Electronically Delivered

November 8, 2024

Licensee
Loving Touch Inc.
3818 Burquest Lane
Brooklyn Center, MN 55429

RE: Project Number(s) SL37500015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on October 4, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in

§ 144G.20.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this survey:

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.0

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. to submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

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

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

If you have any questions, please contact me.

Sincerely,

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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37500	A. BUILDING: _____ B. WING _____	10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOVING TOUCH INC	3818 BURQUEST LN BROOKLYN CENTER, MN 55429

(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: SL35585015-0 On September 30, 2024, through October 2, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were three residents; three receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated September 30, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and	0 510		

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0 510	Continued From page 2 nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program to comply with accepted health care, medical, and nursing standards for infection control when the licensee failed to ensure direct care staff performed adequate hand hygiene (HH) and proper surface disinfection for one of one employee (unlicensed personnel (ULP)-B). 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: During facility tour on September 30, 2024, at 11:35 a.m., the surveyor observed a one level rambler house. From entry, R2 and R3's bedrooms were to the right past the living room and the kitchen was to the left where the desk and computer were used for medication set up	0 510		

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0 510	Continued From page 3 and documentation. The medications were stored in a locked coat closet behind the front door. On October 1, 2024, at 8:27 a.m., ULP-B was observed to wash her hands, obtained the glucometer machine from an open shelf within the kitchen, checked supplies in the kit (lancets-needles, alcohol wipes, gauze, and glucometer strips) before walking into R3's room. Once in R3's room, ULP-B placed the kit on R3's bed, donned (applied) gloves and checked R3's blood glucose by wiping finger with alcohol wipe, poking the same finger, squeezing out a drop of blood and wiping it away with the gauze, then placed the strip to another drop of blood. ULP-B then took the gauze and placed it on the finger to stop any bleeding. ULP-B gathered the dirty supplies placed them loosely inside the glucometer kit, slightly closed it without zipping it shut and adjusted the ceiling fan by pulling the cord and walked out of the room while using the dirty gloves. ULP-B then walked into the kitchen, placed the glucometer kit on the kitchen counter near the kitchen sink, took out the lancet, went to the kitchen cabinet below the sink, opened the cabinet door, then opened a milk jug to place the lancet inside. ULP-B then shut the cabinet door, walked back to the kit, grabbed the dirty gauze and strip which fell on the countertop and placed it in the trash. ULP-B doffed (removed) the gloves, washed hands at the kitchen sink and used a continuous positive airway pressure (CPAP - device that assists with breathing while sleeping) wet wipe to wipe down the glucometer meter and placed it back on the shelf and hand sanitized. The surveyor did not observe ULP-B sanitize the kitchen countertop or cabinet door handle. The surveyor asked why she wiped down the glucometer kit, and ULP-B said R4 gets his blood glucose checked once a month so R3 and	0 510		

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0 510	Continued From page 4 R4 both use the same kit. On October 1, 2024, at 8:42 a.m., after ULP-B set up R3's medications, she washed her hands, brought the medications into R3's room, donned gloves, retrieved water from the water dispenser within the room and administered the medications to R3. With same gloves on, ULP-B turned the light off and closed R3's bedroom door upon exit and walked to the kitchen, removed gloves then washed hands. On October 1, 2024, at 9:03 a.m., ULP-B set up R2's medications, washed her hands, donned gloves, and entered R2's room to administer medications then checked R2's oxygen concentrator (removes nitrogen from room air to give concentrated oxygen) setting which was at 3.5 liters per minute (LPM) so she adjusted it to 4 LPM. ULP-B then walked out of R2's room with same gloves on, put the medication label in the shredder in the kitchen, removed gloves, and washed hands at kitchen sink. On October 1, 2024, at 9:30 a.m., ULP-B stated she was trained to remove gloves at the garbage can in the kitchen so she could wash her hands. She said she always removed gloves and washed hands before going to the next resident. ULP-B stated R3 did not have a sharps container to dispose biohazard waste in his room because it was stored under the kitchen sink because R4 receives blood glucose monitoring once a month, so the sharps container was shared. For disinfecting the glucometer meter, ULP-B stated the Clorox wipes were too harsh on the equipment, so they used CPAP wipes. On October 1, 2024, at 9:40 a.m., both clinical nurse supervisor (CNS)-D and licensed assisted	0 510		

