Electronically Delivered

November 3, 2026

Licensee
Alltracare LLC
3641 Decatur Avenue North
New Hope, MN  55427

RE:  Project Number(s) SL39510016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on October 15, 2026, 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 . . ."

**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;
Level 3: a fine of $1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 4: a fine of $3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 5: a fine of $5,000 per violation, 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 - $500.00**
**St - 0 - 0810 - 144g.45 Subd. 2 (b-F) - Fire Protection And Physical Environment - $1,000.00**

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $1,500.00**. 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.

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

CLN

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 39510 | A. BUILDING: _____ B. WING _____ | 10/15/2026 |

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| ALLTRACARE LLC | 3641 DECATUR AVENUE NORTH NEW HOPE, MN 55427 |

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| 0 000 | Initial Comments<br><br>*****ATTENTION*****<br><br>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.<br><br>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.<br><br>INITIAL COMMENTS:<br><br>SL39510016-0<br><br>On October 12, 2026, through October 15, 2026, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were two residents; two receiving services under the 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.<br><br>PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3. | |
| 0 510 SS=F | 144G.41 Subd. 3 Infection control program<br><br>(a) All assisted living facilities must establish and | 0 510 | | |

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| 0 510 | Continued From page 1<br><br>maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control.<br>(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.<br>(c) The facility must maintain written evidence of compliance with this subdivision.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program that complies with accepted health care, medical and nursing standards for infection control related to handwashing and glove use for one of one unlicensed personnel ((ULP)-A). The deficient practice had the potential to affect residents, employees, and visitors.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>On October 13, 2026, at 11:59 a.m., the surveyor observed ULP-A enter the lower level of the facility from upstairs wearing gloves. ULP-A | 0 510 | | |

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| 0 510 | Continued From page 2<br><br>touched plastic medication bins, medication bottles, a medication pill box, and the licensee's computer. ULP-A reviewed R3's medications on the computer and set up the medication in a disposable medication cup. ULP-A went upstairs while wearing the same gloves, reached into the kitchen cupboard for a glass, got water from the water dispenser on the refrigerator door; knocked on room 2; gave R3 the medications set up in the disposable cup. However, the surveyor intervened before R3 took their medications due to the medications not being set up correctly; and had ULP-A step out of R3's room to further discuss. ULP-A acknowledged the medications were not set up correctly; and went downstairs to call the nurse where they doffed (removed) the gloves without performing hand hygiene.<br><br>On October 13, 2026, at 12:19 p.m., during a continuous observation, the surveyor observed ULP-A don (put on) gloves without hand hygiene, touched plastic medication bins, logged into the licensee's computer to review medications while wearing the same gloves. ULP-A stated they needed to review the medications to see if R2 needed medications; however, R2 did not need any medications. At 12:34 p.m., ULP-A received a phone call from the nurse for further instructions to administer additional medication to R3. ULP-A doffed the gloves without hand hygiene after. ULP-A reviewed the licensee's computer for medications again, ULP-A donned gloves again without performing hand hygiene. ULP-A continued to review medications on the licensee's computer, removed a medication from the licensee's narcotic lock box, counted medications, then put the narcotic lock box back on top the plastic medication bins. ULP-A then stated, "let me change gloves again since I touched everything." ULP-A donned a new pair of | 0 510 | | |

