DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

June 3, 2025

Licensee
Happy Place Care Services LLC
7217 Edgewood Avenue North
Minneapolis, MN 55428

RE: Project Number(s) SL37815016

Dear Licensee:

On April 22, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on December 19, 2024. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Tim Hanna, Supervisor
State Engineering Services Section
Health Regulation Division
Email: Tim.Hanna@state.mn.us
Telephone: 507-208-8982 Fax: 1-866-890-9290

JMD

Electronically Delivered

February 11, 2025

Licensee
Happy Place Care Services LLC
7217 Edgewood Avenue North
Minneapolis, MN 55428

RE: Project Number(s) SL37815016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on December 19, 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.

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.

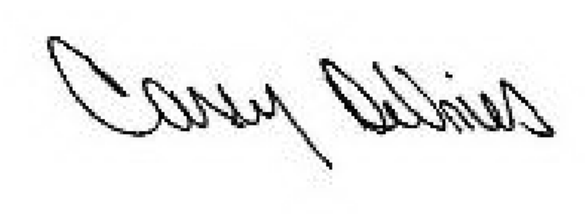
To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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,



Casey DeVries, Supervisor
State Evaluation Team
Email: casey.devries@state.mn.us
Telephone: 651-201-5917 Fax: 1-866-890-9290

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37815	A. BUILDING: _____ B. WING _____	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAPPY PLACE CARE SERVICES LLC	7217 EDGEWOOD AVENUE NORTH MINNEAPOLIS, MN 55428

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL37815016-0 On December 16, 2024, to December 19, 2024 the Minnesota Department of Health conducted an initial survey at the above provider, and the following correction are issued. At the time of the survey there were four residents residing at the assisted living facility, all four residents were receiving services under the assisted living license. An immediate correction order was identified on December 18, 2024, issued for SL37815016-0, tag identification 0780. During the course of the survey, the licensee took action to mitigate the imminent risk. Noncompliance remained and the scope and level remain unchanged.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	

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0 470	Continued From page 1	0 470		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure their 24-hour staffing schedule was posted in a central location which had to potential to affect all staff, residents, and volunteers. This practice resulted in a level two violation (a	0 470		

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0 470	Continued From page 2 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 December 16, 2024, at 10:20 a.m., during the facility tour with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-D, the surveyor observed the licensee's postings lacked a posted 24-hour staffing schedule. LALD/CNS-D stated it should have been posted and may have fallen off the wall. LALD/CNS-D stated they posted the staff schedule every two weeks. The licensee's 4.06 Staffing & Scheduling policy dated October 28, 2021, indicated, "4. The daily work schedule must be posted, after redacting direct-care staff members' resident assignments, at the beginning of each work shift in a central location in each building of a facility or campus, accessible to staff, residents, volunteers, and the public. The facility shall not disclose any information that is protected by law from public disclosure." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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

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0 480	Continued From page 4 existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This had the potential to affect all residents of the assisted living facility. 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 included document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated December 17, 2024, for the specific Minnesota Food Code deficiencies. The Inspection Report was provided to the licensee on December 17, 2024.	0 480		

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0 480	Continued From page 5 TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 485 SS=C	144G.41 Subdivision 1.a (a) Minimum requirements; required food services All assisted living facilities must offer to provide or make available at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes. The facility must not require a resident to include and pay for meals in the resident's contract. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide a menu a week in advance and inform residents in advance of menu changes. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).	0 485		

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0 485	Continued From page 6 The findings include: On December 16, 2024, at 10:20 a.m., during the facility tour with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-D, the surveyor observed the licensee lacked a posted menu. On December 16, 2024, at 11:12 a.m., LALD/CNS-D stated the only way the menu was made available for the residents was the posted menu, and was unable to locate where it was posted. LALD/CNS-D stated they were aware of the requirement to provide the menu to residents in advance. LALD/CNS-D stated they normally posted a menu for the entire month, two weeks in advance. On December 16, 2024, at 11:41 a.m., LALD/CNS-D provided a copy of their December 2024, menu which they printed today (December 16, 2024). The licensee's 12.01 Food Service & Menu Planning policy dated August 21, 2021, indicated, "1. Menus will be prepared at least one (1) week in advance and made available to all residents. [Licensee] will encourage residents' involvement in menu planning." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place	0 550		

