Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF INITIAL LICENSE DENIAL

Electronically Delivered

October 7, 2026

Licensee
Happy Hearts Homecare Corporation
2310 James Avenue North
Minneapolis, MN 55411

RE: Denial of License Number 420326
Health Facility Identification Number (HFID) 41378
Initial survey; Project Number(s) SL41378015

Dear Licensee:

The Minnesota Department of Health (MDH) completed an initial survey on August 4, 2026, for the purpose of assessing compliance with state licensing statutes and determine issuance of an initial license to the above-mentioned provider. Based on the survey, MDH found you not in substantial compliance with the laws pursuant to Minnesota Statute, Chapter 144G. As a result, your authority to continue to operate under a provisional license or be approved for an assisted living facility license is being denied.

INELIGIBILE LICENSURE TIMELINE

Pursuant to Minn. Stat. § 144G.16, subd. 3 (c), the owners and managerial officials of a provisional licensee whose license is denied are ineligible to apply for an assisted living facility license under this chapter for one (1) year following the facility's closure date.

STATE CORRECTION ORDERS

The enclosed State Form documents the state licensing orders. The Department of Health documents state 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 . . ."

REQUEST FOR RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.16, Subd. 4, you may request a reconsideration by the Minnesota Department of Health. The request for reconsideration process must be conducted internally by the Minnesota Department of Health and Chapter 14 does not apply. **This is your only ability to request a reconsideration under this enforcement action.**

To submit a reconsideration request, please visit:

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

Note requests for reconsideration must be received by the department within 15 calendar days of the date of this notice.

REQUIREMENTS FOR NOTIFICATION AND TRANSFER OF RESIDENTS
You must comply with the requirements for notification and coordinated move of residents noted in Minn. Stat. § 144G.52 and Minn. Stat. § 144G55. Additionally, please provide the information described in Minn. Stat. § 144G.20, Subd. 15 (a) (1), (2), (3), (4) and (5) to this department's contact, Casey DeVries, via email at: Casey.DeVries@state.mn.us. Also provide this information to the lead agencies as defined in section 256B.0911, county adult protection and case managers, and the ombudsman for long-term care no later than **October 11, 2026.**

Pursuant to Minn. Stat. § 144G.16, Subd. 5 (3), a provisional licensee whose license is denied is permitted to continue operating as an assisted living facility during the period of time when a transfer of assisted living facility resident(s) from the provisional licensee to a new assisted living facility provider is in process.

Additionally, pursuant to Minn. Stat. § 144G.16, Subd. 5 (1), you may continue operating during the reconsideration process.

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

If you have any additional questions, please do not hesitate to contact Casey DeVries, Supervisor, at Casey.DeVries@state.mn.us. Casey DeVries can also be reached by office phone at 651-201-5917.

Sincerely,

Rick Michals, J.D.
Executive Regional Operations Manager

Minnesota Department of Health
Health Regulation Division

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41378	A. BUILDING: _____ B. WING _____	08/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAPPY HEARTS HOMECARE CORPORATION	2310 JAMES AVE N MINNEAPOLIS, MN 55411

(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: SL41378015-0 On August 3, 2026, through August 4, 2026, 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 residents; two receiving services under the provisional Assisted Living Facility license. An immediate order for correction was identified on August 3, 2026, issued for SL41378015-0, tag identification 0495. During the survey, the licensee took action to mitigate the immediate risk. However, noncompliance remained, and the scope and level remain unchanged.	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 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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0 480	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A,	0 480		

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0 480	Continued From page 2 existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive 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 August 3, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.	0 480		

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0 480	Continued From page 3 TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 485 SS=C	144G.41 Subdivision 1.a (a) Minimum requirements; required food services (a) All assisted living facilities must offer to provide or make available at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes. The facility must not require a resident to include and pay for meals in the resident's contract. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide a menu a week in advance and inform residents in advance of menu changes. This practice resulted in a level one violation (a violation that will cause only minimal impact on the residents 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 the potential to affect a large portion or all the residents).	0 485		

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0 485	Continued From page 4 The findings include: On August 3, 2026, at 10:20 a.m., during the facility tour with owner/unlicensed personnel (O/ULP)-E, the surveyor observed the facility menu posted on the wall. The menu, untitled, was dated June 2026, it was two months old. The menu only identified a main course for the three meals and lacked the following: -menu prepared at least one week in advance and made available to all residents; -meals are made according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines; and -meals to include seasonal fresh fruit and vegetables. On August 4, 2026, at 12:52 p.m., O/ULP-E stated the menu was out of date and was not prepared at least one week in advance. O/ULP-E stated they did not distribute a copy of the menu to their residents. O/ULP-E stated they only had the main course on the menu but stated they did provide more food than the main course. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 495 SS=I	144G.41 Subdivision. 1 (13) Minimum Requirements (13) provide staff access to an on-call registered nurse 24 hours per day, seven days per week. This MN Requirement is not met as evidenced by:	0 495		

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0 495	Continued From page 5 Based on observation, interview, and record review, the licensee failed to provide staff access to a registered nurse (RN) twenty-four (24) hours per day, seven (7) days per week. This had the potential to affect all residents and staff. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) 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 August 3, 2026, during the survey, the licensee had a census of two residents. The licensee's Employee List dated August 3, 2026, indicated clinical nurse supervisor (CNS)-A was hired on August 1, 2026. CNS-A was hired to provide oversight to residents and unlicensed personnel. The licensee's Position Description - Registered Nurse (RN) job description dated 2023, did not indicate the RN's availability requirements. R1 R1 was admitted to the licensee on March 3, 2026. R1's diagnoses included type II diabetes mellitus, chronic diastolic heart failure, chronic heart failure, hypertension (HTN), cocaine abuse, and shortness of breath. R1's Addendum to Contract service plan dated	0 495		