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0 510	Continued From page 5 living director/unlicensed personnel (LALD/ULP)-A stated staff were supposed to be removing gloves within the resident's room and use hand sanitizer upon exiting. Staff should not be coming out of the room with gloves on. Both CNS-D and LALD/ULP-A stated surfaces should be cleaned with a disinfectant and did not know CPAP wipes lacked disinfecting properties. They both stated there should be a sharps container in R3 and R4's rooms. The User's Manual for Single Patient Use Only Blood Glucose Meter dated 2023, indicated on page 51, "The following product has been approved for cleaning and disinfecting the meter and lancing device: Super Sani-Cloth." It was recommended to clean and disinfect the meter once per week and do not allow anyone else to use the meter. The CDC guidance, CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings, revised April 12, 2024, indicated, standard precautions were to be used to care for all patients (residents) in all settings to include HH, and noted to, "Remove and discard PPE [gloves, gowns, face masks, respirators, goggles, and/or face shields], other than respirators, upon completing a task before leaving the patient's room or care area." For processing reusable medical equipment, it noted the following: -clean and reprocess (disinfect or sterilize) reusable medical equipment prior to use on another patient or when soiled and instructs to follow the manufacturer's instructions for cleaning. -maintain separation between clean and soiled equipment to prevent cross contamination.	0 510		

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0 510	Continued From page 6 The licensee's Infection Control policy effective July 24, 2021, indicated the licensee will observe the recommended precautions for home care as identified by the CDC. For standard precautions, it read equipment used for resident care is properly cleaned and reprocessed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 650 SS=F	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (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.	0 650		

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0 650	Continued From page 7 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the employee record contained the required content for four of four employees (unlicensed personnel (ULP)-B, ULP-E, licensed assisted living director/unlicensed personnel (LALD/ULP)-A, house manager/unlicensed personnel (HM/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) 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: PERFORMANCE REVIEWS ULP-B was hired on May 10, 2020, to provide assisted living services to all residents. ULP-B's employee record included a Performance Evaluation completed by HM/ULP-C on July 1, 2022. The record lacked a performance review for 2023. On September 30, 2024, at 1:55 p.m., HM/ULP-C stated she had completed performance reviews on all staff up until 2022, but since then, she thought their Educare trainings (online training platform) and staff supervision/competencies that were completed annually met the requirement and were sufficient. HM/ULP-C stated all staff have not had annual performance reviews completed since 2022.	0 650		

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0 650	Continued From page 8 TREATMENT TRAINING AND COMPETENTCY During facility tour on September 30, 2024, at 11:35 a.m., the surveyor observed a Philips Respironics Trilogy bilevel positive airway pressure (BiPAP) machine on a medical device stand and an oxygen concentrator machine (removes nitrogen from air to deliver more pure oxygen) delivering oxygen to R2. ULP-E was hired on April 15, 2024, to provide assisted living services to all residents. LALD/ULP-A was hired July 29, 2019, to provide assisted living services to residents, supervision of staff, and managerial duties for the licensee. HM/ULP-C was hired on July 29, 2019, to provide assisted living services to residents, supervision of staff, and managerial duties for the licensee. ULP-B, ULP-E, LALD/ULP-A, and HM/ULP-C's employee record lacked documentation of training and competency on the following nursing delegated tasks to include: -trained and demonstrated competency on use of BiPAP to the RN. On September 30, 2024, at 2:45 p.m., LALD/ULP-A stated certain staff were trained on the BiPAP machine by a technician at Corner Home Medical (CHM-medical device supplier) when R2 returned from the hospital in February 2024. CHM trained the manager (M)-F then M-F trained all staff except for the staff that were working the day CHM performed the training. The licensee's Personnel Records policy effective July 24, 2021, indicated, "A record of each paid employee, regularly scheduled volunteer	0 650		

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0 650	Continued From page 9 providing assisted living services, and each individual contractor providing assisted living service for [licensee] will be maintained." The policy also indicated at a minimum, all documents related to the following are kept in the personnel record, as applicable to job requirements: -documentation of orientation; -performance reviews; and -competency evaluations. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing	0 780		

