Electronically Delivered

March 5, 2025

Licensee
Fortunate Homes LLC
7332 France Avenue North
Brooklyn Park, MN 55443

RE: Project Number(s) SL34398016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 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 . . ."

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

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

The correction order documentation should include the following:

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

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

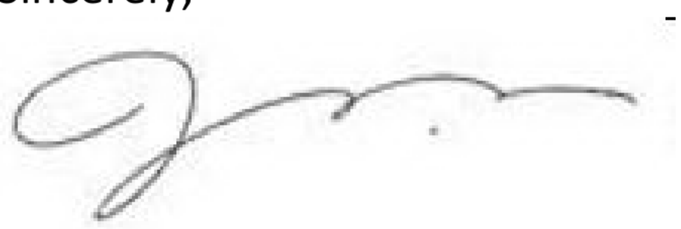
To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: https://forms.office.com/g/Bm5uQEpHVa. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,



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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34398	A. BUILDING: _____ B. WING _____	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FORTUNATE HOMES LLC	7332 FRANCE AVENUE NORTH BROOKLYN PARK, MN 55443

(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: SL34398016-0 On January 27, 2025, through January 30, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were five (5) residents, all of whom received 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.	
0 480 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, existing floor, wall, and ceiling finishes are	0 480		

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: 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, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated January 27, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer	0 480		

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0 480	Continued From page 3 to the FBEIR for any compliance dates.	0 480		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. This had the potential to affect all residents, staff, and visitors.	0 680		

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0 680	Continued From page 4 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's undated EPP binder, lacked evidence of the following required content: -hazard vulnerability assessment (HVA) that was facility-based and community-based (licensee provided HVA for another sister facility); -develop strategies for addressing tornadoes; -policy/procedure to address role of facility under a waiver declared by the secretary in accordance with section 1135 of the act; and -communication plan must include contact information for state licensing/ Certification Agency and Minnesota Office of Ombudsman for Long-Term Care (OOLTC). On January 27, 2025, at 1:24 p.m., the surveyor asked owner/licensed assisted living director (O/LALD)-C about the phone number for "County Department of Public Health," she stated it was for Hennepin County. O/LALD-C tried calling the phone number which was not in service. She stated she would update the contact list to include the correct phone number for state licensing and include the phone number for OOLTC. O/LALD-C stated she would include the correct HVA as it was an error. The surveyor noted the licensee's top three risks listed were fire, severe weather, and flooding. O/LALD-C stated the EPP did not include a plan for tornados and thought it should	0 680		

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0 680	Continued From page 5 have been included since this area was at risk for tornadoes. Regarding the 1135 Waivers, O/LALD-C asked if this pertained to use of volunteers but later provided the surveyor with a PowerPoint titled "1135 Waivers and the Emergency Preparedness Rule" from the Centers for Medicare & Medicaid Services (CMS). The licensee's 9.01 Emergency Preparedness Plan - Appendix Z Compliance policy dated August 1, 2021, indicated the licensee had in place an effective and compliant EPP. In addition, the intent was the plan would be aligned with the Centers for Medicare and Medicaid Services state operational manual Appendix Z. The EPP was based on the assisted living-based and community-based risk assessments, utilizing an all-hazards approach. Key elements of the plan include four primary components: 1. Risk assessment and planning; 2. Policies and procedures; 3. A communication plan; and 4. Staff training and exercises/drills. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
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	0 790		

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0 790	Continued From page 6 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 January 29, 2025, at approximately 9:30 a.m., the surveyor toured the facility with licensed assisted living director (LALD)-D. The following was observed. The portable fire extinguishers throughout the facility lacked records to show monthly visual inspections were complete. The portable fire extinguisher gauge in the dining room area was in the "recharge zone" indicating the fire extinguisher needed to be recharged/serviced. On January 29, 2025, survey staff explained to LALD-D that the portable fire extinguishers must be provided a monthly visual inspection or "quick	0 790		

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0 790	Continued From page 7 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. LALD-D stated they understood the requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. 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	0 800		