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0 495	Continued From page 6 May 5, 2026, indicated R1 received services for grooming, meal prep and service, safety checks every two hours, transfer assistance, ambulation, blood glucose (BG) checks, blood pressure, pulse, oxygen saturation, respiration, temperature, weight, and ambulation assistance. R1's face sheet indicated R1 took hydrocortisone, metformin, albuterol sulfate, and Xarelto. R1's Individual Abuse Prevention Plan (IAPP) indicated R1 required medication management and was vulnerable to abuse and neglect. R2 R2 was admitted to the licensee on May 11, 2026. R2's diagnoses included general anxiety disorder, manic episodes, and insomnia. R2's service plan, which was missing the first page and lacked identification of services the licensee would provide to R2 was signed on April 14, 2026. R2's face sheet indicated R2 received services for visual and auditory hallucinations, blood pressure, pulse, respiration, temperature, meals, and safety checks. R2's Individual Abuse Prevention Plan (IAPP) indicated R2 was vulnerable to abuse and neglect. It further indicated R2 had behaviors including verbal aggression, auditory and visual hallucinations, episodes of mania, exhaustion, and reduced sleep. On August 3, 2026, at 10:20 a.m. during the facility tour, the surveyor observed R1 in their room sleeping in their bed, and R2 in their room	0 495		

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0 495	Continued From page 7 awake. On August 3, 2026, at 8:03 a.m., clinical nurse supervisor (CNS)-A stated they were unable to be onsite for the survey today because they were working at their other place of employment. CNS-A stated they worked at a hospital and had patient assignments. CNS-A and owner/unlicensed personnel (O/ULP)-E both stated the licensee only had one nurse and did not employ a backup nurse. On August 3, 2026, at 9:51 a.m., O/ULP-E contacted CNS-A via phone to join the entrance conference. CNS-A stated they were at their other place of employment and preferred if the surveyor would send them a list of questions for them to answer since they were busy with their other job. On August 3, 2026, at 11:43 a.m., O/ULP-E stated they just hired CNS-A on August 1, 2026. O/ULP-E stated their previous nurse, CNS-F, had a confrontation with a resident and quit the same day after setting up two weeks' worth of medications for the residents; O/ULP-E stated CNS-F feared for their safety after R2 threatened them. O/ULP-E stated CNS-A was hired and then set up medications, however, CNS-A did not complete any of the onboarding screening or education other than a background study. On August 3, 2026, at 1:10 p.m., CNS-A stated they were currently at their other job and were busy but had time for some questions. CNS-A was questioned about their other employment including where they worked and the number of patients they had assigned to them during their shift. CNS-A asked multiple times why the information mattered. The surveyor stated they wanted to know how they could take care of	0 495		

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0 495	Continued From page 8 residents at the facility if they were working with an assigned patient load at a hospital. CNS-A stated they worked eight days per month at the hospital with an average patient assignment of four. On August 3, 2026, at 1:32 p.m., O/ULP-E stated they do have another nurse, the other owner who is a RN, but they were currently out of the country for approximately one month and would not be returning for another week. The licensee's Staffing policy dated March 19, 2026, did not address RN staffing needs. Minnesota Statute 144G.62 Subdivision 1. (a) indicated assisted living facilities must have a registered nurse available for consultation by staff performing delegated nursing tasks, and (b) the appropriate contact person must be readily available either in person, by telephone or other means to the staff at times when the staff are providing services. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	0 495		
0 650 SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules;	0 650		

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0 650	Continued From page 9 (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to include a job description, evidence of current professional licensure, registration, or certification if licensure, registration, or certification required by this chapter or rules in the employee record for one of three employees (clinical nurse supervisor (CNS)-A). 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 the potential to affect a large portion or all of the residents). The findings include: CNS-A was hired on August 1, 2026, to provide	0 650		

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0 650	Continued From page 10 oversight to residents and unlicensed personnel. CNS-A's record lacked a current job description, evidence of current professional licensure, registration, or certification of licensure, registration or certification. On August 4, 2026, at 9:13 a.m., the surveyor observed CNS-A interacting with R1. On August 3, 2026, at 11:43 a.m., owner/unlicensed personnel (O/ULP)-E stated CNS-A was just hired on August 1, 2026, and had not completed any of the onboarding including a job description and licensure information. O/ULP-E stated the only thing they had completed was a background study. O/ULP-E stated they interviewed CNS-A and hired them on the spot and had CNS-A completed medication setups for R1 and R2 before they left. The licensee's Personnel Records policy dated March 19, 2026, indicated: "2. At a minimum, all documents related to the following are kept in the personnel record, as applicable to job requirements -Evidence of current professional licensure, registration or certification -Results of background studies -Records of annual training and infection control training -Documentation of orientation -Documentation of supervision, as applicable -Performance reviews -Competency evaluations -Signed job description -Documentation of annual performance reviews identifying areas of improvement needed and training needs."	0 650		

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0 650	Continued From page 11 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
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 observation, interview, and record review, the licensee failed to conduct a TB test for two of three employees (clinical nurse supervisor (CNS)-A, unlicensed personnel (ULP)-C). Further, the licensee failed to conduct TB symptom screenings and TB training for one of three employees (CNS-A). 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	0 660		

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HAPPY HEARTS HOMECARE CORPORATION	2310 JAMES AVE N MINNEAPOLIS, MN 55411