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0 780	Continued From page 10 smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarm outside and in immediate vicinity of sleeping rooms #1, #2 and #3. This deficient condition had the ability to affect all staff and residents. 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). Findings include: On a facility tour on October 02, 2024, at 12:15 p.m. with owner/house manager (O/HM)-B, surveyor observed that a smoke alarm was not provided outside and in the immediate vicinity of sleeping rooms #1, #2 and #3. This was discovered when the O/HM-B tested the smoke alarms and the smoke alarm in the hallway was an old one and not on the current system. O/HM-B verbally confirmed survey staff observations during the facility tour. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 780		

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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
0 780	Continued From page 11 (21) days	0 780		
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, 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. 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, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On October 02, 2024, at 11:25 a.m. to 12:45 p.m., surveyor toured the facility with unlicensed	0 800		

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	37500	A. BUILDING: _____ B. WING _____	10/04/2024

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0 800	Continued From page 12 personnel/house manager (ULP/HM)-C. The following was observed. GENERAL MAINTENANCE: Main-floor bathroom door and door trim scratched and missing paint. Trim around bedroom doors #1 and #2 scratched and missing paint. Living room outlet, by television, was missing an outlet cover. Front door paint was coming off on the bottom of the door. Bedroom #1 has a bent outlet on the wall under the television. Backyard deck boards were deteriorating and missing paint. ULP/HM-C stated they understood the above-listed deficiencies. TIME PERIOD FOR CORRECTION: twenty-one (21) days.	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of	0 810		

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0 810	Continued From page 13 a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: 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 and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 810		

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0 810	Continued From page 14 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 October 02, 2024, at 12:15 p.m., house manager/unlicensed personnel (HM/ULP)-C provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The FSEP (fire safety and evacuation plan) included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate) but the plan was designed for a building with life safety systems such as fire alarm pull stations. The policy had not been updated to provide complete actions for employees to take in the event of a fire or similar emergency at the licensed facility which did not have life safety systems or a fire-resistant construction type. HM/ULP-C stated they understood the areas of their policy that were incomplete and would work on bringing them into compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		

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01060	Continued From page 15	01060		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not	01060		

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01060	Continued From page 16 returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation and failed to notify the Office of Ombudsman for Long-Term Care (OOLTC) of the emergency relocation for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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: R1's diagnoses included gallbladder cancer, chronic obstructive pulmonary disease, asthma, and high blood pressure. R1's discharge summary dated September 11, 2024, indicated R1 received medication management, nutrition, assistance with activities of daily living, and safety. R1's nurse notes indicated the following: -September 5, 2024, R2 sent to the hospital due to deteriorating health condition and a part of the emergency relocation content (date, location and	01060		

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01060	Continued From page 17 contact information, reason, and estimated length of stay) were included within the nurses note; and -September 10, 2024, R1 passed away at the hospital. R1's record lacked evidence of a written notice provided to the resident, the resident's legal representative, and/or designated representative that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the OOLTC; - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. On September 30, 2024, at 12:40 p.m., unlicensed personnel (ULP)-B stated clinical nurse supervisor/assisted living director (CNS/ALD)-A filled out the notification but it did not get sent to the resident or resident's legal/designated representative. She said the licensee notified OOLTC within 24 hours of discharge from licensee on September 12, 2024, because R1 passed away at the hospital. She was not aware OOLTC had to be notified if the resident did not return within four days. The licensee's Discharge and Transfer of Residents policy dated July 24, 2021, noted in the event of an emergency relocation, the facility	01060		

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01060	Continued From page 18 would provide a written notice as soon as possible to the resident, legal representative, and designated representative, and if the resident had not returned within four days, a copy would be provided to the OOLTC. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01060		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be 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.	01620		

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01620	Continued From page 19 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to complete a change in condition assessment when transfer assistance and oxygen therapy changed for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's diagnoses included chronic respiratory failure with hypoxia (low oxygen level), obstructive sleep apnea (repeated breathing interruptions during sleep), chronic pain, and muscle weakness. On October 1, 2024, at 9:03 a.m., the surveyor observed unlicensed personnel (ULP)-B administer medications to R2 and checked R2's oxygen level which was set at 3.5 liters per minute (LPM), and it was adjusted to 4 LPM. R2's admission assessment completed on February 4, 2024, noted, "Readmission assessment from hospital discharge on [January 23, 2024]." The assessment indicated R2 required 2-3 LPM of oxygen via oxygen concentrator (removes nitrogen from room air to provide concentrated oxygen) and required assist of two people with transfers.	01620		