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0 800	Continued From page 8 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 January 29, 2025, at approximately 9:30 a.m., the surveyor toured the facility with licensed assisted living director (LALD)-D. The following was observed. GENERAL MAINTENANCE: The lights in the lower-level living area and bedroom 5 did not have covers on the light fixtures. The lack of bulb protection has the potential to cause injury. The deck handrail on the deck stairway was falling off the deck and was not secured. LALD-D stated they were aware that the deck handrail needed to be resecured. The lower-level water closet was leaking, and water was present on the floor around the water closet. A leaking water closet has the potential to cause water damage. On January 29, 2025, LALD-D stated they understood the above-listed deficiencies. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment	0 810		

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0 810	Continued From page 9 (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 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,	0 810		

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0 810	Continued From page 10 staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On January 29, 2025, at approximately 10:00 a.m., the surveyor observed the bedroom identification did not match the exit plan diagrams outlined in the FSEP. The exit plan diagrams must be correctly labeled to reduce confusion in a fire or similar emergency. On January 29, 2025, licensed assisted living director (LALD)-D 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 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. The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and	0 810		

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0 810	Continued From page 11 evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation nor did it include instructions for staff to follow in case of relocation. On January 29, 2025, at approximately 10:30 a.m., LALD-D stated they understood the areas of their policy that were incomplete and would work on bringing them into compliance. The policy reviewed was an unedited policy purchased from a third-party provider that was not specific to the facility. TRAINING: The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. No training documentation was provided. On January 29, 2025, LALD-D stated they understood the requirements for training residents and staff and would implement a training program that was compliant with statute requirements. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 830 SS=F	144G.45 Subd. 3 Local laws apply Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements, except a facility with a licensed resident capacity of six or fewer is exempt from rental licensing	0 830		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 830	Continued From page 12 regulations imposed by any town, municipality, or county. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to follow applicable state and local laws, regulations, standards, ordinances, and codes related to smoking for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 January 27, 2025, at 10:06 a.m., upon entry of facility for the first time, the surveyor observed a split-level home and from the entry way, there were steps to go downstairs and upstairs. The garage door, sliding glass door to exit the house, and front door were located off the entry way. Prior to taking the stairs, the surveyor noted a smell of cigarette smoke mixed with a different scent (not an air refresher). The surveyor was brought downstairs to the living room to set up for the entrance conference. The downstairs had two bedrooms which doors were closed to the left of the stairs directly across from each other, a bathroom next to one of the bedrooms, then there was a doorway to go into the living room where the third bedroom was off the living room and	0 830		

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	34398	A. BUILDING: _____ B. WING _____	01/30/2025

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0 830	Continued From page 13 separated from the other two rooms. The surveyor noted the door separating the living room/bedroom from the other two bedrooms self-closed to where there was a crack but did not shut all the way. On January 27, 2025, at 12:15 p.m., the surveyor went up the first set of stairs to reach the entry way and noted a strong smell of possibly incense (material used to produce a fragrant odor when burned) or cigarette smoke. The surveyor did not observe anyone in the area. On January 27, 2025, at 2:50 p.m., an unnamed individual explained to surveyor that R1 smoked in his room, and he/she was not happy his/her clothes smelling of smoke but did not want to "rat him [R1] out." On January 27, 2025, at 3:20 p.m., unlicensed personnel (ULP)-B stated R1 was redirected to smoke outside as she had found him smoking in his room once or twice. She also stated if R1 was caught smoking in his room, she would chart it in the behavior section of R1's record. On January 28, 2025, at 8:35 a.m., the surveyor arrived at the facility and noted a strong cigarette smoke upon entry. On January 28, 2025, at 10:12 a.m., R1 welcomed the surveyor into his room for an interview. R1 sat down on the edge of his bed facing a coffee table with his back against the entry door. The surveyor observed a haze throughout the room which smelled of incense and cigarette smoke. The room was very disheveled, loose rugs, clothing, and holiday lights lying on the floor. The coffee table was covered with various items such as loose ash,	0 830		