(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
0 660	Continued From page 12 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 the potential to affect a large portion or all of the residents). The findings include: The licensee TB risk assessment was completed on May 10, 2026. CNS-A CNS-A was hired on August 1, 2026, to provide oversight to residents and unlicensed personnel. CNS-A record lacked TB symptom screening, TB testing, and TB training. On August 4, 2026, at 9:13 a.m., the surveyor observed CNS-A interacting with R1. ULP-C ULP-C was hired on July 23, 2026, to provide direct care services to residents. ULP-C's record lacked TB testing. On August 3, 2026, at 10:45 a.m., the surveyor observed ULP-C interacting with R1. On August 3, 2026, at 11:43 a.m., owner/unlicensed personnel (O/ULP)-E stated CNS-A was just hired on August 1, 2026, and had not completed any of the onboarding which included TB training, TB symptom screening, and TB testing. O/ULP-E stated the only thing they had completed was a background study. O/ULP-E stated they interviewed CNS-A and hired them on the spot and had CNS-A complete medication setups for R1 and R2 before they left.	0 660		

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0 660	Continued From page 13 On August 4, 2026, at 8:36 a.m., O/ULP-E stated they did not complete TB testing when ULP-C was hired. O/ULP-E stated ULP-C was tested at their previous place of employment (unrelated to the licensee) and did not need to be tested. The surveyor explained a previous test with a different employer did not exempt ULP-C from TB testing requirements unless it had been completed within the past 90 days. O/ULP-E stated they were unaware it was the requirement and would have ULP-C tested immediately. The licensee's Tuberculosis Screening/Prevention policy dated March 19, 2026, indicated: "Happy Hearts Homecare will observe the recommended precautions related to TB prevention as identified by the Centers for Disease Control and Prevention (CDC) and the Minnesota Department of Health (MOH). The precautions include the following elements. -Risk Assessment -TB Screening -Staff Education." The Minnesota Department of Health TB FAQ, last updated on June 5, 2026, indicated, "All Minnesota health care personnel should receive TB education annually, regardless of facility risk level classification. TB education should include information on TB exposure risk factors (both occupational and nonoccupational), the signs and symptoms of TB disease, and TB infection control policies and procedures." It further indicated a TB screening test was required to be completed at the time of hire, or "A test should be dated with 90 days of hiring is acceptable, if not conducted by the licensee.	0 660		

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0 660	Continued From page 14 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; 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 a written emergency preparedness plan (EPP) with all the required	0 680		

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0 680	Continued From page 15 content for staff, residents, and visitors to view. 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 August 4, 2026, at 2:03 p.m., the surveyor reviewed the licensee's emergency preparedness plan, untitled and dated May 15, 2026. The EPP was a partially filled out template and lacked the following required content: - all-hazards risk assessment; - incident command; - identify at risk population needs like maintaining independence, communication, transportation, supervision and medical care; - identify which staff would assume specific roles in another's absence through succession planning and delegation of authority; - develop policies and procedures (P/P) to address safe evacuation from the facility, including consideration of care/tx needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); - primary/alternate communication means with external sources of assistance; - include a process for cooperation and collaboration with local, tribal, regional, State and Federal EP to maintain integrated response; - develop/implement EP P/P to address the following whether evacuated or shelter in place for staff/residents:	0 680		

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0 680	Continued From page 16 - food, water, medical supplies, pharmaceutical supplies; - alternate sources of energy to maintain: - temperatures to protect residents' health/safety; - safe/sanitary storage of provisions; - emergency lighting; - fire detection, extinguishing, alarm systems; and - sewage and waste disposal. - qualified person who is authorized in writing to act in the absence of the administrator; - communication plan must include all the following names/contact information: staff, entities providing services under agreement, residents' physicians, other facilities, volunteers; - P/P must address: use of volunteers, including the process/role for integration; - training program must include all of the following: - initial training in EP P/P to all new and existing staff, individuals providing services under arrangement, and volunteers consistent with their expected role; - provide EP training at least annually; - maintain documentation of all EP training; and - demonstrate staff knowledge of EP. - conduct exercises to test the EP at least twice per year, including unannounced staff drills using the EP (was not stored in the binder) -must include the following: -participate in an annual full-scale exercise that is community based OR conduct an annual, individual, facility-based functional exercise OR if the facility experiences an actual emergency requiring activation of plan, facility is exempt from engaging in its next required full-scale exercise; -conduct an additional annual exercise that may include: a second full-scale exercise that	0 680		

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0 680	Continued From page 17 is community-based or an individual, facility based functional exercise OR mock disaster drill OR table-top exercise, and -analyze the facility's response to and maintain documentation of all drills, tabletop exercises and emergency events & revise plan as needed. - communication plan must include all of the following: means to provide information about the facility's occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. On August 4, 2026, at 11:45 a.m., owner/unlicensed personnel (O/ULP)-E stated the EPP was not completely filled out. O/ULP-E stated they did not realize sections of the EPP were incomplete. The licensee's Emergency Preparedness policy dated March 19, 2026, indicated: "Policy Statement: [Licensee] will have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services. The plan considers the organization's commitment to provide services while ensuring the safety of its employees and residents. Happy Hearts Homecare will implement the Emergency Management program* as soon as the agency becomes aware of the existence of an emergency." Minnesota Administrative Rule 4659.0100 Emergency Disaster and Preparedness Plan dated August 11, 2021, indicated assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title	0 680		

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0 680	Continued From page 18 42, section 483.73, or successor requirements. The code references documents, specifications, methods, and standards in the State Operations Manual Appendix Z - Emergency Preparedness for All Provider and Certified Supplier Types. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 730 SS=F	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 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	0 730		

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0 730	Continued From page 19 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 observation, interview, and record review, the licensee failed to ensure resident records included documentation of services provided for two of two residents (R2, R3). 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 the potential to affect a large portion or all of the residents). The findings include:	0 730		