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01620	Continued From page 20 R2's Master Care Plan updated by a registered nurse (RN) on July 13, 2024, read R2 required assist of two for transfers and 2-3 LPM of oxygen via oxygen concentrator. R2's hospital discharge orders dated January 28, 2024, ordered 4 LPM of continuous oxygen. R2's Med Admin Summary-Month dated September 1 through 30, 2024, read to give oxygen 4 LPM continuous via nasal canula (tubing that brings oxygen to nostrils). During interview on October 1, 2024, at 1:00 p.m., R2 stated he was able to perform pivot transfers from one seat to the next seat with one staff person. He stated he was unable to walk but was beginning physical therapy soon so he could walk again. During observation on October 2, 2024, at 10:30 a.m., ULP-B assisted R2 with a pivot transfer from the recliner to wheelchair by placing the wheelchair, locking the wheels, and removing blankets to help position R2's feet before standing. R2 was able to perform majority of the transfer using his upper body strength. ULP-B stated R2 only required one person assistance with transfers. R2's medical record lacked a change in condition RN assessment to include the current needs of R2 (one assist with transfers and 4 LPM of oxygen). During interview on October 2, 2024, at 10:45 a.m., clinical nurse supervisor (CNS)-D stated R2 was assist of two before he was hospitalized. CNS-D stated during the post hospital	01620		

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01620	Continued From page 21 re-assessment, she compared the assessment from before hospitalization to current care needs. CNS-D also stated she was at the facility every Saturday to talk with residents and staff to determine if cares have changed. CNS-D stated she must have missed updating the assessment to include 4 LPM of oxygen and reduce transfer assistance to one staff. CNS-D stated when cares changed, she updated the service plan but didn't know it required signatures from resident or resident's designated representative. The licensee's Assessment and Reassessment policy effective July 24, 2021, indicated ongoing resident monitoring must be conducted as needed based on changes in the needs of the resident and may be completed by other licensed nurses acting within their scope of licenses. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for	01640		

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01640	Continued From page 22 Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have a current signed service plan which identified specific services to be provided and failed to document services provided for one of three residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On October 1, 2024, at 9:03 a.m., the surveyor observed unlicensed personnel (ULP)-B administer medications to R2, and check R2's oxygen level which was set at 3.5 liters per minute (LPM) and it was adjusted to 4 LPM. R2 admitted for services on February 8, 2023, with diagnoses including chronic respiratory failure with hypoxia (low oxygen level), obstructive	01640		

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01640	Continued From page 23 sleep apnea (repeated breathing interruptions during sleep), chronic pain, and muscle weakness. R2's [Licensee] Home Health Aide Care Plan dated February 8, 2023, indicated R2 received assistance with dressing, compression socks, bathing, mobility, two-person transfers, meals, medication administration, and homemaker services. The care plan was only signed by a former registered nurse on February 8, 2023. R2's medical record lacked a signature or other authentication by the licensee and by the resident documenting agreement on the services to be provided. R2's medical record also lacked documentation of oxygen services provided. On October 1, 2024, at 2:30 p.m., licensed assisted living director/ULP (LALD/ULP)-A stated the licensee changed R2's oxygen tubing/nasal canula every Thursday because the tubing got hard. On October 2, 2024, at 10:30 a.m., ULP-B stated she cleaned the oxygen concentrator filter monthly and changed the oxygen tubing weekly on Mondays and as needed. ULP-B stated she oversaw ordering supplies for R2's respiratory equipment. ULP-B stated she never documented that she completed those tasks. She was unaware she needed to. On October 1, 2024, at 12:18 p.m., ULP-B stated R2 would not have a signed the service agreement because they utilized a new contract which did not include the service plan exhibit. ULP-B stated the licensee only had the home health aide care plan which was not signed by R2. ULP-B then explained the other residents	01640		

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01640	Continued From page 24 who were admitted before R2 used the old contract which had the service plan exhibit to include all of the required information including signatures. The licensee's Service Plan policy effective July 24, 2021, indicated, "the initial service plan and any revisions are signed by a representative from [Licensee] and the resident or resident's representative, indicating agreement with the services to be provided." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01650 SS=E	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse	01650		