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0 830	Continued From page 14 empty ash tray, loose coins, bottles of cleaners, bottles of over-the-counter medications, cigarette lighters, small transparent glass water pipe or bong (filtration device used for smoking cannabis, tobacco, or other herbal substances), plain wooden incense holder and ash catcher that was approximately ten inches long and one inch wide with extinguished incense stick still attached and a row of ash on the wood tray, etc. R1 packed tobacco into a filtered cigarette tube by using a bag of tobacco (observed multiple bags) and a cigarette packing device which packed tobacco into the tube. When R1 finished packing one, he grabbed his lighter and almost lit the cigarette but stopped and put it down. The surveyor asked if he smoked in his room, he said no but burned incense. R1's blinds were drawn and closed shut and did not appear the window was open (room was not cold nor did the blinds move with air flow). On January 28, 2025, at 11:11 a.m., clinical nurse supervisor (CNS)-A stated R1 had smoked marijuana in his room before, so she contacted R1's parents and explained they had a zero-tolerance policy. CNS-A stated she had not seen R1 smoke in his room after that. She also explained staff had not caught him smoking in his room, but staff knew if they found him smoking in his room, they would redirect him outside. CNS-A also stated they have never seen it but smelled it. CNS-A was told by R1 he was spiritual so she thought he burned incense for that reason. On January 28, 2025, at 11:15 a.m., CNS-A and owner/licensed assisted living director (O/LALD)-C went into R1's room where the surveyor stayed just outside the bedroom door. CNS-A asked R1 if he was smoking because there was a haze, R1 said he was not smoking	0 830		

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0 830	Continued From page 15 and was burning an incense. R1 was lying in bed actively burning something either from the water pipe or an incense, which at that time it did not appear he was smoking as he was lying in bed with the covers drawn. After leaving R1's room, O/LALD-C stated other residents had not complained about the smell but she agreed the smell can be strong. O/LALD-C also stated no one had caught R1 smoking in the room but staff suspect he did, and this was brought up for discussion at care conferences with the county case manager where R1 denied smoking in his room. O/LALD-C also stated they were waiting to catch R1 physically smoking in the room to have physical proof to take further action. CNS-A and O/LALD-C stated they have tried to come up with an agreement to have staff hold the lighter and/or cigarettes but due to his confrontational ways and being told by the county case manager they could not hold his personal possessions due to the assisted living resident bill of rights. O/LALD-C went on to explain they have tried redirecting R1 and when R1 smoked outside, he smoked at different parts of the yard, never in the designated areas, "he just does what he wants." CNS-A stated she did not assess whether R1 was safely able to burn incense and incense burning was not addressed in the nursing assessment, O/LALD-C stated she was not aware R1 burned incense. The surveyor asked CNS-A and O/LALD-C why staff were documenting that R1 was smoking in his room, O/LALD-C stated staff were not documenting it correctly, she said staff suspect it but did not see him smoking in the room. On January 28, 2025, at 12:40 p.m., an unnamed individual informed the surveyor about the smell of marijuana, so the surveyor went into the hallway off R1's room and noted a potent smell of marijuana. CNS-A was informed of this, so she	0 830		

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0 830	Continued From page 16 went downstairs, stated she did not have a good sense of smell, and knocked on R1's door then entered the room. R1 was on his bed and quickly put something under the coffee table. The blinds were still closed but was moving around from the wind. CNS-A asked R1 if he was smoking and he denied smoking and said he was burning incense, which he picked up the wood incense holder and showed CNS-A (there was an extinguished stick with ash on the tray and was not actively burning). CNS-A stated there was a strong smell and he stood up and began yelling at CNS-A saying, "you cannot just walk in here!" CNS-A asked what the small round black container contained, R1 said it was "weed." She asked R1 again if she could see what he put under the coffee table, he began yelling so she left the room. R1 was admitted to licensee on November 22, 2022, for assisted living services and had diagnoses of schizoaffective disorder bipolar type (mental health condition with mix of schizophrenia symptoms, such as hallucinations and delusions, and mood disorder symptoms, such as depression and mania), chemical dependency, post-traumatic stress disorder (PTSD), and asthma. R1's Service Plan (Waiver)-Addendum to Contract signed January 10, 2025, indicated R1 received assistance with housekeeping, laundry, meal assistance, medication administration, safety checks, behavior management, and one-to-one socialization. R1's Resident Agreement Assisted Living (contract) signed by R1 on November 23, 2022, indicated on page nine (9) the following: "15. RESIDENT'S USE OF THE FACILITIES	0 830		