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0 730	Continued From page 20 R1 R1 was admitted to the licensee on March 3, 2026. R1's Addendum to Contract-Waiver-MN service plan dated May 5, 2026, indicated R1 received services for ambulation, bathing assistance, bedmaking, dressing, glasses care, grooming, housekeeping, laundry, meal preparation and serving, medication administration, vital signs (VS), safety checks, shopping assistance, and transfer assistance. R1's Service Recap Summary for July and August 2026, indicated the licensee lacked documentation for the following services and dates: -ambulation; July 22; -bathing assistance; July 27; -bedmaking; July 21 and 27; -dressing; July 27; -glasses care; July 27; -grooming; July 13 and 27; -housekeeping light; July 21 and 27; -meal preparation and service; July 11, 21 and 27; -medication administration; July 2-6, 9, 11-21, 23, and 27; -safety checks every two hours, July they missed 58 documentations; -transfer assistance; July 11, 21, 24 and 27; and -VS; July 13, 17, 23, 25, and 27, August 1 and 2. R2 R2 was admitted to the licensee on May 11, 2026. R2's Addendum to Contract-Waiver-MN service plan dated May 5, 2026, indicated R2 received services for bathing assistance, dressing, housekeeping light/heavy, laundry, manage	0 730		

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0 730	Continued From page 21 behaviors, meal assistance, meal reminder, vital signs, safety checks, and shopping assistance. R2's Service Recap Summary for July and August 2026, indicated the licensee lacked documentation for the following services and dates: -bathing assistance; July 27 and 28; -dressing; July 11, 21, 27 and 28; -housekeeping heaving; July 21 and 23; -housekeeping light; July 21 and 23; -manage behavior; July 5, 11, 12, 21, 24, 27, and 28; -meal assistance; July 6, 11, 21, 23, and 27; -meal reminder; July 6, 11, 13, 21, 23, and 27; -safety checks every two hours; July they missed 211 documentations; -VS; July 13, 27, and 28. On August 4, 2026, at 9:13 a.m., the surveyor observed unlicensed personnel (ULP)-B administer medication for R1. On August 4, 2026, at 9:37 a.m., owner/unlicensed personnel (ULP)-E stated some of the missed service documentation were on days when R1 was out of the facility. The surveyor explained it still required documentation with an explanation of why the services were not administered. Clinical nurse supervisor (CNS)-A and O/ULP-E both stated they expected staff to document on the services even if a resident was out of the facility. CNS-A stated it was good information to know and would follow up with the staff on documentation. CNS-A stated R1 and R2's service documentation showed further training was needed for the ULPs. The licensee's Clinical Records policy dated March 19, 2026, indicated, "Documentation of	0 730		

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0 730	Continued From page 22 services provided as identified in the service plan." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is	0 810		

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0 810	Continued From page 23 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 ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. 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 the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated August 4, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 920 SS=C	144G.50 Subd. 2 (c) Contract information (c) The contract must include: (1) a disclosure of the category of assisted living	0 920		

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0 920	Continued From page 24 facility license held by the facility and, if the facility is not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license; (2) a description of all the terms and conditions of the contract, including a description of and any limitations to the housing or assisted living services to be provided for the contracted amount; (3) a delineation of the cost and nature of any other services to be provided for an additional fee; (4) a delineation and description of any additional fees the resident may be required to pay if the resident's condition changes during the term of the contract; (5) a delineation of the grounds under which the resident may be transferred or have housing or services terminated or be subject to an emergency relocation; (6) billing and payment procedures and requirements; and (7) disclosure of the facility's ability to provide specialized diets. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to include a delineation of cost with their assisted living contract. 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).	0 920		

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0 920	Continued From page 25 The findings include: The licensee's blank Assisted Living Contract template dated 2023 lacked the following required information: -a delineation of the cost and nature of any other services to be provided for an additional fee; and -a delineation and description of any additional fees the resident may be required to pay if the resident's condition changes during the term of the contract. On August 4, 2026, at 10:02 a.m. owner/unlicensed personnel (O/ULP)-E stated they charge residents based on what the resident's case manager (CM) approved on their waiver. O/ULP-E stated they did not have a delineation of cost to provide to residents. O/ULP-E stated they used the same blank contract provided to the surveyor for both of their current residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 920		
01460 SS=F	144G.63 Subdivision 1 Orientation of staff and supervisors (a) All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility, except as provided	01460		

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01460	Continued From page 26 in paragraph (b). (b) A staff person is not required to repeat the orientation required under subdivision 2 if the staff person transfers from one licensed assisted living facility to another facility operated by the same licensee or by a licensee affiliated with the same corporate organization as the licensee of the first facility, or to another facility managed by the same entity managing the first facility. The facility to which the staff person transfers must document that the staff person completed the orientation at the prior facility. The facility to which the staff person transfers must nonetheless provide the transferred staff person with supplemental orientation specific to the facility and document that the supplemental orientation was provided. The supplemental orientation must include the types of assisted living services the staff person will be providing, the facility's category of licensure, and the facility's emergency procedures. A staff person cannot transfer to an assisted living facility with dementia care without satisfying the additional training requirements under section 144G.83. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employees received orientation to assisted living statutes for one of one supervisor of unlicensed personnel (clinical nurse supervisor (CNS)-A). 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	01460		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41378	A. BUILDING: _____ B. WING _____	08/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01460	Continued From page 27 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: CNS-A was hired on August 1, 2026, to provide oversight to residents and unlicensed personnel. CNS-A's employee record lacked required orientation training to include the following topics: - overview of Assisted Living statutes; - review of provider's policies and procedures; - Assisted Living Bill of Rights; - handing of resident complaints, reporting of complaints, where to report; - consumer advocacy services; - review of types of Assisted Living services the employee will provide and provider's scope of license; - principles of person-centered planning/service delivery; and - hearing loss training (optional). On August 3, 2026, at 11:43 a.m., owner/unlicensed personnel (O/ULP)-E stated CNS-A was just hired on August 1, 2026, and had not completed employee onboarding which included orientation. O/ULP-E stated the only thing they had completed was a background study. O/ULP-E stated they interviewed CNS-A and hired them on the spot and had CNS-A complete medication setups for R1 and R2 before they left. On August 4, 2026, at 9:13 a.m., the surveyor observed CNS-A interacting with R1. The Staff Orientation and Education policy dated March 19, 2026, indicated:	01460		