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| 0 510 | Continued From page 3<br><br>gloves without hand hygiene. ULP-A touched the computer again to verify medications. ULP-A put the medication box back inside of the plastic medication bins. ULP-A then went upstairs while wearing the same gloves, went into the kitchen cupboard to get a glass, got water from the refrigerator door, and gave the medications to R3. ULP-A then went downstairs again where they doffed the gloves without performing hand hygiene after.<br><br>ULP-A was hired on February 10, 2025.<br><br>ULP-A's Competency dated March 17, 2025, indicated ULP-A passed competency evaluation by a registered nurse (RN) for hand washing.<br><br>On October 13, 2026, at 12:58 p.m., ULP-A acknowledged they did not perform hand hygiene during the surveyor's observations. ULP-A stated they were trained by agent/owner (A/O)-E to wash their hands before and after resident cares. ULP-A then stated the nurse had originally trained them upon hire.<br><br>On October 15, 2026, at 3:32 p.m., licensed assisted living director/registered nurse (LALD/RN)-C stated they expected staff to wash their hands before setting up medications and in between resident cares or tasks; before going into the kitchen; or with use of the bathroom. LALD/RN-C stated they thought the staff needed more education; and needed to make sure hand sanitizers were more available in the facility.<br><br>The licensee's undated Hand-Washing policy indicated hand washing would be performed by all employees, as necessary, between tasks and procedures, and after bathroom use, to prevent cross-contamination. Also, the policy indicated | 0 510 | | |

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| 0 510 | Continued From page 4<br><br>when conducting a procedure that required the use of gloves, proper hand hygiene should be completed before donning gloves and after doffing gloves.<br><br>The Centers for Disease Control and Prevention (CDC) 2007 Guideline for Isolation Precautions: Preventing Transmission of Infections Agents in Healthcare Settings updated September 2024, on page 129, table 4, indicated recommendations for application of standard precautions for the care of all patients in all healthcare settings included the following:<br>- Hand hygiene recommendations after touching blood, body fluids, secretions, excretions, contaminated items, immediately after removing gloves, and between patient contacts; and<br>- Personal protective equipment (PPE) gloves recommendations for touching blood, body fluids, secretions, excretions, contaminated items, for touching mucous membranes, and nonintact skin.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 510 | | |
| 0 650 SS=F | 144G.42 Subd. 8 (a) Staff records<br><br>(a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation:<br>(1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; | 0 650 | | |

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| 0 650 | Continued From page 5<br><br>(2) records of orientation, required annual training and infection control training, and competency evaluations;<br>(3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision;<br>(4) documentation of annual performance reviews that identify areas of improvement needed and training needs;<br>(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<br>(6) documentation of the background study as required under section 144.057.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure employee records included all required content for two of two unlicensed personnel ((ULP)-A, ULP-B).<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>ULP-A<br>ULP-A was hired on February 10, 2025.<br><br>On October 13, 2026, at 11:59 a.m., the surveyor observed ULP-A assist R3 with medication | 0 650 | | |

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| 0 650 | Continued From page 6<br>administration.<br><br>ULP-A's employee record lacked evidence of completed annual performance reviews; and documentation of supervision by the RN within 30 days of performing delegated tasks.<br><br>ULP-B<br>ULP-B was hired on December 2, 2024.<br><br>ULP-B's employee record lacked evidence of completed annual performance reviews; and documentation of supervision by the RN within 30 days of performing delegated tasks.<br><br>On October 13, 2026, at 7:22 a.m., agent/owner (A/O)-E stated they sit down with staff every month to review any issues but have not documented a performance review. A/O-E stated they thought the nurse had been doing the supervision with all their competency evaluations; however, these had not been documented either. A/O-E stated they knew the nurses often followed up with the staff and provided oversight and re-training if needed.<br><br>On October 13, 2026, at 12:25 p.m., ULP-A stated the nurse observed them after they did their training and competency evaluations; and again, with any new residents. ULP-A stated the nurses observed them periodically as well.<br><br>On October 15, 2026, at 3:27 p.m., licensed assisted living director/registered nurse (LALD/RN)-C stated they were aware of the required content of personnel records but acknowledged the missing content. LALD/RN-C stated they have done the reviews and supervisions on the staff. | 0 650 | | |

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| 0 650 | Continued From page 7<br><br>The licensee's undated Employee Records policy indicated employee records must include documentation of annual performance reviews that identify areas of improvement needed and training needs.<br><br>The licensee's undated Supervision of Unlicensed Personnel policy indicated staff who would provide assisted living services specified in section 144G.08, subdivision 9, clauses 1 to 5, would be supervised periodically; and direct supervision of an employee would be documented in the employee file.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 650 | | |
| 0 660 SS=F | 144G.42 Subd. 9 Tuberculosis prevention and control<br><br>(a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines.<br>(b) The facility must maintain written evidence of compliance with this subdivision. | 0 660 | | |