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0 830	Continued From page 17 While you are a Resident of the Community, you agree: I. Not to use or store in the Suite or elsewhere on the Community's premises any flammable or explosive substances; J. Not to smoke in the Suite, common areas or elsewhere on the Community's premises unless otherwise designated by the Community and not engage in smoking conduct that endangers people or property, even in designated areas" R1's Resident Note-One Resident dated January 12, 2025, at 9:23 p.m., included the following entry by ULP-G, "Client was smoking in his room when staff told him to go to smoke outside he started yelling at staff and calling her names." R1's Service Recap Summary-Month dated January 1 through 27, 2025, indicated the following under "Notes:" -ULP-B documented "he was smoking in his bedroom," on January 3, 4, 5, 8, 9, 13, 17, 18, 19, 22, and 27, 2025, on the AM (morning) shift; - ULP-B documented "he was smoking in his bedroom," on January 4, 5, 9, 13, 14, 17, 22, and 23, 2025, on the PM (afternoon) shift; and -ULP-F documented "he was smoking in his bedroom," on January 9, 2025, on the NOC (overnight) shift. R1's Assessment As Of Date (nursing assessment) dated October 17, 2024, and January 10, 2025, assessed R1 was not able to smoke safely, independently, without intervention. Both assessments indicated R1 hid and smoked in the room, cursed and held his fist tight while shouting as a dense mechanism. The assessments also included R1 smoked about 10 cigarettes throughout the day and was re-educated on safe smoking outside in the	0 830		

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0 830	Continued From page 18 designated area. On page 13, under "property destruction," indicated R1 continued to smoke in his room with no redirection, made the house smell of smoke right from the entry way, and was in violation of the contract that he signed under resident use of the facility not to smoke in any area of the facility other than the designated smoking area. Both assessments included the same eight interventions for staff to implement if R1 was found smoking inside the facility. On January 29, 2025, at 11:50 a.m., during phone interview, CNS-A was unsure when R1's last care conference was, but stated they documented the care conference on a form from Rtask (online health record). She directed the surveyor to contact O/LALD-C for that information. At 12:26 p.m., an email was sent to O/LALD-C requesting documentation of the most recent care conference. At 1:35 p.m., O/LALD-C stated they were already updating their smoking policy and were going to set up another care conference. On January 29, 2025, at 9:45 p.m., O/LALD-C sent an email to the surveyor with the following information, "I can not {sic} find the care conference nothing is populating in our rtasks {sic} only the emails i {sic} have from the case managers." The Minnesota Department of Health's Minnesota Clean Indoor Air Act (MCIAA) amendment effective on August 1, 2019, and last updated September 7, 2023, noted smoking was prohibited in health care facilities and clinics. In addition, an indoor area meant a space between a floor and a ceiling that is at least half enclosed	0 830		

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0 830	Continued From page 19 by walls, doorways, or windows (opened or closed) around the perimeter. A wall included retractable dividers, garage doors, plastic sheeting or any other temporary or permanent physical barrier. MCIAA defined smoking to include carrying or using an activated electronic delivery device. Minnesota State Statute 144.414 Prohibitions; Subdivision 3 dated 2022, indicated under a section titled Health care facilities and clinics. (a) Smoking is prohibited in any area of a hospital, health care clinic, doctor's office, licensed residential facility for children, or other health care-related facility, except that a patient or resident in a nursing home, boarding care facility, or licensed residential facility for adults may smoke in a designated separate, enclosed room maintained in accordance with applicable state and federal laws. The licensee's undated Tobacco-Free Policy indicated the following procedures: 1. Staff, visitors, and clients will be informed of the [Licensee's] tobacco-free policy through signs posted throughout properties owned and operated by [Licensee]; 2. [Licensee] will assist resident who want to quit cigarettes by helping them access smoking cessation programs and materials; 3. Any client [resident] or visitor observed using tobacco or electronic cigarettes on owned or leased premises will be asked to discontinue in a tactful manner; and 4. Any employee/resident that violates this policy will be handled through the standard disciplinary procedure following the resident agreement. No further information was provided.	0 830		