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01460	Continued From page 28 "1. Upon hire and before providing service to residents, all employees attend a general orientation conducted by Happy Hearts Homecare. Those providing direct services will complete a competency evaluation as part of the orientation process.* 2. Orientation is provided by the Clinical Nurse Supervisor or delegate. All clinical topics will be addressed by the RN or other appropriately licensed health care professional. 3. Orientation topics will include, but not be limited to, the following a. Overview of Minnesota Assisted Living Statute 144G and Minnesota Rules Chapter 4659 b. Review of the employee's job description and responsibilities c. Introduction to and review of the organization's policies and procedures related to the provision of assisted living services by the individual staff person d. Handling of emergencies and the use of emergency services e. Compliance with Minnesota's Vulnerable Adult (Sections 626.556 and 5572), including requirements based on organizational policy, identification of incidents of maltreatment (abuse, financial exploitation and neglect) and that ay act that constitutes maltreatment is prohibited f. The Assisted Living Bill of Rights and the employee's responsibilities to ensure the exercise and protection of those rights g. The principles of person-centered planning and service delivery and how they apply to direct support services provided by staff h. Grievance Policy/Process, including reports to the Office of Health Facility Complaints i. Consumer advocacy services, including i. Office of Ombudsman for Long-Term-Care ii. Office of Ombudsman for Mental Health and Developmental Disabilities	01460		

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01460	Continued From page 29 iii. Managed Care Ombudsman at the Department of Human Services iv. County managed care advocates v. Other advocacy services j. The types of assisted living services the employee will be providing based on the Uniform Checklist Disclosure of Services and the organization's category of licensure k. The organizational chart and roles of staff within the facility." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01460		
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of	01470		

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01470	Continued From page 30 complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by:	01470		

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01470	Continued From page 31 Based on observation, interview, and record review, the licensee failed to ensure employees completed required orientation before providing services for one of two unlicensed direct care employees (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-C was hired on July 23, 2026, to provide direct care services to residents. ULP-C's employee record lacked required orientation training for the following topics: -review of provider's policies and procedures; and -principles of person-centered planning/service delivery. On July 4, 2026, 8:43 a.m., O/ULP-E stated ULP-C's above-mentioned orientation topics were not completed. O/ULP-E stated all orientation was completed in Educare (charting software) and if it wasn't completed in Educare, then it wasn't completed. O/ULP-E stated they changed the module they were using for training in Educare but should have kept using the Guide to Assisted Living module which included all orientation topics. ULP-C was not on-site during the survey.	01470		

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01470	Continued From page 32 The Staff Orientation and Education policy dated March 19, 2026, indicated: "1. Upon hire and before providing service to residents, all employees attend a general orientation conducted by Happy Hearts Homecare. Those providing direct services will complete a competency evaluation as part of the orientation process.* 2. Orientation is provided by the Clinical Nurse Supervisor or delegate. All clinical topics will be addressed by the RN or other appropriately licensed health care professional. 3. Orientation topics will include, but not be limited to, the following a. Overview of Minnesota Assisted Living Statute 144G and Minnesota Rules Chapter 4659 b. Review of the employee's job description and responsibilities c. Introduction to and review of the organization's policies and procedures related to the provision of assisted living services by the individual staff person d. Handling of emergencies and the use of emergency services e. Compliance with Minnesota's Vulnerable Adult (Sections 626.556 and 5572), including requirements based on organizational policy, identification of incidents of maltreatment (abuse, financial exploitation and neglect) and that ay act that constitutes maltreatment is prohibited f. The Assisted Living Bill of Rights and the employee's responsibilities to ensure the exercise and protection of those rights g. The principles of person-centered planning and service delivery and how they apply to direct support services provided by staff h. Grievance Policy/Process, including reports to the Office of Health Facility Complaints i. Consumer advocacy services, including i. Office of Ombudsman for Long-Term-Care	01470		

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01470	Continued From page 33 ii. Office of Ombudsman for Mental Health and Developmental Disabilities iii. Managed Care Ombudsman at the Department of Human Services iv. County managed care advocates v. Other advocacy services j. The types of assisted living services the employee will be providing based on the Uniform Checklist Disclosure of Services and the organization's category of licensure k. The organizational chart and roles of staff within the facility." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01610 SS=F	144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered	01610		

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01610	Continued From page 34 planning and care delivery. 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) conducted a comprehensive assessment on, or before, the date of admission for two of two residents (R1, 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 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 R1 was admitted to the licensee on March 3, 2026. R1's Addendum to Contract-Waiver-MN service plan dated May 5, 2026, indicated R1 received services for ambulation, bathing assistance, bedmaking, dressing, glasses care, grooming, housekeeping, laundry, meal preparation and serving, medication administration, vital signs, safety checks, shopping assistance, and transfer assistance. R1's Admission Assessment dated March 4, 2026, was completed one day after R1's date of admission.	01610		