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| 0 660 | Continued From page 8<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to establish and maintain a tuberculosis (TB) infection control program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included baseline screening for TB history and TB symptoms; and failed to provide TB training for two of two unlicensed personnel ((ULP)-A, ULP-B).<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>The licensee's Facility TB Risk Assessment Worksheet for Health Care Settings licensed by MDH dated June 3, 2026, indicated the facility was a low-risk setting.<br><br>ULP-A<br>ULP-A was hired on February 10, 2025.<br><br>On October 13, 2026, at 11:59 a.m., the surveyor observed ULP-A assist R3 with medication administration.<br><br>ULP-A's personnel record lacked baseline TB screening that included TB history and symptoms. | 0 660 | | |

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| 0 660 | Continued From page 9<br><br>ULP-A's transcript dated October 12, 2026, indicated ULP-A had initial TB-related training on February 16, 2025. ULP-A's personnel record lacked evidence of annual TB-related training in 2026.<br><br>On October 13, 2026, at 12:25 p.m., ULP-A stated they had completed TB-related training at hire only.<br><br>ULP-B<br>ULP-B was hired on December 2, 2024.<br><br>ULP-B's personnel record lacked baseline TB screening that included TB history and symptoms.<br><br>ULP-B's transcript dated October 12, 2026, indicated ULP-B had TB-related training on October 3, 2025, which was 366 days after the date of hire. ULP-B's personnel record lacked evidence of initial TB-related training in 2024.<br><br>On October 12, 2026, at 3:15 p.m., agent/owner (A/O)-E stated the baseline TB screening that included TB history and symptoms was part of the hiring process, but they were not sure how it was missed for ULP-A and ULP-B.<br><br>On October 15, 2026, at 2:57 p.m., licensed assisted living director/registered nurse (LALD/RN)-C stated they were not aware of the requirement to have annual TB training. LALD/RN-C stated they had reviewed the personnel files for TB testing only but did not review the records for baseline TB screening that included TB history and symptoms. LALD/RN-C stated ULP-A and ULP-B were hired prior to taking over as the LALD. LALD/RN-C stated they include the baseline TB screening that included | 0 660 | | |

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| 0 660 | Continued From page 10<br>TB history and symptoms when they do the hiring.<br><br>The licensee's undated Tuberculosis Screening policy indicated each employee must have evidence of baseline TB screening consisting of two components that included assessing current symptoms of active TB disease and testing for the presence of infection with TB.<br><br>The licensee's undated Tuberculosis Prevention and Control policy indicated TB training would be provided for all employees at the time of employment and annually during infection control in-services.<br><br>Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, indicated on page 10, baseline TB screening consisted of three components: Assessment of current symptoms of active TB disease; assessment of TB history; and testing for the presence of infection with TB by administration of either a two-step tuberculin skin test or single TB blood test.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 660 | | |
| 0 680 SS=F | 144G.42 Subd. 10 Disaster planning and emergency preparedness<br><br>(a) The facility must meet the following requirements:<br>(1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies | 0 680 | | |

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| 0 680 | Continued From page 11<br><br>temporary relocation sites, and details staff assignments in the event of a disaster or an emergency;<br>(2) post an emergency disaster plan prominently;<br>(3) provide building emergency exit diagrams to all residents;<br>(4) post emergency exit diagrams on each floor; and<br>(5) have a written policy and procedure regarding missing residents.<br>(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.<br>(c) The facility must meet any additional requirements adopted in rule.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to maintain a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. This had the potential to affect all residents, staff, and visitors.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).<br><br>The findings include: | 0 680 | | |