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0 830	Continued From page 20 TIME PERIOD FOR CORRECTION: Two (2) days Based on observation, interview, and record review, the licensee failed to comply with all state and local governing laws, and codes for fire safety, building, and zoning requirements. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: On January 29, 2025, at approximately 10:00 a.m., the surveyor toured the facility with unlicensed personnel (ULP)-A. At the time of the survey, the surveyor observed the water heater was being replaced. On January 29, 2025, at approximately 10:30 a.m., the surveyor spoke with the landlord and confirmed the licensee did not have a recent building permit on file to replace the water heater. Under MN Rules 1300.0120, An owner or authorized agent who intends to construct, enlarge, alter, repair, move, demolish, or change the occupancy of a building or structure, or to erect, install, enlarge, alter, repair, remove, convert, or replace any gas, mechanical, electrical, plumbing system, or other equipment,	0 830		

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0 830	Continued From page 21 the installation of which is regulated by the code; or cause any such work to be done, shall first make application to the building official and obtain the required permit. No further information was provided.	0 830		
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 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 observation, interview, and record review, the licensee failed to ensure the	01620		

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01620	Continued From page 22 registered nurse (RN) completed a smoking reassessment for R1 when staff documented numerous times R1 smoked in the bedroom. 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: On January 27, 2025, at 10:06 a.m., upon entry of facility for the first time, the surveyor observed a split-level home and from the entry way, there were steps to go downstairs and upstairs. The garage door, sliding glass door to exit the house, and front door were located off the entry way. Prior to taking the stairs, the surveyor noted a smell of cigarette smoke mixed with a different scent (not an air refresher). The surveyor was brought downstairs to the living room to set up for the entrance conference. The downstairs had two bedrooms which doors were closed to the left of the stairs directly across from each other, a bathroom next to one of the bedrooms, then there was a doorway to go into the living room where the third bedroom was off the living room and separated from the other two rooms. The surveyor noted the door separating the living room/bedroom from the other two bedrooms self-closed to where there was a crack but did not shut all the way. R1 was admitted to licensee on November 22, 2022, for assisted living services and had	01620		

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01620	Continued From page 23 diagnoses of schizoaffective disorder bipolar type (mental health condition with mix of schizophrenia symptoms, such as hallucinations and delusions, and mood disorder symptoms, such as depression and mania), chemical dependency, post-traumatic stress disorder (PTSD), and asthma. R1's Service Plan (Waiver)-Addendum to Contract signed January 10, 2025, indicated R1 received assistance with housekeeping, laundry, meal assistance, medication administration, safety checks, behavior management, and one-to-one socialization. R1's Resident Note-One Resident dated January 12, 2025, at 9:23 p.m., included the following entry by unlicensed personnel (ULP)-G, "Client was smoking in his room when staff told him to go to smoke outside he started yelling at staff and calling her names." R1's Service Recap Summary-Month dated January 1 through 27, 2025, indicated the following under "Notes:" -ULP-B documented "he was smoking in his bedroom," on January 3, 4, 5, 8, 9, 13, 17, 18, 19, 22, and 27, 2025, on the AM (morning) shift; - ULP-B documented "he was smoking in his bedroom," on January 4, 5, 9, 13, 14, 17, 22, and 23, 2025, on the PM (afternoon) shift; and -ULP-F documented "he was smoking in his bedroom," on January 9, 2025, on the NOC (overnight) shift. R1's Assessment As Of Date (nursing assessment) dated October 17, 2024, and January 10, 2025, assessed R1 was not able to smoke safely, independently, without intervention. Both assessments indicated R1 hid and smoked	01620		