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0 550	Continued From page 7 information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post information directing individuals to the Office of Health Facility Complaints (OHFC) at the Minnesota Department of Health (MDH) if they had complaints about the facility or person providing 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On December 16, 2024, at 10:20 a.m., during the facility tour with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-D,	0 550		

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0 550	Continued From page 8 the surveyor observed the licensee's Grievance/Complaint posting which lacked posted information to direct individuals to OHFC at MDH if they had complaints about the facility or person providing services. LALD/CNS-D stated they were unsure what OHFC was and the information was not posted in the facility. The licensee's 2.10 Complaint/Grievance Posting policy indicated: "1. [Licensee] will post, in a conspicuous place, information about our complaint/ grievance procedure, and the name, telephone number, and email contact information for the individual(s) who are responsible for handling resident complaint/grievances. 2. The posting will also have the contact information for the Office of Ombudsman for Long Term Care and the Ombudsman for Mental Health and Developmental Disabilities. a. OFFICE OF OMBUDSMAN FOR LONG-TERM CARE PO Box 64971 St. Paul, MN 55164-0971 1-800-657-3591 or 651-431-2555 Email: MBA.OOLTC@state.mn.us http://www.mnaging.org/Advocate/OLTC.aspx b. OFFICE OF OMBUDSMAN FOR MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES 121 7th Place East Metro Square Building St. Paul, MN 55101-2117 1-800-657-3506 or 651-757-1800 Email: Ombudsman.mhdd@state.mn.us https://mn.gov/omhdd/ 3. In addition, the posting will include information for reporting suspected maltreatment to the Minnesota Adult Abuse Center a. MINNESOTA ADULT ABUSE REPORTING CENTER (MAARC) Phone: 1-844-880-1574 For more information:	0 550		

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0 550	Continued From page 9 https://mn.gov/dhs/adult-protection/" No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure tuberculosis (TB) testing was completed within 90 days prior to the date of hire for one of three employees (unlicensed personnel (ULP-E)). 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	0 660		

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0 660	Continued From page 10 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: The licensee's facility TB risk assessment dated November 1, 2024, indicated the facility was at a low risk level. ULP-E was hired on June 20, 2022, to provide direct cares to residents. ULP-E's employee record included a negative QuantiFERON TB Gold Plus test result dated January 28, 2021; the test did not have ULP-E's name on it. The test was completed more than 90 days prior to ULP-E's hire date. On December 17, 2024, at 10:45 a.m., license assisted living director/clinical nurse supervisor (LALD/CNS)-D stated they were not aware a TB test needed to be completed within 90 days of the date of hire; ULP-E did not have one completed by the licensee when they were hired. The CDC Tuberculosis Guidance website, last updated December 15, 2023, indicated all health personnel should receive baseline TB testing upon hire. The Minnesota Department of Health TB FAQ, last updated on December 13, 2024, indicated TB testing should be dated within 90 days before hiring. The licensee's 8.16 Tuberculosis Screening policy dated October 28, 2024, indicated: "Staff Screening	0 660		

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0 660	Continued From page 11 Staff whose essential job functions require work within the same air space of home care clients will be screened and tested for tuberculosis prior to the staff being exposed to clients. Baseline (upon hire) screening will be completed, but serial (annual) screening will only be required with increased occupational risk or exposure. Screening will be conducted as follows: 1. New staff will be screened for active signs of TB using the Baseline TB Screening Tool for HCWs . 2. New staff will have an IGRA blood test or a two-step Mantoux conducted with results documented on the Baseline TB Screening Tool for HCWs. 3. No staff will be permitted to begin work where the work involves sharing the air space with residents until the negative results of the first Mantoux are read and documented or a negative IGRA blood test result is received and documented. 4. Staff TB screening results will be kept in each employee medical file. 5. Staff should be screened for signs and symptoms on an annual basis." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37815	A. BUILDING: _____ B. WING _____	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAPPY PLACE CARE SERVICES LLC	7217 EDGEWOOD AVENUE NORTH MINNEAPOLIS, MN 55428

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0 680	Continued From page 12 temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop a written emergency preparedness plan (EPP) with all the required content, reviewed/updated annually and post it prominently in a conspicuous place for staff, residents, and visitors to view. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 680		