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01610	Continued From page 35 R2 R2 was admitted to the licensee on May 11, 2026. R2's Addendum to Contract-Waiver-MN service plan dated May 5, 2026, indicated R2 received services for bathing assistance, dressing, housekeeping light/heavy, laundry, manage behaviors, meal assistance, meal reminder, vital signs, safety checks, and shopping assistance. R2's Admission Assessment dated May 12, 2026, was completed one day after R2's date of admission. On August 4, 2026, at 9:13 a.m., the surveyor observed unlicensed personnel (ULP)-B administer medication for R1. On August 4, 2026, at 9:37 a.m., clinical nurse supervisor (CNS)-A and owner/unlicensed personnel (O/ULP)-E stated the admission assessments were completed by the previously employed nurse. CNS-A and O/ULP-E stated they thought they had five days to complete an admission assessment. The surveyor explained those were not 144G regulations, and the admission assessment was required to be completed on or before the date of admission. The licensee's Assessment and Reassessment policy dated March 19, 2026, indicated: "2. The initial RN assessment shall be completed prior to the date on which the prospective resident executes a contract or on the date on which the prospective resident moves in, whichever is earlier. If necessary, based on geography or urgent or unexpected circumstances, the assessment may be conducted via telecommunications based on practice standards that meet the resident's needs	01610		

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01610	Continued From page 36 and reflect person-centered planning and care delivery." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01610		
01760 SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure staff documented medication administration for one of one resident (R1) receiving medication management. 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	01760		

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01760	Continued From page 37 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: R1 was admitted to the licensee on March 3, 2026. R1's Addendum to Contract-Waiver-MN service plan dated May 5, 2026, indicated R1 received services for ambulation, bathing assistance, bedmaking, dressing, glasses care, grooming, housekeeping, laundry, meal preparation and serving, medication administration, vital signs, safety checks, shopping assistance, and transfer assistance. R1's Med Admin Summary (medication administration record (MAR)) for July and August 2026, lacked the following documentation: -Cortef 5 milligram (mg) tablet, take three tablets by mouth (PO) in the morning and one tablet PO once at 2:00 p.m.; lacked documentation on July 1, 2, 6, 9, 12-15, 18, 20, 23, 27, and August 1; -ferrous sulfate 325mg, take one tablet PO every Monday, Wednesday and Friday; lacked documentation on July 6, 13, 20, 27; -fluticasone 50 micrograms (mcg) nasal spray, use one spray in each nostril daily; lacked documentation on July 2, 6, 13, 18, 20, 23, 27, and August 1; -lidocaine viscous 2% solution, swish 5 milliliters (ml) and hold for 30 second solution in the mouth expectorate, do not swallow; lacked documentation on July 1, 2-5, 6, 9-23, 27, and August 1; -metformin hydrochloride (HCL) extended release (ER), 500mg tablet, take two tablets PO twice	01760		

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01760	Continued From page 38 daily; lacked documentation on July 2, 6, 13, 18, 20, 23, 27, and August 1; -polyethylene glycol 3350, take one capful, 17 grams (g), mixed with full glass of water everyday as directed; lacked documentation on July 2, 6, 13, 18, 20, 23, 27, and August 1; -vitamin D 25mcg, take one tablet PO daily; lacked documentation on July 2, 6, 13, 18, 20, 23, 27, and August 1; and -Xarelto 20mg tablet, take one tablet PO everyday with evening meal; lacked documentation on July 1, 9, 14, and 15. On August 4, 2026, at 9:13 a.m., the surveyor observed unlicensed personnel (ULP)-B administer medication for R1. On August 4, 2026, at 9:37 a.m., owner/unlicensed personnel (ULP)-E stated some of the missed documentation was on days when R1 was out of the facility. Clinical nurse supervisor (CNS)-A and O/ULP-E both stated they expected staff to still document on the MAR if a resident was out of the facility. CNS-A stated it was good information to know and would follow up with the staff on documentation. The licensee's Medication Documentation policy dated March 18, 2026, indicated: "2. If the administration of one or more medications was not completed, staff will document the following a. The reason why the medication was not administered b. Follow up procedures to meet the resident's needs in compliance with the Medication Management Plan c. Appropriate notification to RN Supervisor or other persons as instructed regarding missed dosages	01760		

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01760	Continued From page 39 d. Medication Error report, if appropriate." No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01760		

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

Food & Beverage Inspection Report

Establishment Info

Happy Hearts Homecare Corporate
2310 JAMES AVE N
Mineapolis, MN 55411
Hennepin County
Parcel:

Phone:
info@happyheartshomecaremn.com

License Info

License: HFID 41378

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

Inspection Info

Report Number: F1029261245
Inspection Type: Full - Single
Date: 8/3/2026 Time: 11:15:45 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 3
Total Priority 2 Orders: 2
Total Priority 3 Orders: 8
Delivery:

New Order: 2-100 Supervision
2-102.12AMN *Priority Level: Priority 3 CFP#: 2*
MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.
COMMENT: NO CFPM. PIC INSTRUCTED TO ENSURE ESTABLISHMENT EMPLOYS AN INDIVIDUAL WITH A STATE ISSUED CFPM CERTIFICATE. SEE BELOW FOR INFORMATION ON CFPM CERTIFICATE ATTAINMENT.

https://www.health.state.mn.us/communities/environment/food/cfpm/index.html

https://www.health.state.mn.us/communities/environment/food/cfpm/cfmfs.html

https://fmctraining.web.health.state.mn.us/search

https://mn-mdh.portal.opengov.com/categories/1087/record-types/6498
Comply By: 8/28/2026 Originally Issued On: 8/3/2026

! **New Order: 2-200 Employee Health**
2-201.11C *Priority Level: Priority 1 CFP#: 3*
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 at the specific request of the regulatory authority.
COMMENT: NO EMPLOYEE ILLNESS LOG. PIC INSTRUCTED TO MAINTAIN AN UP-TO-DATE EMPLOYEE ILLNESS LOG READILY PRODUCIBLE UPON REQUEST. ILLNESS LOGGING, EXCLUSION, AND REPORTING REQUIREMENTS REVIEWED.

