Electronically Delivered

May 16, 2025

Licensee
Cozy Baraka Home Care Inc
9317 Northwood Parkway
New Hope, MN  55427

RE:  Project Number(s) SL37402016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 16, 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,

Renee L. Anderson

Renee L. Anderson, Supervisor
State Evaluation Team
Email: Renee.L.Anderson@state.mn.us
Telephone: 651-201-5871 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 |
|---|---|---|---|
| | 37402 | A. BUILDING: _____ B. WING _____ | 04/16/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| COZY BARAKA HOME CARE INC | 9317 NORTHWOOD PARKWAY NEW HOPE, MN 55427 |

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| 0 000 | Initial Comments<br><br>*****ATTENTION******<br><br>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey.<br><br>Determination of whether a violation has been 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.<br><br>INITIAL COMMENTS:<br>SL37402016-0<br><br>On April 14, 2025, through April 16 , 2025, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were zero (0) residents receiving services under the provider's Assisted Living license. | 0 000 | Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction.<br><br>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.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>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. | |
| 0 660 SS=F | 144G.42 Subd. 9 Tuberculosis prevention and control | 0 660 | | |

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| 0 660 | Continued From page 1<br><br>(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.<br>(b) The facility must maintain written evidence of compliance with this subdivision.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included an employee TB symptom and history screen and completion of a two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test, no greater than 90 days prior to hire date for two of two employees (registered nurse( RN)-C, unlicensed personnel (ULP)-D).<br><br>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 | 0 660 | | |

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| 0 660 | Continued From page 2<br>a large portion or all of the residents).<br><br>The findings include:<br><br>The Facility TB Risk Assessment dated April 6, 2025, indicated the facility was a low risk setting for TB transmission.<br><br>RN-C<br>RN-C was hired June 21, 2023, and provided staff supervision and direct cares for residents of the facility.<br><br>RN-C's employee record included documentation of a TB history and symptom screening form completed, April 5, 2025, which was not completed at time of hire, and lacked completion of either a two-step TST or other evidence of TB screening such as a blood test.<br><br>ULP-D<br>ULP-D was hired October 15, 2024, and provided direct cares for residents of the facility.<br><br>ULP-D's employee record included documentation of a TB history and symptom screening form completed, October 15, 2024, a positive QuantiFERON-TB-Gold Plus (blood test), which was completed on November 28, 2024, which was forty-two days after hire date, and negative chest x-ray, which was completed on December 6, 2024, subsequent to ULP-D's positive QuantiFERON-TB-Gold Plus.<br><br>On April 16, 2025, at 2:28 p.m., clinical nurse supervisor (CNS)-A stated ULP-D lacked TB testing upon hire. CNS-A further stated ULP-D was new to the country, and there had been miscommunication between licensee and ULP-D regarding what would be required at time of hire. | 0 660 | | |

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| 0 660 | Continued From page 3<br><br>On April 16, 2025, at 2:30 p.m., CNS-A stated RN-C's employee record lacked a completed TB history and symptom screen at time of hire. CNS-A further stated RN-C also worked at a hospital, where she had TB testing completed, however, RN-C had not provided a copy of her TB testing to licensee.<br><br>The licensee's Tuberculosis Screening policy dated August 1, 2021, indicated licensee would establish and maintain a comprehensive infection control program according to the most current tuberculosis infection control guidelines issued by the CDC Division of Tuberculosis Elimination as published in the CDC's Morbidity and Mortality Weekly Report (MMWR). Furthermore, staff whose essential job functions require work within the same air space of home care clients would be screened and tested for TB prior to the staff being exposed to the clients. Moreover, no staff would be permitted to begin work where the work involves sharing the air space with residents until the negative results of the first Mantoux (skin test) were read and documented, or a negative IGRA (blood test) result was received and documented.<br><br>The Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013 noted training was required at the time of hire and included: pathogenesis, signs symptoms, and the licensee's infection control plan. In addition, baseline screening for all health care workers (HCW) included a history and symptom screen and testing for the presence of TB infection. The regulations noted a blood test should include the date of the test. According to the regulations, if a HCW had documentation for latent TB, that documentation could be substituted for | 0 660 | | |

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| 0 660 | Continued From page 4<br>documentation of a previous positive TST or blood test.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 660 | | |
| 0 730 SS=D | 144G.43 Subd. 3 Contents of resident record<br><br>Contents of a resident record include the following for each resident:<br>(1) identifying information, including the resident's name, date of birth, address, and telephone number;<br>(2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative;<br>(3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known;<br>(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;<br>(5) the resident's advance directives, if any;<br>(6) copies of any health care directives, guardianships, powers of attorney, or conservatorships;<br>(7) the facility's current and previous assessments and service plans;<br>(8) all records of communications pertinent to the resident's services;<br>(9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; | 0 730 | | |