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01650	Continued From page 25 change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plan contained all the required content 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 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). The findings include: R2 R2 admitted for service on February 8, 2023, with diagnoses including chronic respiratory failure with hypoxia (low oxygen level), obstructive sleep apnea (repeated breathing interruptions during sleep), chronic pain, and muscle weakness. R2's [Licensee] Home Health Aide Care Plan dated February 8, 2023, indicated R2 received assistance with dressing, compression socks,	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37500	A. BUILDING: _____ B. WING _____	10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOVING TOUCH INC	3818 BURQUEST LN BROOKLYN CENTER, MN 55429

(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
01650	Continued From page 26 bathing, mobility, two-person transfers, meals, medication administration, and homemaker services. R2's service plan lacked the following required content: -frequency of each service, according to the resident's current assessment and resident preferences; -the identification of staff or categories of staff who will provide the services; -the schedule and methods of monitoring assessments of the resident; -the schedule and methods of monitoring staff providing services; and -a contingency plan that includes: -the action to be taken if the scheduled service cannot be provided; -information and a method to contact the facility; -the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and -the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. R3 R3 admitted for service on June 2, 2020, with diagnoses including atrial fibrillation (irregular and rapid heart rate), chronic kidney disease, diabetes, and chronic obstructive pulmonary disease. R3's Exhibit 2: Service Plan dated July 14, 2022, indicated R3 received the following services: assistance with dressing and grooming, bathing, toileting, stand by assist with mobility, meals, and	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37500	A. BUILDING: _____ B. WING _____	10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOVING TOUCH INC	3818 BURQUEST LN BROOKLYN CENTER, MN 55429

(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
01650	Continued From page 27 medication administration. R3's service plan lacked the following required content: -frequency of each service, according to the resident's current assessment and resident preferences; -the identification of staff or categories of staff who will provide the services; -a contingency plan that includes: -the action to be taken if the scheduled service cannot be provided; -information and a method to contact the facility; -the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and -the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. On October 1, 2024, at 12:18 p.m., unlicensed personnel (ULP)-B stated R2 would not have a signed the service agreement because they utilized a new contract which did not include the service plan exhibit. ULP-B stated the licensee only had the home health aide care plan which was not signed by R2. ULP-B then explained the other residents who were admitted before R2 used the old contract which had the service plan exhibit, but she acknowledged R3's service plan did not include the frequency of each service, who would provide the services and the contingency plan was left blank. The licensee's Service Plan policy effective July 24, 2021, indicated the service plan would include the following:	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37500	A. BUILDING: _____ B. WING _____	10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOVING TOUCH INC	3818 BURQUEST LN BROOKLYN CENTER, MN 55429

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01650	Continued From page 28 -description of the services to be provided; -fees for services and the frequency of each service; -identification of the staff who will provide the services; -the schedule and methods of monitoring reviews or assessments of the resident; -the schedule and methods of monitoring staff who will provide the services; and -the contingency plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37500	A. BUILDING: _____ B. WING _____	10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOVING TOUCH INC	3818 BURQUEST LN BROOKLYN CENTER, MN 55429

(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
01940	Continued From page 29 services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of one resident (R2) who received treatment services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 admitted for services on February 8, 2023, with diagnoses including chronic respiratory failure with hypoxia (low oxygen level), obstructive sleep apnea (repeated breathing interruptions during sleep), chronic pain, and muscle weakness. R2's [Licensee] Home Health Aide Care Plan dated February 8, 2023, indicated R2 received	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37500	A. BUILDING: _____ B. WING _____	10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOVING TOUCH INC	3818 BURQUEST LN BROOKLYN CENTER, MN 55429