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| 0 680 | Continued From page 12<br><br>The licensee's undated EPP lacked evidence of the following required content:<br>- process for emergency preparedness (EP) collaboration;<br>- subsistence needs for staff and residents;<br>- procedures for tracking staff and patients;<br>- policy and procedure for sheltering in Place;<br>- policies and procedures for medical documents;<br>- policies and procedures for volunteers;<br>- emergency officials contact information;<br>- primary and alternate means for communication;<br>- methods for sharing information;<br>- sharing information on occupancy/needs;<br>- long-term care (LTC) family notifications;<br>- emergency preparedness training and testing; and<br>- testing requirements - emergency prep training and testing.<br><br>On October 13, 2026, at 8:57 a.m., licensed assisted living director/registered nurse (LALD/RN)-C acknowledged the missing required content for the EPP. LALD/RN-C stated the licensee had not completed any community-based exercises.<br><br>The licensee's undated Emergency Management policy indicated the licensee would have in place an emergency preparedness plan to assure the safety and well-being of residents and staff during periods of an emergency or disaster that would disrupt services.<br><br>Minnesota Administrative Rule 4659.0100 dated August 11, 2021, indicated assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title | 0 680 | | |

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| 0 680 | Continued From page 13<br><br>42, section 483.72, or successor requirements. This part referenced documents, specifications, methods, and standards in "State Operations Manual Appendix Z - Emergency Preparedness for All Provider and Certified Supplier Types: Interpretive Guidance."<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 680 | | |
| 0 810 SS=I | 144G.45 Subd. 2 (b-f) Fire protection and physical environment<br><br>(b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:<br>(1) location and number of resident sleeping rooms;<br>(2) staff actions to be taken in the event of a fire or similar emergency;<br>(3) fire protection procedures necessary for residents; and<br>(4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation.<br>(c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter.<br>(d) Fire safety and evacuation plans shall be readily available at all times within the facility.<br>(e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at | 0 810 | | |

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| 0 810 | Continued From page 14<br><br>least once per year.<br>(f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G.<br><br>This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated October 15, 2026, for the specific violations related the physical environment under Minnesota Statute 144G.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days. | 0 810 | | |

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| 0 950 | Continued From page 15 | 0 950 | | |
| 0 950 SS=C | 144G.50 Subd. 3 Designation of representative<br><br>(a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract:<br><br>"RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES.<br><br>You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable."<br><br>(b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to provide the required statutory language on a document separate from the contract; and failed to offer the resident the opportunity to identify a designated representative | 0 950 | | |

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| 0 950 | Continued From page 16<br><br>or decline a designated representative in writing for one of one resident (R2).<br><br>This practice resulted in a level one violation (a violation that will cause only 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).<br><br>The findings include:<br><br>R2 was admitted to the licensee on April 18, 2024.<br><br>R1's Service Plan - Modification dated January 1, 2026, indicated R2 received assistance with medication administration.<br><br>R2's Resident Contract for Assisted Living dated April 16, 2026, had a section for resident to designate a representative or decline to name a representative, however, the resident did not indicate a designated representative and no initials were in the box by the resident to indicate they declined to name a representative.<br><br>On October 12, 2026, at 1:51 p.m., agent/owner (A/O)-E stated the residents did not get the statutory language on a document separate from the contract; only what was provided on the contract. A/O-E stated the residents did get a copy of their contacts.<br><br>On October 15, 2026, at 3:05 p.m., licensed assisted living director/registered nurse (LALD/RN)-C stated they were familiar with what a designated representative was but did not know the statutory language needed to be on a | 0 950 | | |

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| 0 950 | Continued From page 17<br><br>separate page form the contract or that the residents needed to initial to decline to designate a representative.<br><br>The licensee's undated Assisted Living Contracts policy indicated the licensee must offer the resident the opportunity to identify a representative in writing on the contract. The policy indicated the contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if they decline to name a representative. Also, the policy indicated the licensee would provide the statutory language on a document separate from the contract.<br><br>No additional information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 950 | | |
| 01500 SS=D | 144G.63 Subd. 5 Required annual training<br><br>(a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include:<br>(1) training on reporting of maltreatment of vulnerable adults under section 626.557;<br>(2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;<br>(3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective | 01500 | | |