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0 680	Continued From page 13 The findings include: On December 16, 2024, at 10:20 a.m., during the facility tour with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-D, the surveyor observed the licensee's EPP was not prominently displayed nor was there posted signage directing staff, residents, and visitors where the EPP was located. On December 16, 2024, at 10:36 a.m., LALD/CNS-D stated the EPP was located in the facility office which was locked when not in use. The surveyor observed the EPP located on the top of a black filing cabinet in the corner of the office. On December 17, 2024, at 11:06 a.m., the surveyor reviewed the licensee's Emergency Preparedness Manual, last reviewed/updated on January 17, 2022. LALD/CNS-D stated it had been a while since they last reviewed the EPP. LALD/CNS-D stated they thought the EPP was required to be updated biannually. LALD/CNS-D they had so many things to do they kept overlooking the EPP updates. The EPP lacked the following required content: -reviewed or updated annually; -missing resident plan reviewed quarterly; -identify a qualified person who is authorized in writing to act in the absence of the administrator; -evacuation location agreement; -includes policy and procedures (P/P) for at minimum food and water quantity; and -communication plan must include all the following names/contact information: staff, entities providing services under agreement, residents' physicians, other facilities, volunteers. On December 17, 2024, at 11:29 a.m.,	0 680		

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0 680	Continued From page 14 LALD/CNS-D stated they had a backup LALD who worked for them but was not identified in the EPP. LALD/CNS-D stated they had an evacuation location but would have to locate their agreement. The licensee's 9.02 Disaster Planning and Emergency Preparedness policy dated October 28, 2021, indicated, "[Licensee] will have in place a general emergency preparedness plan, that is in alignment with facility's requirement to also comply with CMS Appendix Z." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 780 SS=G	144G.45 Subd. 2 (a) (1) Fire protection and physical environment 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 smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing	0 780		

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0 780	Continued From page 15 buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide emergency escape and rescue openings in compliance with Minnesota State Fire Code under Minnesota Rules, chapter 7511.. This had the potential to affect some residents, staff, and visitors. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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: On December 18, 2024, at approximately 4:00 p.m. during a survey, staff toured the facility with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-D. During the tour, survey staff asked LALD/CNS-D to open the windows in the resident bedrooms for measurement. OCCUPIED SLEEPING ROOMS: Bedroom 30: The egress window crank was broken. As a result the window would not open	0 780	During the course of the survey, the licensee took action to mitigate the imminent risk. Noncompliance remained and the scope and level remain unchanged.	

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0 780	Continued From page 16 and did not allow egress out of the space. On December 18, 2024, the surveyor explained to LALD/CNS-D the potential hazard a nonoperable egress window presents. LALD/CNS-D stated they understood the deficiency and would address the window immediately. TIME PERIOD FOR CORRECTION: Immediate	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	0 800		

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0 800	Continued From page 17 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 December 18, 2024, at approximately 2:30 p.m., survey staff toured the facility with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-D the following was observed. GENERAL MAINTENANCE: Cracking on the walls was observed throughout the facility. LALD/CNS-D stated they will repair the cracking. Peeling paint was observed in the kitchen area. LALD/CNS-D stated they would repair the peeling paint. On December 18, 2024, LALD/CNS-D stated they understood the above-listed deficiencies. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for	0 810		

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0 810	Continued From page 18 residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training 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 resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	0 810		

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0 810	Continued From page 19 or has potential to affect a large portion or all of the residents). The findings include: On December 18, 2024, at approximately 3:00 p.m., survey staff observed the posted fire evacuation diagrams did not match the bedroom identification present on each bedroom door. Exit plan diagrams must be correctly labeled to reduce confusion and potential obstructions to egress in a fire or similar emergency. On December 18, 2024, LALD/CNS-D failed to provide documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. On December 18, 2024, LALD/CNS-D stated they understood the requirements to develop and maintain a FSEP and would work to bringing the facility into compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01880 SS=D	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	01880		

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01880	Continued From page 20 review, the licensee failed to monitor the temperature of their medication storage refrigerator to ensure medications were stored according to manufacturer directions for one of one residents (R2) with refrigerated medications. 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). The findings include: R2 was admitted to the licensee on June 22, 2022, and had a diagnosis of type two diabetes. R2's Service Plan dated July 10, 2024, indicated R2 received assistance with medications and blood glucose (BG) monitoring. R2's Med Sheet (medication administration record (MAR)) for December 2024, indicated R2 took the following medications: -R2 Humalog Mix 75/25 KwikPen 100 units (u)/milliliter (ml); inject 65u subcutaneously (SQ) every morning and 55u each night for; -R2 Humalog KwikPen 100u/ml; inject SQ three times daily per sliding scale before meals; and -R2 Ozempic 2 milligram (mg)/3ml, inject 0.25mg SQ every 28 days, then 0.5mg every week for blood sugar management. On December 16, 2024, at 10:41 a.m., the surveyor observed the medication refrigerator in the facility office with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-D.	01880		