(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
01940	Continued From page 30 assistance with dressing, compression socks, bathing, mobility, two-person transfers, meals, medication administration, and homemaker services. At the top of the care plan under, "Special Equipment/Instructions," it indicated shower chair, wheelchair, portable oxygen tank, and bilevel positive airway pressure (BiPAP) machine. R2's hospital discharge orders dated January 28, 2024, ordered 4 LPM of continuous oxygen, and use of BiPAP at night. R2's medical record lacked the following: -a statement of the type of services that will be provided; -documentation of specific resident instructions relating to the treatments; -procedures for notifying a registered nurse (RN) or appropriate licensed health professional when a problem arises with treatments or therapy services; and -any resident-specific requirements related to documentation of treatment or therapy received. On October 1, 2024, at 9:03 a.m., the surveyor observed unlicensed personnel (ULP)-B administer medications to R2, and check R2's oxygen level which was set at 3.5 liters per minute (LPM) and it was adjusted to 4 LPM. The surveyor observed a BiPAP machine next to R2's recliner within the bedroom. On October 1, 2024, at 1:00 p.m., R2 stated staff helped him with the BiPAP when he went to bed around 10:30 p.m.-11:00 p.m. and wore it until about 10:00 a.m.-11:00 a.m. when he woke up. On October 2, 2024, at 10:45 a.m., clinical nurse supervisor (CNS)-D stated she had updated R2's	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37500	A. BUILDING: _____ B. WING _____	10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01940	Continued From page 31 service plan when changes were necessary, but she did not know it required signatures from the resident or the resident's designated representative. The licensee's Treatment and Therapy Management policy effective July 24, 2021, read "If the RN or licensed professional delegates treatments or therapies, the professional will monitor and evaluate its effectiveness on a regular basis as specified in the service plan." The policy also read, "The RN or licensed professional will prepare an individualized treatment or therapy management plan for each resident receiving ordered or prescribed treatments or therapy services, which addresses: A. Type of service to be provided B. Procedures for documenting treatment or therapies C. Procedures for monitoring treatments or therapies to prevent possible complications or adverse reactions D. Identification of treatment or therapy delegated to unlicensed personnel E. Procedures for notifying the RN or licensed health professional when a problem arises related to the treatment or therapy service." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		

Minnesota Department of Health

625 Robert Street North
St Paul
651-201-4500

Type: Full
Date: *09/30/24*
Time: 11:20:38
Report: 7994241180

Food and Beverage Establishment Inspection Report

Location:

Loving Touch Inc
3818 Burquest Ln
Brooklyn Center, MN55429
Hennepin County, 27

Establishment Info:

ID #: 0038595
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7632050965
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.

3-500B Microbial Control: hot and cold holding

3-501.16A2 ***** Priority 1 *****

MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

FRIDGE WAS CLEANED OUT EARLIER TODAY AND THE INTERNAL TEMP WAS FOUND ABOVE 41 F. ADJUST COOLER AS NEEDED AND PROVIDE WORKING THERMOMETERS.

Comply By: 09/30/24

4-300 Equipment Numbers and Capacities

4-302.12B ***** Priority 2 *****

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.

NO WORKING THERMOMETERS WERE PRESENT. REPLACE BATTERIES AND CHECK CURRENT THERMOMETER FOR ACCURACY.

Comply By: 09/30/24

4-300 Equipment Numbers and Capacities

4-302.13A ***** Priority 2 *****

MN Rule 4626.0710A Provide a readily accessible temperature measuring device for measuring the washing and sanitizing temperatures in manual warewashing operations.

FACILITY DID NOT HAVE AN APPROVED WAY TO MEASURE THE INTERNAL TEMPERATURE OF THE DISHWASHER. INSPECTOR COVERED VARIOUS WAYS TO MEASURE THE INTERNAL TEMP AND LEFT TEST STRIPS FOR FACILITY TO TEST DISHWASHER.

Comply By: 09/30/24

Type: Full
Date: *09/30/24*
Time: 11:20:38
Report: 7994241180
Loving Touch Inc

Food and Beverage Establishment Inspection Report

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

INSPECTION CONDUCTED IN THE PRESENCE OF HRD STAFF AND FINDINGS SHARED AT THE END OF INSPECTION.

WILL EMAIL SUPPORTING DOCUMENTS AND LINKS TO HRD STAFF AT THE END OF THE DAY.

KITCHEN IS RESIDENTIAL AND FOOD IS PREPARED FOR SAME DAY SERVICE.

FLOOR IS WOOD, CABINETS ARE WOOD WITH HALLOWED ENCLOSED BASES, LAMINATE COUNTER TOPS AND SMOOTH PAINTED CEILING. ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT ANY TIME THERE IS FOUND TO BE A RISK OF CONTAMINATION OR CONCERN THE PHYSICAL FACILITIES WILL BE REQUIRED TO BE BROUGHT UP TO CODE.

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 7994241180 of 09/30/24.