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| 0 730 | Continued From page 5<br><br>(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;<br>(11) documentation that services have been provided as identified in the service plan;<br>(12) documentation that the resident has received and reviewed the assisted living bill of rights;<br>(13) documentation of complaints received and any resolution;<br>(14) a discharge summary, including service termination notice and related documentation, when applicable; and<br>(15) other documentation required under this chapter and relevant to the resident's services or status.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review the licensee failed to complete a discharge summary for one of one discharged resident (R1).<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).<br><br>The findings include:<br><br>R1 was admitted to facility on March 13, 2025, and received assisted living services.<br><br>R1's service plan dated March 29, 2025, indicated R1 was receiving assistance with | 0 730 | | |

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| 0 730 | Continued From page 6<br><br>medication management, medication administration, activities of daily living, dressing and grooming, behavior management, monthly vital signs, mobility, laundry, and housekeeping.<br><br>R1 was discharged on March 29, 2025. R1's record lacked evidence of a discharge summary, including service termination notice and related documentation, when applicable; upon discharge.<br><br>On April 14, 2025, at 12:59 p.m., clinical nurse supervisor (CNS)-A stated licensee lacked documentation, in R1's medical record of a discharge summary. CNS-A further stated, because R1 transferred to licensee's sister community, licensee did not consider R1 as discharged; therefore, discharge summary documentation had not been completed.<br><br>On April 14, 2025, at 2:41 p.m., the licensee's transfer/discharge of a resident policy was requested; however, was not provided.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 730 | | |
| 0 775 SS=E | 144G.45 Subd. 2. (a) Fire protection and physical environment<br><br>Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to comply with the | 0 775 | | |

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| 0 775 | Continued From page 7<br><br>requirements of Minnesota State Fire Code Rules, Chapter 7511.<br><br>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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).<br><br>On April 15, 2025, clinical nurse supervisor (CNS)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. Fire sprinklers and a fire alarm system were included as part of the FSEP.<br><br>On April 15, 2025, at 12:30 p.m., the surveyor toured the facility with CNS-A. During the facility tour, the surveyor observed fire sprinkler and fire alarm systems were installed. Inspection tags or stickers were not attached to the fire sprinkler system or fire alarm panel. During the facility tour interview, CNS-A stated the fire sprinkler system had not been inspected in the last year. CNS-A stated the fire alarm system had been inspected after the last survey in 2023. The surveyor requested copies of the most recent fire alarm system inspection report from CNS-A. CNS-A stated if located, a copy of this report would be emailed to the surveyor no later than 8:00 a.m. on April 16, 2025. The surveyor received an email from CNS-A on April 16, 2025, at 3:12 a.m. with an attached employee and resident fire safety training document. The document indicated on February 18, 2025, the city inspected the alarm system and smoke detector system. A fire alarm | 0 775 | | |

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| 0 775 | Continued From page 8<br><br>system inspection report was not provided. Fire sprinkler and fire alarm systems shall be inspected annually and maintained in accordance with Minnesota State Fire Code (MSFC) in Minnesota Rules Chapter 7511. Fire sprinkler and fire alarm system inspection reports must include the condition and performance of these life safety systems.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 775 | | |
| 0 810 SS=F | 144G.45 Subd. 2 (b-f) Fire protection and physical environment<br><br>(b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:<br>(1) location and number of resident sleeping rooms;<br>(2) staff actions to be taken in the event of a fire or similar emergency;<br>(3) fire protection procedures necessary for residents; and<br>(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.<br>(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.<br>(d) Fire safety and evacuation plans shall be readily available at all times within the facility.<br>(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 | 0 810 | | |

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| 0 810 | Continued From page 9<br>least once per year.<br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with required content, and provide required training and drills. This had the potential to directly affect all residents, staff, and visitors.<br>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).<br>The findings include:<br>On April 15, 2025, clinical nurse supervisor (CNS)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility.<br>FIRE SAFETY AND EVACUATION PLAN<br>The licensee failed to identify the location and number of resident sleeping rooms. On April 15, 2025, at 12:30 p.m., the surveyor toured the facility with CNS-A. During the facility tour, the surveyor observed CNS-A verbally identified resident sleeping rooms 5 and 6 in the basement. Numbers were not posted on or at these resident sleeping room doors. Additionally, the posted | 0 810 | | |

