Electronically Delivered

October 28, 2026

Licensee
New Hope Care LLC
7949 Orchard Avenue North
Brooklyn Park, MN 55443

RE: Project Number(s) SL36973016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on September 30, 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.

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

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement;
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;
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 - 0340 - 144g.30 Subd. 5 - Correction Orders - $500.00
St - 0 - 0810 - 144g.45 Subd. 2 (b-F) - Fire Protection And Physical Environment - $500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $1,000.00**. 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

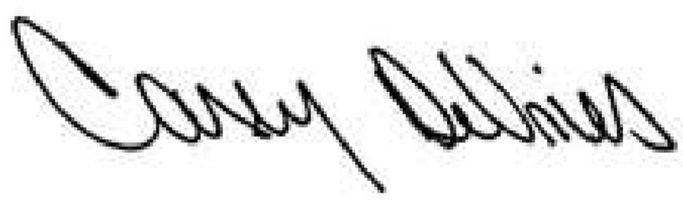
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms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



Casey DeVries, Supervisor
State Evaluation Team
Email: Casey.DeVries@state.mn.us
Telephone: 651-201-5917 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
	36973	A. BUILDING: _____ B. WING _____	09/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW HOPE CARE LLC	7949 ORCHARD AVENUE NORTH BROOKLYN PARK, MN 55443

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments *****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: SL36973016-0 On September 28, 2026, through September 30, 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 four residents; four receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 340 SS=F	144G.30 Subd. 5 Correction orders (a) A correction order may be issued whenever	0 340		

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0 340	Continued From page 1 the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, an agent of the facility, or staff of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction. (b) The commissioner shall mail or email copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must: (1) document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute their plan of correction (POC) following their previous routine and follow up (LOF) surveys concluded on July 30, 2024, and October 9, 2024, respectively. 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	0 340		

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0 340	Continued From page 2 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: The licensee received their correction orders via electronic delivery on August 26, 2024, following their July 30, 2024, survey, and October 21, 2024, following their LOF survey. The longest period for correction on the correction orders from the date of receipt was 21 days. MN Statute 144G.30 Subd. 5 (c) (1) indicates by the correction order date; the facility must document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon complaint investigation, and as otherwise needed. On September 28, 2026, through September 30, 2026, the Minnesota Department of Health conducted a routine survey and re-issued correction orders related to the following: - food safety; - emergency preparedness plan; - fire extinguishers; - physical-environment maintenance; - fire-safety and evacuation; - content of required orientation; and - service plan content. On September 30, 2026, at 2:00 p.m., licensed assisted living director (LALD)-D stated that they had implemented their POC, but that they could use additional assistance. When the surveyor asked LALD-D what they meant, LALD-D stated they would use the service of a consultant to help them to be compliant. During the review of the	0 340		

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0 340	Continued From page 3 licensee's POC with LALD-D regarding the above re issued tags, the surveyor determined that the licensee had not fully implemented their POC and had not identified or addressed the root causes of the issues. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 340		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (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	0 480		

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0 480	Continued From page 4 operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	0 480		

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0 480	Continued From page 5 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated September 29, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually	0 680		

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0 680	Continued From page 6 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 have a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all residents receiving services under the assisted living license. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's undated EPP lacked the following required content: - process for EPP collaboration; - development of EPP policies and procedures; - procedures for tracking staff and residents; - medical documents - policy and procedure; - arrangement with other facilities; - development of communication plan; - names and contact information; - emergency officials contact information; - primary and alternate means for communication;	0 680		

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0 680	Continued From page 7 - methods for sharing information; - sharing information on occupancy/needs; and - family notifications. On September 28, 2026, at 2:20 p.m., licensed assisted living director (LALD)-D stated they reviewed and updated their EPP to be compliant with state requirements, and that they were not aware it needed to be signed and dated. After the surveyor reviewed the licensee's EPP with LALD-D, LALD-D stated their EPP was still missing content. The licensee's Emergency Preparedness - Appendix Z Compliance policy dated May 15, 2025, indicated it is the intent that [licensee] has in place an effective and compliant Emergency Preparedness Plan. The plan will be aligned with the Centers for Medicare and Medicaid Services State Operation Manual Appendix Z: "State Operations Manual Appendix Z - Emergency Preparedness for All Provider and Certified Supplier Types: Interpretive Guidance." 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 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. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		

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0 775 SS=E	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated September 28, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Two (2) days	0 775		
0 790 SS=B	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment	0 790		

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0 790	Continued From page 9 (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. 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 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: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated September 28, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		

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0 800 SS=E	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, record review, and interview, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated September 28, 2026, for the specific violations related the physical environment under Minnesota Statute 144G.	0 800		

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0 800	Continued From page 11 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 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.	0 810		

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	36973	A. BUILDING: _____ B. WING _____	09/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW HOPE CARE LLC	7949 ORCHARD AVENUE NORTH BROOKLYN PARK, MN 55443

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 810	Continued From page 12 This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. 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). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated September 28, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff	01470		

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01470	Continued From page 13 person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation 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: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated	01470		

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01470	Continued From page 14 age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employees completed required orientation training prior to providing services, for three of three employees (unlicensed personnel (ULP)-B, ULP-C, ULP-F). 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). The findings include: ULP-B ULP-B started employment with the licensee on July 28, 2025, to provide assisted living services. ULP-C ULP-C started employment with the licensee on October 26, 2021, to provide assisted living	01470		