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01620	Continued From page 24 in the room, cursed and held his fist tight while shouting as a defense mechanism. The assessments also included R1 smoked about 10 cigarettes throughout the day and was re-educated on safe smoking outside in the designated area. On page 13, under "property destruction," indicated R1 continued to smoke in his room with no redirection, made the house smell of smoke right from the entry way, and was in violation of the contract that he signed under resident use of the facility not to smoke in any area of the facility other than the designated smoking area. Both assessments included the same eight interventions for staff to implement if R1 was found smoking inside the facility. R1's medical record lacked new interventions to implement based on what staff had observed and documented. During interview on January 27, 2025, at 2:50 p.m., an unnamed individual explained to surveyor that R1 smoked in his room and was not happy his/her clothes smelled of smoke but did not want to "rat him [R1] out." On January 27, 2025, at 3:20 p.m., ULP-B stated R1 was redirected to smoke outside as she had found him smoking in his room once or twice. She also stated if R1 was caught smoking in his room, she would chart it in the behavior section of R1's record. On January 28, 2025, at 8:35 a.m., the surveyor arrived at facility and noted a strong smell of smoke upon entry. On January 28, 2025, at 10:12 a.m., R1 welcomed the surveyor into his room for an interview. R1 sat down on the edge of his bed	01620		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	Continued From page 25 facing a coffee table with his back against the entry door. The surveyor observed a haze throughout the room which smelled of incense and cigarette smoke. The room was very disheveled, loose rugs, clothing, and holiday lights lying on the floor. The coffee table was covered with various items such as loose ash, empty ash tray, loose coins, bottles of cleaners, bottles of over-the-counter medications, cigarette lighters, small transparent glass water pipe or bong (filtration device used for smoking cannabis, tobacco, or other herbal substances), plain wooden incense holder and ash catcher that was approximately ten inches long and one inch wide with extinguished incense stick still attached and a row of ash on the wood tray, etc. R1 packed tobacco into a filtered cigarette tube by using a bag of tobacco (observed multiple bags) and a cigarette packing device which packed tobacco into the tube. When R1 finished packing one, he grabbed his lighter and almost lit the cigarette but stopped and put it down. The surveyor asked if R1 smoked in his room, and R1 said no but burned incense. R1's blinds were drawn and closed shut and did not appear the window was open (room was not cold nor did the blinds move with air flow). On January 28, 2025, at 11:15 a.m., clinical nurse supervisor (CNS)-A and owner/licensed assisted living director (O/LALD)-C went into R1's room where the surveyor stayed just outside the bedroom door. CNS-A asked R1 if he was smoking because there was a haze, R1 said he was not smoking and was burning an incense stick. R1 was lying in bed actively burning something either from the water pipe or an incense, which at that time it did not appear he was smoking as he was lying in bed with the covers drawn. After leaving R1's room, O/LALD-C	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34398	A. BUILDING: _____ B. WING _____	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FORTUNATE HOMES LLC	7332 FRANCE AVENUE NORTH BROOKLYN PARK, MN 55443