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| 0 810 | Continued From page 10<br><br>FSEP floor plan did not include resident sleeping room number labels. Resident sleeping room numbers are required to be included on the fire safety and evacuation floor plan and used with the numbers installed on the resident sleeping room doors to provide efficient communication for exiting in the event of a fire or similar emergency. During the facility tour interview, CNS-A verified the resident sleeping room number identifiers were lacking.<br>Record review of the available documentation indicated the licensee failed to develop and maintain the FSEP with procedures specific to the facility and the building occupants evident by the following:<br>- The FSEP fire extinguisher locations were not accurate. The safety information part of the plan indicated fire extinguishers were located by the nurse station, downstairs, and next to the exit door. On April 15, 2025, at 12:30 p.m., the surveyor toured the facility with CNS-A. During the facility tour, the surveyor observed one portable fire extinguisher was installed on the main floor. During the facility tour interview, CNS-A verified only one fire extinguisher was installed in the building.<br>- The FSEP directed the building occupants to evacuate to the church parking lot across the street. On April 15, 2025, at 12:30 p.m., the surveyor toured the facility with CNS-A. During the facility tour, the surveyor observed a church was not located across the street. During an interview, on April 15, 2025, at 1:40 p.m., CNS-A stated this part of the plan had been written for another facility location.<br>- The FSEP included an annex H fire policy and procedure for Ottowa Home Health Service. During an interview, on April 15, 2025, at 1:40 p.m., CNS-A stated this part of the plan had been written for another facility. | 0 810 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 37402 | A. BUILDING: _____ B. WING _____ | 04/16/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COZY BARAKA HOME CARE INC | 9317 NORTHWOOD PARKWAY NEW HOPE, MN 55427 |

| (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 |
|---|---|---|---|---|
| 0 810 | Continued From page 11<br>-The FSEP fire safety policy dated August 1, 2021, was a template from a third party provider. This fire safety policy included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The employee actions were limited to the RACE (Remove, Alarm, Confine, and Extinguish or Evacuate) acronym. This fire policy inaccurately referenced smoke compartment doors and fire doors in a building that did not have any fire resistant construction.<br>- The FSEP included general resident fire protection and evacuation actions but failed to provide specific procedures for resident movement and evacuation during a fire or similar emergency evident by a lack of these procedures in the plan.<br>During an interview, on April 15, 2025, at 1:40 p.m., CNS-A verified the FSEP needed revision and required more detailed site specific procedures.<br>TRAINING<br>Record review of the available documentation indicated the licensee failed to provide training to employees on the FSEP at least twice per year evident by a lack of documentation to support this training had been completed. One training record dated December 29, 2024, was provided for review while the surveyor was onsite. This training record listed eleven names and did not include a description of the type of training that was completed. The record did not identify this training session as employee FSEP training.<br>During an interview on April 15, 2025, at approximately 1:30 p.m., the surveyor requested additional employee FSEP training records for the last year from CNS-A. CNS-A stated these employee training records were not available | 0 810 | | |

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|---|---|---|---|---|
| 0 810 | Continued From page 12<br>onsite and they would email these records to the surveyor no later than 8:00 a.m. on April 16, 2025. The surveyor received an email from CNS-A on April 16, 2025, at 3:12 a.m., with an attached employee and resident fire safety training document. The document listed 8 names but did not include both the first and last names. The documentation did not identify which participants were employees.<br>Record review indicated the licensee failed to provide fire safety and evacuation training to residents at least once per year evident by a lack of documentation to support this training had been completed. During an interview on April 15, 2025, at approximately 11:50 a.m., the surveyor requested records for resident training on fire safety and evacuation completed in the last year from CNS-A. CNS-A stated residents participated in fire drills and this was documented on the fire drill logs. CNS-A stated resident training records were not available onsite and they would email these records to the surveyor no later than 8:00 a.m. on April 16, 2025. The surveyor received an email from CNS-A on April 16, 2025, at 3:12 a.m. with an attached employee and resident fire safety training document. The document listed 8 names but did not include both the first and last names. The documentation did not identify which participants were residents.<br>DRILLS<br>Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month evident by a lack of completed evacuation drill logs. Fire drill records dated December 10, 2024, and March 12, 2025, were provided. During an interview on April 15, 2025, at approximately 11:50 a.m., the surveyor requested additional employee evacuation drill records for the past year from CNS-A. CNS-A stated fire drill | 0 810 | | |

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|---|---|---|---|---|
| 0 810 | Continued From page 13<br><br>records were not available onsite and they would email these records to the surveyor no later than 8:00 a.m. on April 16, 2025.<br>No further information was provided.<br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 810 | | |
| 01290 SS=D | 144G.60 Subdivision 1 Background studies required<br><br>(a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information.<br>(b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12.<br>(c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure all employees had a cleared Department of Human Services (DHS) NETStudy 2.0 background study affiliated to the current license for one of one of employee (unlicensed personnel (ULP)-D).<br><br>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 | 01290 | | |