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| 01500 | Continued From page 18<br>gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases;<br>(4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders;<br>(5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and<br>(6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person.<br>(b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics:<br>(1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication;<br>(2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or<br>(3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. | 01500 | | |

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| 01500 | Continued From page 19<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment for one of two unlicensed personnel (ULP)-A.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).<br><br>The findings include:<br><br>On October 13, 2026, at 11:59 a.m., the surveyor observed ULP-A assist R3 with medication administration.<br><br>ULP-A was hired on February 10, 2025.<br><br>ULP-A's personnel record lacked evidence of annual training for infection control techniques and principles of person-centered planning/service delivery.<br><br>On October 13, 2026, at 12:34 p.m., ULP-A stated they did not complete any annual training on infection control techniques or person-centered planning/service delivery since hire. ULP-A stated they had only completed what had been assigned in Edcuare (common online education program). | 01500 | | |

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| 01500 | Continued From page 20<br><br>On October 15, 2026, at 3:29 p.m., licensed assisted living director/registered nurse (LALD/RN)-C stated they would assign Educare courses annually according to the required courses per Statute; however, it may have been an oversight.<br><br>The licensee's undated Annual Training Requirements policy indicated all staff that provided direct care services in an assisted living must complete at least eight (8) hours of annual training for each twelve (12) months of employment; and the annual training must include the following:<br>- infection control techniques used in the home; and<br>- the principles of person-centered planning and service delivery and how they apply to direct support services provided by staff.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01500 | | |
| 01620 SS=F | 144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring<br><br>(a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment.<br>(b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic | 01620 | | |

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| 01620 | Continued From page 21<br>distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery.<br>(c) Resident reassessment and monitoring must be conducted by a registered nurse:<br>(1) no more than 14 calendar days after initiation of services;<br>(2) as needed based on changes in the resident's needs; and<br>(3) at least every 90 calendar days.<br>(d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment.<br>(e) 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.<br>(f) 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.<br><br>This MN Requirement is not met as evidenced by: | 01620 | | |

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| 01620 | Continued From page 22<br><br>Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident monitoring and reassessment not to exceed 90 calendar days from the last date of assessment for one of one resident (R2).<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>R2 was admitted to the licensee on April 18, 2024.<br><br>R2's Addendum to Contract - Waiver - MN dated August 17, 2026, indicated R2 received assistance with medication administration.<br><br>R2's Assessment History by Client dated October 14, 2026, indicated assessments were completed on October 2, 2025, February 16, 2026, and August 31, 2026. The assessment completed on February 16, 2026, indicated 134 days had passed since the previous assessment completed on October 2, 2025; and the assessment completed on August 31, 2026, indicated 196 days had passed since the previous assessment completed on February 16, 2026.<br><br>On October 15, 2026, at 3:16 p.m., licensed assisted living director/registered nurse (LALD/RN)-C stated the late assessments were | 01620 | | |

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| 01620 | Continued From page 23<br><br>due to having a new nurse as they were not getting notifications of when assessments were due. LALD/RN-C stated the licensee had to make changes with Residex (licensee's electronic medical record) to make sure the new nurse could get the notifications of when assessments were due. LALD/RN-C stated they had noticed a late assessment in February; and again, in August. LALD/RN-C stated they did not know how to set up the nurse settings on the software.<br><br>The licensee's undated Nursing Assessment and Reassessment of Residents policy indicated on-going reassessment and monitoring would be conducted as needed based on changes in the needs of the residents; and could not exceed 90 calendar days from the last assessment.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01620 | | |
| 01640 SS=F | 144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to<br><br>(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 Long-Term Care and the Office of Ombudsman | 01640 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 39510 | A. BUILDING: _____ B. WING _____ | 10/15/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ALLTRACARE LLC | 3641 DECATUR AVENUE NORTH NEW HOPE, MN 55427 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 01640 | Continued From page 24<br><br>for Mental Health and Developmental Disabilities.<br>(c) The facility must implement and provide all services required by the current service plan.<br>(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.<br>(e) Staff providing services must be informed of the current written service plan.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure a current service plan was completed within fourteen days of starting services; and failed to obtain a signature or other authentication by the licensee to document agreement of services to be provided for one of one resident (R2).<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>R2 was admitted to the licensee on April 18, 2024.<br><br>R2's Service Plan - Modification dated January 1, 2026, indicated R2 received assistance with medication administration. R2's service plan lacked a signature or other authentication by the licensee and R2 or R2's representative. | 01640 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 39510 | A. BUILDING: _____ B. WING _____ | 10/15/2026 |

