS WITH HOLLOW BASES, A SMOOTH TEXTURE CEILING, A HIGH TEMPERATURE DISHWASHER, & VINYL PLANK FLOORS.

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

I acknowledge receipt of the St Cloud District Office inspection report number F1051251004 from 4/28/2025

Ballah

Kai Yang,
Public Health Sanitarian 1
320-640-3532
kai.yang@state.mn.us

St Cloud District Office
Minnesota Department of Health
4140 Thielman Lane, Suite 101
St Cloud, MN 56301

Temperature Observations/Recordings

Establishment Info

Pleasant Assisted Living LLC
Brooklyn Park
County/Group: Hennepin County

Inspection Info

Report Number: F1051251004
Inspection Type: Full
Date: 4/28/2025
Time: 11:00:00 AM

Food Temperature: Product/Item/Unit: SLICED AMERICAN CHEESE**; Temperature Process:** Cold-Holding
Location: Upright Refrigerator at 39 Degrees F.
Comment:
Violation Issued?: No

St Cloud District Office
Minnesota Department of Health
4140 Thielman Lane, Suite 101
St Cloud, MN 56301

Sanitizer Observations/Recordings

Establishment Info

Pleasant Assisted Living LLC
Brooklyn Park
County/Group: Hennepin County

Inspection Info

Report Number: F1051251004
Inspection Type: Full
Date: 4/28/2025
Time: 11:00:00 AM

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** High Temp Dishwasher
Location: Dishwashing Area **Equal To** 160 Degrees F.
Comment:
Violation Issued?: No