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01880	Continued From page 21 The surveyor observed the medication refrigerator lacked a thermometer. LALD/CNS-A stated they were not monitoring the temperature of the medication refrigerator and did not know temperature monitoring was required. The surveyor observed the following medications in the medication refrigerator: -R2 Humalog Mix 75/25 KwikPen 100 units (u)/milliliter (ml); inject 65u subcutaneously (SQ) every morning and 55u each night; 11 KwikPens; -R2 Humalog KwikPen 100u/ml; inject SQ three times daily per sliding scale before meals, 11 KwikPens; and -R2 Ozempic 2 milligram (mg)/3ml, inject 0.25mg SQ every 28 days, then 0.5mg every week; one pen. Manufacturer instructions for Humalog 75/25, last revised July 2023, indicated to store unused pens in the refrigerator at 36-46 degrees F; do not use if it has been frozen. Manufacturer instructions for Humalog (insulin lispro), last revised in August 2023, indicated to store unused pens in the refrigerator at 36-46 degrees F; do not use if it has been frozen. Manufacturer instructions for Ozempic, dated November 2024, indicated to store unused pens in the refrigerator at 36-46 degrees F; do not use if it has been frozen. The licensee's 7.11 Medication Storage policy dated October 28, 2021, indicated, "Medications will be stored consistent with manufacturer's recommendations (refrigerated, room temperature, or frozen)." No further information was provided.	01880		

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01880	Continued From page 22 TIME PERIOD FOR CORRECTION: Seven (7) days	01880		

Minnesota Department of Health

625 Robert Street North
St Paul
651-201-4500

Type: Full
Date: *12/17/24*
Time: 12:20:49
Report: 7994241240

Food and Beverage Establishment Inspection Report

Location:

Happy Place Care Services LLC
7217 Edgewood Avenue North
Happy Place Care Services
Minneapolis, MN55428
Hennepin County, 27

Establishment Info:

ID #: 0039896
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/21

Operator:

Phone #: 6122429501
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.

3-300B Protection from Contamination: cross-contamination, eggs

3-302.11A(1) ***** Priority 1 *****

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

EGGS STORED ABOVE OTHER FOODS IN THE FRIDGE. MOVE THESE AS LOW AS POSSIBLE.

Comply By: 12/17/24

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 DOES NOT HAVE AN APPROVED TEMPERATURE MEASURING DEVICE TO TEST THE DISHWASHER. INSPECTOR LEFT A TEST STRIP AND STAFF WILL EMAIL A PICTURE ONCE CYCLE IS COMPLETED.

Comply By: 12/17/24

4-100 Equipment Construction Materials

4-101.19

MN Rule 4626.0495 Remove non-food-contact surfaces of equipment that are exposed to splash, spillage, or other food soiling, or that require frequent cleaning, that are not constructed of a corrosion-resistant, non-absorbent, and smooth material.

PROTECTIVE FILM IS STILL ON THE NEW REFRIGERATOR. REMOVE THE FILM AND CLEAN THE SURFACE.

Comply By: 12/17/24

Type: Full
Date: *12/17/24*
Time: 12:20:49
Report: 7994241240
Happy Place Care Services LLC

Food and Beverage Establishment Inspection Report

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

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 CERAMIC TILE, 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 7994241240 of 12/17/24.

Certified Food Protection Manager: Nelson O Assick

Certification Number: 10817 Expires: 10/07/27

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 #: 7994241240

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**	12/17/24
No. of Repeat RF/PHI Categories Out	0	**Time In**	12:20:49
Legal Authority MN Rules Chapter 4626		**Time Out**	

Happy Place Care Services LLC	**Address** 7217 Edgewood Avenue North	**City/State** Minneapolis, MN	**Zip Code** 55428	**Telephone** 6122429501
License/Permit # 0039896	**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				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	X	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:** 12/17/24

Inspector (Signature) Crystal Elva