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|---|---|---|---|---|
| 01640 | Continued From page 25<br><br>R2's Addendum to Contract - Waiver - MN dated August 17, 2026, indicated R2 received assistance with medication administration. R2's service plan lacked a signature or other authentication by the licensee and R2 or R2's representative.<br><br>R2's record lacked evidence of a service plan prior to January 1, 2026.<br><br>On October 12, 2026, at 1:46 p.m., agent/owner (A/O)-E confirmed the licensee did not have a signed serviced plan for R2. A/O-E stated the service plan was supposed to be signed at admission, but it was missed. A/O-E stated they remembered going through the services with R2 that were indicated on the service plan, however, they did not think R2 signed the service plan as the licensee kept all the records at the facility which they could not find it in the paper records.<br><br>On October 12, 2026, at 2:13 p.m., A/O-E showed the surveyor the service plan noted above that was dated August 17, 2026, and indicated that was the service plan they had reviewed with R2. A/O-E stated R2 tended to fight against signing documents.<br><br>On October 15, 2026, at 9:59 a.m., A/O-E confirmed the two service plans provided to the surveyor were the only two service plans the licensee had for R2; and confirmed the service plans lacked a signature or other authentication by the licensee and R2.<br><br>The licensee's undated Service Plan policy indicated a service plan would be finalized with each resident no later than 14 calendar days after the start of services; and the service plan must | 01640 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 39510 | A. BUILDING: _____ B. WING _____ | 10/15/2026 |

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| ALLTRACARE LLC | 3641 DECATUR AVENUE NORTH NEW HOPE, MN 55427 |

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|---|---|---|---|---|
| 01640 | Continued From page 26<br>include a signature by the assisted living provider and by the resident or resident's representative documenting the agreement on the services to be provided.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01640 | | |
| 01910 SS=F | 144G.71 Subd. 22 Disposition of medications<br><br>(a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal.<br>(b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances.<br>(c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to provide documentation in the resident's record regarding the disposition of | 01910 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 39510 | A. BUILDING: _____ B. WING _____ | 10/15/2026 |

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|---|---|---|---|---|
| 01910 | Continued From page 27<br><br>medication to include quantity and names of staff and other individuals involved in the disposition of medications for one of one discharged resident (R1).<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>R1 was admitted to the licensee on December 11, 2024, and discharged on April 7, 2026.<br><br>R1's Discharge/Transfer Summary dated April 7, 2026, indicated R1 had received assistance with medications. Under section, Medication Disposition, indicated R1 would be taking bubble packs of medication until April 11, 2026; and opened bottles of Tylenol, fluticasone (only available as an inhaler or nasal spray), polyethylene glycol, and opened Advair Diskus. Under section, Medication Reconciliation, indicated R1 had bubble packs for medications supplied by [pharmacy], Tylenol, MiraLAX (polyethylene glycol), and Flomax (excluded fluticasone and Advair Diskus). Under section, Records Disposition, indicated R1 had reviewed medications, signed paperwork, and taken medications.<br><br>R1's Medication Disposition - Resident dated March 1, 2026 to October 12, 2026, did not indicate any medications; and had a blank space | 01910 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 39510 | A. BUILDING: _____ B. WING _____ | 10/15/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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|---|---|---|---|---|
| 01910 | Continued From page 28<br>for Releasing Signature and Receiving Signature.<br><br>R1's record lacked a disposition of medications to include the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition.<br><br>On October 13, 2026, at 8:09 a.m., agent/owner (A/O)-E stated the licensee did not have a medication disposition with signatures.<br><br>On October 15, 2026, at 3:12 p.m., licensed assisted living director/registered nurse (LALD/RN)-C stated clinical nurse supervisor (CNS)-D had completed the discharge for R1. LALD/RN-C stated CNS-D had reviewed all medications; and had R1 and their caregiver sign the medication disposition but had sent the signed medication disposition with the resident as the nurse did not know.<br><br>The licensee's undated Medication Disposition or Disposal policy indicated resident's current medications that were secured or stored by the facility would be given to the resident or the resident's representative when the resident's medication management services were terminated. The policy indicated staff would document in the resident's record, the name of the person to whom the medication was given to, the time and date, the name of each medication dose, and the amount of medication remaining.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01910 | | |