Certified Food Protection Manager: Fadumo A Ali

Certification Number: 107993 Expires: 08/20/27

Inspection report reviewed with person in charge and emailed.

Signed: _____
Establishment Representative

Signed: Crystal Elva
Crystal Elva
Public Health Sanitarian 3
St Paul
651-201-3981
Crystal.Elva@state.mn.us

Report #: 7994241180

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health

625 Robert Street North
St Paul

No. of RF/PHI Categories Out	1	**Date**	09/30/24
No. of Repeat RF/PHI Categories Out	0	**Time In**	11:20:38
Legal Authority MN Rules Chapter 4626		**Time Out**	

Loving Touch Inc	**Address** 3818 Burquest Ln	**City/State** Brooklyn Center, MN	**Zip Code** 55429	**Telephone** 7632050965
License/Permit # 0038595	**Permit Holder**	**Purpose of Inspection** Full	**Est Type**	**Risk Category**

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item — Mark "X" in appropriate box for COS and/or R

IN= in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

	Compliance Status		COS	R
	Supervision			
1	IN OUT	PIC knowledgeable; duties & oversight		
2	IN OUT N/A	Certified food protection manager, duties		
	Employee Health			
3	IN OUT	Mgmt/Staff;knowledge,responsibilities&reporting		
4	IN OUT	Proper use of reporting, restriction & exclusion		
5	IN OUT	Procedures for responding to vomiting & diarrheal events		
	Good Hygenic Practices			
6	IN OUT N/O	Proper eating, tasting, drinking, or tobacco use		
7	IN OUT N/O	No discharge from eyes, nose, & mouth		
	Preventing Contamination by Hands			
8	IN OUT N/O	Hands clean & properly washed		
9	IN OUT N/A N/O	No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10	IN OUT	Adequate handwashing sinks supplied/accessible		
	Approved Source			
11	IN OUT	Food obtained from approved source		
12	IN OUT N/A N/O	Food received at proper temperature		
13	IN OUT	Food in good condition, safe, & unadulterated		
14	IN OUT N/A N/O	Required records available; shellstock tags, parasite destruction		
	Protection from Contamination			
15	IN OUT N/A N/O	Food separated and protected		
16	IN OUT N/A	Food contact surfaces: cleaned & sanitized		
17	IN OUT	Proper disposition of returned, previously served, reconditioned, & unsafe food		

	Compliance Status		COS	R
	Time/Temperature Control for Safety			
18	IN OUT N/A N/O	Proper cooking time & temperature		
19	IN OUT N/A N/O	Proper reheating procedures for hot holding		
20	IN OUT N/A N/O	Proper cooling time & temperature		
21	IN OUT N/A N/O	Proper hot holding temperatures		
22	IN OUT N/A	Proper cold holding temperatures		
23	IN OUT N/A N/O	Proper date marking & disposition		
24	IN OUT N/A N/O	Time as a public health control: procedures & records		
	Consumer Advisory			
25	IN OUT N/A	Consumer advisory provided for raw/undercooked food		
	Highly Susceptible Populations			
26	IN OUT N/A	Pasteurized foods used; prohibited foods not offered		
	Food and Color Additives and Toxic Substances			
27	IN OUT N/A	Food additives: approved & properly used		
28	IN OUT	Toxic substances properly identified, stored, & used		
	Conformance with Approved Procedures			
29	IN OUT N/A	Compliance with variance/specialized process/HACCP		

Risk factors (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is **not** in compliance — Mark "X" in appropriate box for COS and/or R — **COS=** corrected on-site during inspection **R=** repeat violation

			COS	R
		Safe Food and Water		
30	IN OUT N/A	Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32	IN OUT N/A	Variance obtained for specialized processing methods		
		Food Temperature Control		
33		Proper cooling methods used; adequate equipment for temperature control		
34	IN OUT N/A N/O	Plant food properly cooked for hot holding		
35	IN OUT N/A N/O	Approved thawing methods used		
36	X	Thermometers provided & accurate		
		Food Identification		
37		Food properly labled; original container		
		Prevention of Food Contamination		
38		Insects, rodents, & animals not present		
39		Contamination prevented during food prep, storage & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
		Proper Use of Utensils		
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
		Utensil Equipment and Vending		
47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48	X	Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
		Physical Facilities		
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) **Date:** 09/30/24

Inspector (Signature) Crystal Elva