PAPER EMPLOYEE ILLNESS LOG PROVIDED TO PIC DURING INSPECTION.

SEE BELOW FOR ELECTRONIC VERSIONS OF THE EMPLOYEE ILLNESS LOG.

https://www.health.state.mn.us/people/foodsafety/dwi/empillog.pdf

https://www.health.state.mn.us/people/foodsafety/dwi/empillloghm.pdf

https://www.health.state.mn.us/people/foodsafety/dwi/empillogso.pdf

https://www.health.state.mn.us/people/foodsafety/dwi/empillogsp.pdf
Comply By: 8/3/2026 Originally Issued On: 8/3/2026

! **New Order: 3-100 Food Characteristics: unadulterated**
3-101.11 *Priority Level: Priority 1 CFP#: 13*
MN Rule 4626.0125 Remove all unsafe and adulterated foods from the premises.
COMMENT: SPOILED CARROTS IN COOLER AND SPOILED POTATOES IN CABINET. PIC INSTRUCTED TO DISCARD AND TO BE WATCHFUL FOR SIGNS OF CONTAMINATION AND SPOILAGE.
Comply By: 8/3/2026 Originally Issued On: 8/3/2026

New Order: 3-300C Protection from Contamination: equipment/utensils, consumers
3-304.14B *Priority Level: Priority 3 CFP#: 41*
MN Rule 4626.0285B Wiping cloths used for wiping counters and other equipment surfaces must be held in an approved sanitizing solution and laundered daily.
COMMENT: DAMP WIPING CLOTH NOT IN USE AND NOT IN SANITIZER SOLUTION. PIC INSTRUCTED TO HOLD IN SANITIZER SOLUTION IF FABRIC WIPING CLOTHS WILL BE USED AND TO OBTAIN ACCOMPANYING TEST STRIPS IF MIXING SANITIZER IN HOUSE. PIC INFORMED THAT DISPOSABLE SINGLE USE WIPES, INTENDED SPECIFICALLY FOR *FOOD CONTACT SURFACES*, WOULD BE A VIABLE ALTERNATIVE TO FABRIC WIPING CLOTHS.
Comply By: 8/3/2026 Originally Issued On: 8/3/2026

New Order: 4-100 Equipment Construction Materials
4-101.17 *Priority Level: Priority 3 CFP#: 47*
MN Rule 4626.0490 Discontinue using wood and wood wicker as a food contact surface.
COMMENT: WOOD MORTAR AND PESTLE AND KNIFE BLOCK. PIC INSTRUCTED TO REMOVE.
Comply By: 8/3/2026 Originally Issued On: 8/3/2026

New Order: 4-100 Equipment Construction Materials
4-101.18 *Priority Level: Priority 3 CFP#: 47*
MN Rule 4626.0493 Discontinue using cleaning aids or utensils that can scratch or scour the nonstick coating of pots, pans, griddles, cookie sheets, waffle makers and other cookware.
COMMENT: NONSTICK COOKING SURFACE ON PAN FLECKING OFF. PIC INSTRUCTED TO REMOVE FROM SERVICE AND TO ONLY USE COOKING AND CLEANING ITEMS ON NONSTICK SURFACES THAT WILL NOT SCRATCH AND COMPROMISE THE MATERIAL.
Comply By: 8/3/2026 Originally Issued On: 8/3/2026

New Order: 4-200 Equipment Design and Construction
4-204.112A *Priority Level: Priority 3 CFP#: 36*
MN Rule 4626.0620A Provide a temperature measuring device located in the warmest part of mechanically refrigerated units and coolest part of hot food storage units that are capable of measuring air temperature or a simulated product temperature.
COMMENT: INTERNAL THERMOMETER ABSENT IN COOLER. PIC INSTRUCTED TO ENSURE COOLER HAS INTERNAL THERMOMETER IN WARMEST PART.
Comply By: 8/7/2026 Originally Issued On: 8/3/2026

New Order: 4-300 Equipment Numbers and Capacities
4-302.12B *Priority Level: Priority 2 CFP#: 36*
MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.
COMMENT: NO SMALL DIAMETER THERMOMETER. EXAMPLE PROVIDED. PIC INSTRUCTED TO ENSURE A FUNCTIONAL SMALL DIAMETER PROBE THERMOMETER IS PRESENT AT ESTABLISHMENT.
Comply By: 8/7/2026 Originally Issued On: 8/3/2026

New Order: 4-300 Equipment Numbers and Capacities
4-302.13B *Priority Level: Priority 2 CFP#: 48*
MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.
COMMENT: NO MEANS OF VERIFYING DISHWASHER SANITIZING TEMPERATURE. PIC INSTRUCTED TO USE IRREVERSIBLE MIN/MAX THERMOMETER OR THERMAL STICKERS-TAGS TO PERIODICALLY VERIFY DISHWASHER IS REACHING MANUFACTURER'S LISTED SANITZING TEMPERATURE.
Comply By: 8/7/2026 Originally Issued On: 8/3/2026

New Order: 4-500 Equipment Maintenance and Operation
4-501.11AB *Priority Level: Priority 3 CFP#: 47*
MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.
COMMENT: TEMPERATURE DISPLAY ON COOLER NOT WORKING. PIC INSTRUCTED TO ENSURE COOLER'S COMPONENTS ARE WORKING AND IN GOOD REPAIR.
Comply By: 8/7/2026 Originally Issued On: 8/3/2026