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| | 39510 | A. BUILDING: _____ B. WING _____ | 10/15/2026 |

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|---|---|---|---|---|
| 02430 | Continued From page 29 | 02430 | | |
| 02430 SS=F | 144G.91 Subd. 15 Confidentiality of records<br><br>(a) Residents have the right to have personal, financial, health, and medical information kept private, to approve or refuse release of information to any outside party, and to be advised of the assisted living facility's policies and procedures regarding disclosure of the information. Residents must be notified when personal records are requested by any outside party.<br>(b) Residents have the right to access their own records.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure residents' personal health and medical information was kept private when the licensee used Whats App to communicate in a group chat for changes in residents' condition, medications, and treatment needs. This had the potential to affect all residents who resided at the assisted living facility.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>On October 12, 2026, at 11:26 a.m., during the | 02430 | | |

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| | 39510 | A. BUILDING: _____ B. WING _____ | 10/15/2026 |

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|---|---|---|---|---|
| 02430 | Continued From page 30<br><br>entrance conference, licensed assisted living director/registered nurse (LALD/RN)-C stated the licensee had a secured chat (Whats App) that could be used by unlicensed personnel (ULPs) or nursing to communicate changes in resident needs, plans of admission of new residents, new or changed medications, and quality management meetings. LALD/RN-C stated the group chat included all employees that worked at the facility. LALD/RN-C stated they would use resident initials and not their names.<br><br>On October 15, 2026, at 2:57 p.m., LALD/RN-C stated the licensee used Whats App to notify staff of changes in schedules and in-services. LALD/RN-C stated if there were mentions of residents, they would use the residents' initials only. LALD/RN-C stated staff would use Whats App on their personal cell phones; and acknowledged the licensee did not have control over who was able to access the personal phones.<br><br>The licensee's undated Consent of Use and Disclosure of Protected Health Information policy defined protected health information as "individually identifiable health information" that is transmitted or maintained in any medium that is defined as electronic media or any other form.<br><br>The licensee's undated Resident Records policy indicated all resident information should be regarded as confidential and available only to authorized users; and resident records would be protected against loss, tampering or unauthorized disclosure in compliance with relevant federal and state laws.<br><br>No further information was provided. | 02430 | | |

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|---|---|---|---|
| | 39510 | A. BUILDING: _____ B. WING _____ | 10/15/2026 |

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| ALLTRACARE LLC | 3641 DECATUR AVENUE NORTH NEW HOPE, MN 55427 |

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|---|---|---|---|---|
| 02430 | Continued From page 31<br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 02430 | | |

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

# Food & Beverage Inspection Report



## Establishment Info

Alltracare LLC
3641 Decatur Ave N
New Hope, MN 55427
Hennepin County
Parcel:

Phone:

## License Info

License: 0043692

Risk:
License: -1
Expires on: 12/31/2024
CFPM: KATO SEMAKULA
CFPM #: FM60011; Exp: 7/10/0208

## Inspection Info

Report Number: F8087261268
Inspection Type: Full - Single
Date: 10/13/2026 Time: 12:30:00 PM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

No orders were issued for this inspection report.

## Food & Beverage General Comment

THIS WAS AN ANNOUNCED AND SCHEDULED FULL INSPECTION.