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|---|---|---|---|---|
| 01290 | Continued From page 14<br><br>resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).<br><br>The findings include:<br><br>ULP-D had a hire date of October 15, 2024, and provided direct care and services to residents.<br><br>ULP-D's employee record included a DHS background study clearance form dated October 7, 2024. The background study was affiliated with Health Facility Identification Number (HFID) 36907, which was also owned by the licensee. ULP-D's record lacked a cleared DHS background study affiliated to the surveyed licensee's facility, HFID number 37402.<br><br>On April 14, 2025, at 11:12 a.m., during the entrance conference, clinical nursing supervisor (CNS)-A stated she was aware of the required contents of the employee records. Furthermore, she was responsible for completion of background studies for new hires.<br><br>On April 16, 2025, at 10:35 a.m., via email, the surveyor requested a NETStudy 2.0 background study roster for current employees of the licensee.<br><br>On April 16, 2025, at 11:35 a.m., CNS-A stated via email correspondence, she was unable to locate a NETStudy 2.0 background study for ULP-D, affiliated with HFID 37402. Furthermore, CNS-A stated she completed a background study for ULP-D, affiliated with HFID 37402, after that time, which she later provided to surveyor. | 01290 | | |

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|---|---|---|---|---|
| 01290 | Continued From page 15<br><br>The licensee's Background Studies policy dated August 1, 2021, indicated licensee would conduct a DHS background study on all employees, volunteers, and contractors. Furthermore, no employee would provide direct services or have independent direct contact with any residents until acceptable results of the background study was received. Moreover, licensee would initiate a background study on all employees being considered for hire and would use the Minnesota DHS NETStudy online program.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Two (2) days | 01290 | | |
| 01910 SS=D | 144G.71 Subd. 22 Disposition of medications<br><br>(a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal.<br>(b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances.<br>(c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other | 01910 | | |

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| 01910 | Continued From page 16<br>individuals involved in the disposition.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to document in the resident's record the disposition of medications, including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition for one of one discharged resident (R1).<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).<br><br>The findings include:<br><br>R1 was admitted to facility on March 13, 2025, and was discharged March 29, 2025.<br><br>R1's service plan dated March 29, 2025, indicated R1 was receiving services including assistance with medication management.<br><br>R1's medication administration record dated March 2025, indicated R1 was taking the following medications upon discharge: Aspirin, calcium, Certavite Senior, lacosamide, sertraline, topiramate, Melatonin, acetaminophen, and Senna-S.<br><br>R1's record lacked documentation of the | 01910 | | |

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|---|---|---|---|---|
| 01910 | Continued From page 17<br><br>disposition of medications, including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition upon discharge.<br><br>On April 14, 2025, at 12:59 p.m., clinical nurse supervisor (CNS)-A stated, because R1 transferred to the licensee's sister community, they did not consider R1 as having been discharged; therefore, disposition of medication documentation had not been completed.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01910 | | |

Minnesota Department of Health
Food, Pools, & Lodging Services
P.O. Box 64975
Saint Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *04/15/25*
Time: 10:00:00
Report: 1043251102

# Food and Beverage Establishment Inspection Report



**Location:**
Cozy Baraka Home Care
9317 Northwood Parkway
New Hope, MN55427
Hennepin County, 27

**Establishment Info:**
ID #: 0038930
Risk:
Announced Inspection: No

**License Categories:**

Expires on: / /

**Operator:**

Phone #: 6122429073
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.

No NEW orders were issued during this inspection.

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

Inspection was completed with Rhonda Makela as the lead Health Regulation Division Nurse Evaluator completing the site survey.

Discussed highly susceptible populations, illness policy, ware washing, cleaning, vomit/fecal procedures, test kits, food storage, same day service, and food handling procedures.

This facility currently does not have any residents.

Facility has a residential kitchen with cabinets on 6-8 inch legs, smooth ceiling, a separate designated handwashing sink, and a sanitizing dishwasher. Sanitizing option on dishwasher must always be used when running a cycle

Contact Health Regulation Division for plan review approval when facility/kitchen undergoes remodeling.

***If any customer complains of illness, establishment is required to notify the Minnesota Department of Health and provide the foodborne illness hotline phone number to the customer: 1-877-366-3455***

Type: Full
Date: *04/15/25*
Time: 10:00:00
Report: 1043251102
Cozy Baraka Home Care

# Food and Beverage Establishment Inspection Report

**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 1043251102 of 04/15/25.

Certified Food Protection Manager: Rahel Aron

Certification Number: FM111200 Expires: 05/02/25

**Inspection report reviewed with person in charge and emailed.**

Signed: _____
Mardiya Jaffer
CNS-A

Signed: _____
Blia Lor
Public Health Sanitarian I
651-355-0641
blia.lor@state.mn.us