New Order: 4-600 Cleaning Equipment and Utensils
4-601.11C *Priority Level: Priority 3 CFP#: 49*
MN Rule 4626.0840C Clean non-food contact surfaces of equipment and maintain free of accumulations of dust, dirt, food residue, and other debris.
COMMENT: GREASE, RESIDUES, AND DEBRIS BUILT UP ON MICROWAVE OVEN, OVEN, DISHWASHER DISPLAY AND OTHER EQUIPMENT FINISHES. PIC INSTRUCTED TO CLEAN AND MAINTAIN CLEAN.
Comply By: 8/3/2026 Originally Issued On: 8/3/2026

! **New Order: 4-600 Cleaning Equipment and Utensils**
4-602.11A *Priority Level: Priority 1 CFP#: 16*
MN Rule 4626.0845A Clean and sanitize food-contact surfaces of equipment and utensils: 1. before each use with a different type of raw animal food; 2. each time there is a change from working with raw foods to working with ready-to-eat foods; 3. between uses with raw fruits and vegetables and TCS foods; 4. before using or storing a food temperature measuring device; 5. at any time during the operation when contamination may have occurred.
COMMENT: ESTABLISHMENT NOT CONSISTENTLY USING DISHWASHER TO SANITIZE AND ONLY WASHING IN SINK WITH SOAP. PIC INSTRUCTED TO DISCONTINUE PRACTICE AND TO ENSURE ALL DISHES, EQUIPMENT, AND UTENSILS ARE SANITIZED PRIOR TO AIR DRYING.

DIRTY DISHES AND UTENSILS IN CABINETS AND DRAWERS. PIC INSTRUCTED TO ENSURE ALL DISHES, EQUIPMENT, AND UTENSILS ARE EFFECTIVELY WASHED, RINSED, SANITIZED, AND AIR DRIED PRIOR TO PLACING BACK INTO THE STORAGE AREAS.
Comply By: 8/3/2026 Originally Issued On: 8/3/2026

New Order: 6-500 Physical Facility Maintenance/Operation and Pest Control
6-501.12A *Priority Level: Priority 3 CFP#: 55*
MN Rule 4626.1520A Clean and maintain all physical facilities clean.
COMMENT: DEBRIS AND BUILDUP UNDER SINK AND OTHER AREAS OF KITCHEN. PIC INSTRUCTED TO CLEAN AND MAINTAIN CLEAN.
Comply By: 8/3/2026 Originally Issued On: 8/3/2026

Food & Beverage General Comment

Food and beverage inspection conducted as part of HRD evaluation survey of ALF.

State Nurse Evaluator: Joey Keen, BSEd, RN.

Establishment residential in nature: laminate floor, wood/faux wood drawers and cabinetry, laminate countertops, smooth painted walls, and hard textured ceiling.

Establishment with Frigidaire dishwasher (FGHD2465NF1A) to high heat sanitize equipment and utensils.

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

I acknowledge receipt of the Metro District Office inspection report number F1029261245 from 8/3/2026

Trevor McCliment

ABDIRIZAK DIIS
ADMINISTRATOR - PERSON IN CHARGE (PIC)

Trevor McCliment,
Public Health Sanitarian 3
651-201-3957
trevor.mccliment@state.mn.us

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

Temperature Observations/Recordings

Establishment Info

Happy Hearts Homecare Corporate
Mineapolis
County/Group: Hennepin County

Inspection Info

Report Number: F1029261245
Inspection Type: Full
Date: 8/3/2026
Time: 11:15:45 AM

New Record: Product/Item/Unit: MARINARA**; Temperature Process:** Cold-Holding
Location: FRIDGE at 41 Degrees F.
Comment:
Violation Issued?: No

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

Sanitizer Observations/Recordings

Establishment Info

Happy Hearts Homecare Corporate
Mineapolis
County/Group: Hennepin County

Inspection Info

Report Number: F1029261245
Inspection Type: Full
Date: 8/3/2026
Time: 11:15:45 AM

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

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ASSISTED LIVING | ASSISTED LIVING WITH DEMENTIA CARE

Project No: SL41378015-0	**Date:** August 4, 2026
Facility Name: HAPPY HEARTS HOMECARE CORPORAT	
Facility Address: 2310 James Ave N, Minneapolis, Minnesota 55411	

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Twenty One (21) days

1. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that include the location and number of resident rooms. [Minn. Stat. 144G.45 subd.2]

   Comments: The door of resident sleeping rooms were not identified with numbers as indicated on the posted evacuation floor plan map. The resident sleeping room doors are required to be identified with a number matching the number on the posted evacuation floor plan map, in order to provide direction to the building occupants and emergency responders in the event of a fire or similar emergency.

2. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that include employee actions to be taken in the event of a fire or similar emergency. [Minn. Stat. 144G.45 subd.2]

   Comments: Licensee's FSEP failed to include site-specific employee actions relative to the facility's building layout, evacuation routes, and ways to remove residents. Staff responsibilities and evacuation procedures were not clearly defined.

3. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that include fire protection procedures necessary for residents. [Minn. Stat. 144G.45 subd.2]

   Comments: The policy section titled, Emergency Preparedness Plan: Handout for Residents, included a bullet point where the provider could fill in procedures for a fire scenario, but it was left blank. No evacuation procedures were provided for residents.

4. Employees of assisted living facilities shall receive training on the fire safety and evacuation plans (FSEP) upon hiring and at least twice per year thereafter. [Minn. Stat. 144G.45 subd.2]

   Comments: The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. LALD-A stated that they group training and fire drills into one. No training documentation was provided with the fire drill reports.