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01620	Continued From page 26 stated other residents had not complained about the smell but she agreed the smell can be strong. O/LALD-C also stated no one had caught R1 smoking in the room but staff suspect he did, and this was brought up for discussion at care conferences with the county case manager where R1 denied smoking in his room. O/LALD-C also stated they were waiting to catch R1 physically smoking in the room to have physical proof to take further action. CNS-A and O/LALD-C stated they have tried to come up with an agreement to have staff hold the lighter and/or cigarettes but due to his confrontational ways and being told by the county case manager they could not hold his personal possessions due to the assisted living resident bill of rights. O/LALD-C went on to explain they have tried redirecting R1 and when R1 smoked outside, he smoked at different parts of the yard, never in the designated areas, "he just does what he wants." CNS-A stated she did not assess whether R1 was safely able to burn incense and incense burning was not addressed in the nursing assessment, O/LALD-C stated she was not aware R1 burned incense. The surveyor asked CNS-A and O/LALD-C why staff were documenting that R1 was smoking in his room, O/LALD-C stated staff were not documenting it correctly, she said staff suspect it but did not see him smoking in the room. On January 28, 2025, at 12:08 p.m., the surveyor asked another unnamed individual whether the smell of smoke bothered him/her, he/she said that someone did smoke in their room, but it did not bother him/her because he/she was a former smoker. On January 28, 2025, at 12:40 p.m., the second unnamed individual informed the surveyor about the smell of marijuana, so the surveyor went into	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34398	A. BUILDING: _____ B. WING _____	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FORTUNATE HOMES LLC	7332 FRANCE AVENUE NORTH BROOKLYN PARK, MN 55443

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01620	Continued From page 27 the hallway off R1's room and noted a potent smell of marijuana. CNS-A was informed of this, so she went downstairs, stated she did not have a good sense of smell, and knocked on R1's door then entered the room. R1 was on his bed and quickly put something under the coffee table. The blinds were still closed but was moving around from the wind. CNS-A asked R1 if he was smoking and he denied smoking and said he was burning incense, which he picked up the wood incense holder and showed CNS-A (there was an extinguished stick with ash on the tray and was not actively burning). CNS-A stated there was a strong smell and he stood up and began yelling at CNS-A saying, "you cannot just walk in here!" CNS-A asked what the small round black container contained, R1 said it was "weed." She asked R1 again if she could see what he put under the coffee table, he began yelling so she left the room. The licensee's 6.01 Assessments, Reviews & Monitoring policy dated August 1, 2021, indicated 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. The licensee's 6.03 Uniform Assessment Tool policy dated August 1, 2021, indicated the licensee would assess risk of smoking, including the ability to smoke without causing burns or injury to the resident or others of damage to property. Minnesota Administrative Rule 4659.0150, subpart 2, M, 8, dated August 11, 2021, indicated the uniform assessment tool must include assessment of risk factors, including smoking	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34398	A. BUILDING: _____ B. WING _____	01/30/2025

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01620	Continued From page 28 and the ability to smoke without causing burns or injury to the resident or others, or damage to property. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		

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

Type: Full
Date: *01/27/25*
Time: 11:00:00
Report: 1047251021

Food and Beverage Establishment Inspection Report

Location:
Fortunate Homes Llc
7332 France Avenue North
Brooklyn Park, MN55443
Hennepin County, 27

Establishment Info:
ID #: 0038506
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 9529945356
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

The following orders were issued during this inspection.

2-100 Supervision

2-102.12DMN

MN Rule 4626.0033D Post the certified food protection manager certificate.
NO STATE CFPM CERTIFICATE POSTED AT ESTABLISHMENT.
Comply By: 02/27/25

4-500 Equipment Maintenance and Operation

4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.
PLASTIC DRAWERS IN FRIDGE HAVE SHATTERED.
Comply By: 01/27/25

Surface and Equipment Sanitizers

Hot Water: = at 170 Degrees Fahrenheit
Location: Dishwasher
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 37 Degrees Fahrenheit - Location: Refrigerator- spaghetti
Violation Issued: No

Type: Full
Date: *01/27/25*
Time: 11:00:00
Report: 1047251021
Fortunate Homes Llc

Food and Beverage Establishment Inspection Report

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

The inspection was completed with the operator and reviewed with MDH Nurse Evaluator A. Bohnen.

The establishment has a residential kitchen and serves food that is prepared that day. The kitchen has wood cabinets, laminate floor, painted walls, solid counter top, and a painted ceiling.

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

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

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 1047251021 of 01/27/25.

Certified Food Protection Manager: Lucy A. Fallah

Certification Number: CFPM-704 Expires: 09/09/27

Inspection report reviewed with person in charge and emailed.

Signed: _____

Nelson Wanjau
Operator

Signed: _____

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