INSPECTION CONDUCTED IN THE PRESENCE OF HRD NURSE EVALUATOR.

THE FOLLOWING OBSERVATIONS WERE MADE:

CEILING: PAINTED, SMOOTH, APPEARS TO BE DURABLE - COMPLIANT
FLOORS: LAMINATE PLANK - NON COMPLIANT
COUNTERTOPS: LAMINATE - NON COMPLIANT
CABINETS: WOOD - NON COMPLIANT
REFRIGERATOR/FREEZER: WHIRLPOOL
DISHWASHER: FRIGIDARE
STOVE/RANGE: FRIGIDARE
MICROWAVE: WHIRLPOOL
HAND WASHING SINK: YES - LEFT SIDE OF 2-BIN PORCELAIN KITCHEN SINK

NON COMPLIANT COUNTERTOP, FLOOR AND CABINETS ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT SUCH A TIME THEY ARE FOUND TO BE A CONCERN OR RISK OF CONTAMINATION, THEY WILL BE ORDERED TO BE REPLACED AND BROUGHT UP TO CODE.

DISHWASHER IS RESIDENTIAL BUT HAS SANITIZING RINSE CYCLE OPTION. TEMPERATURE PROBE USED TO ENSURE UTENSIL SURFACE TEMPERATURES REACH 165.

HOT WATER TEMPERATURE AT THE KITCHEN SINK REACHED 120 DEGREES.

INSPECTION REPORT EMAILED TO FACILITY AND HRD NURSE SURVEYOR.

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

**I acknowledge receipt of the Metro District Office inspection report number F8087261268 from 10/13/2026**

*John Boettcher*

SALOME ASETTO
PROGRAM MANAGER/SUPERVISOR

John Boettcher,
Public Health Sanitarian 3
651-201-5076
john.boettcher@state.mn.us

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

# Temperature Observations/Recordings



## Establishment Info

Alltracare LLC
New Hope
County/Group: Hennepin County

## Inspection Info

Report Number: F8087261268
Inspection Type: Full
Date: 10/13/2026
Time: 12:30:00 PM

**Equipment Temperature: Product/Item/Unit:** AMBIENT AIR**; Temperature Process:** Ambient Air
**Location:** Upright Freezer at -4 Degrees F.
Comment:
*Violation Issued?: No*

**Equipment Temperature: Product/Item/Unit:** AMBIENT AIR**; Temperature Process:** Ambient Air
**Location:** Upright Cooler at 38 Degrees F.
Comment:
*Violation Issued?: No*

**Food Temperature: Product/Item/Unit:** MILK**; Temperature Process:** Cold-Holding
**Location:** Upright Cooler at 38 Degrees F.
Comment:
*Violation Issued?: No*

DEPARTMENT OF HEALTH

# Physical Environment Inspection Report

ASSISTED LIVING | ASSISTED LIVING WITH DEMENTIA CARE

| | |
|---|---|
| **Project No:** SL39510016-0 | **Date:** 10/15/2026 |
| **Facility Name:** ALLTRACARE LLC | |
| **Facility Address:** 3641 DECATUR AVENUE NORTH NEW HOPE, MN | |

☒ **TAG IDENTIFICATION: 0810**

**SCOPE/ SEVERITY:** Level 3; Widespread **TIME PERIOD OF CORRECTION:** Seven (7) days

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

   *Comments: The licensee failed to include in the FSEP site-specific staff actions that correspond with the building's layout, evacuation routes, and the methods for removing residents during a fire emergency. Part of the policy directed residents to perform a defend-in-place and to otherwise remain in place or move to a different floor. However, the building was not designed to support a defend-in-place strategy and lacked required life-safety features such as fire-resistant construction, smoke compartments, fire-rated doors, or a sprinkler system. Additionally, the FSEP inaccurately stated that the facility was equipped with a sprinkler system, fire alarm pull stations, and oxygen lines, which do not exist in the building. Maintaining a policy that does not reflect the actual building design or available safety features significantly increases risk to residents and may result in serious injury or death in the event of a fire.*

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

   *Comments: The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency.*