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01470	Continued From page 15 services. On September 29, 2026, at 8:30 a.m., and 12:27 p.m., the surveyor observed ULP-C administer medications to the licensee's residents. ULP-F ULP-F started employment with the licensee on October 22, 2022, to provide assisted living services. ULP-B, ULP-C, and ULP-F's training record lacked the following topics: - review of provider's policies and procedures; and - review of types of Assisted Living services the employee will provide and provider's scope of license. On September 29, 2026, at 1:50 p.m., clinical nurse supervisor (CNS)-A stated they had assigned all their employees the required training. CNS-A also stated they followed Residex (training software) syllabus to assign training. When the surveyor reviewed the syllabus with CNS-A, it lacked the missing topics noted above. The licensee's Staff Orientation and Education policy dated August 1, 2021, indicated all staff providing assisted living through the licensee will be prepared to provide safe, effective services to all residents through a thorough orientation and education program pertinent to the needs of the residents. The policy also included the missing topic above. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		

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01530 SS=F	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation	01530		

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01530	Continued From page 17 for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure direct care staff received the required two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date for three of three employees (unlicensed personnel (ULP)-B, ULP-C, ULP-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-B ULP-B started employment with the licensee on July 28, 2025, to provide assisted living services. ULP-B's My Transcript dated May 18, 2026, indicated ULP-B had completed 0.5 hours of mental illness training in the following topic: - mental illness 3 - personality disorders, substance abuse, and de-escalation. ULP-B's record lacked the following topics: - recognizing symptoms of common mental illness diagnoses, including but not limited to	01530		

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01530	Continued From page 18 mood disorders, anxiety disorders, trauma- and stressor-related disorders. - crisis resolution and suicide prevention, including procedures for contacting county crisis response teams, and 988 suicide and crisis lifelines. ULP-C ULP-C started employment with the licensee on October 26, 2021, to provide assisted living services. On September 29, 2026, at 8:30 a.m., and 12:27 p.m., the surveyor observed ULP-C administer medications to the licensee's residents. ULP-C's My Transcript dated March 14, 2026, indicated ULP-C had completed 0.5 hours of mental illness training in the following topic: - mental illness 3 - personality disorders, substance abuse and de-escalation. ULP-C's record lacked the following topics: - recognizing symptoms of common mental illness diagnoses, including but not limited to mood disorders, anxiety disorders, trauma- and stressor-related disorders; and - crisis resolution and suicide prevention, including procedures for contacting county crisis response teams and 988 suicide and crisis lifelines. ULP-F ULP-F started employment with the licensee on October 22, 2022, to provide assisted living services. ULP-F's My Transcript dated May 9, 2026, indicated ULP-F had completed 0.5 hours of mental illness training in the following topic:	01530		

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01530	Continued From page 19 - mental illness 3 - personality disorders, substance abuse and de-escalation. ULP-F's record lacked the following topics: - recognizing symptoms of common mental illness diagnoses, including but not limited to mood disorders, anxiety disorders, trauma- and stressor-related disorders; and - crisis resolution and suicide prevention, including procedures for contacting county crisis response teams, and 988 suicide and crisis lifelines. On September 29, 2026, at 2:20 p.m., licensed assisted living director (LALD)-D stated employees received eight hours of dementia care training via Educare (training software). LALD-D also stated they were not aware of the requirement for the initial two hours of mental illness training. The licensee's undated Dementia Education policy indicated direct care employees must have completed at least eight hours of initial dementia education within 160 working hours of the employment start date. The policy lacked verbiage for mental illness requirement. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01610 SS=D	144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment.	01610		

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01610	Continued From page 20 (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 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. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted a comprehensive assessment on, or before, the date of admission for one of three residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 was admitted to the licensee on August 24, 2026, for assisted living services. R2's Service Plan dated August 24, 2026,	01610		

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01610	Continued From page 21 indicated R2 received services for assistance with dressing, self-care, oral hygiene, hair care, grooming, toileting, bathing, medication reminders, laundry, meal preparation, and okay checks. R2's Admission Assessment was completed on August 25, 2026, a day after R2 was admitted. On September 30, 2026, at 1:30 p.m., clinical nurse supervisor (CNS)-A stated R2 was admitted late in the day and that they did not have enough time to complete the initial assessment the same day. The licensee's undated Comprehensive Resident Assessment policy indicated initial and ongoing assessments are the foundation for establishing a client service plan that addresses client needs and preferences and provides direction to agency staff. The policy lacked verbiage to include timeframe to complete initial assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01610		
01620 SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (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	01620		

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01620	Continued From page 22 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 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. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (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. (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. (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	01620		

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01620	Continued From page 23 resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted resident reassessment and monitoring no more than 14 calendar days after initiation of services for one of three residents (R2). In addition, the licensee failed to complete reassessment and monitoring at least every 90 calendar days for one of three residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R2 R2 was admitted to the licensee on August 24, 2026, for assisted living services. R2's Service Plan dated August 24, 2026, indicated R2 received services for assistance with dressing, self-care, oral hygiene, hair care, grooming, toileting, bathing, medication reminders, laundry, meal preparation, and okay checks. R2's Admission Assessment was completed on August 25, 2026, and 14-day assessment completed on September 29, 2026, 35 days after	01620		

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01620	Continued From page 24 the admission assessment was completed. R3 R3 was admitted to the licensee on September 4, 2025, for assisted living services. R3's Service Plan dated September 4, 2025, lacked the services R3 received. R3's Services Delivered - One Resident dated September 28, 2026, indicated R3 received services for behavior management, medication administration, safety check, socialization, and grooming. R3's record included three 90-day assessments completed on December 4, 2025, June 4, 2026, and September 4, 2026. R3's 90-day assessment completed on June 4, 2026, was 182 days late, and the assessment completed on September 4, 2026, was 117 days late. On September 30, 2026, at 1:40 p.m., clinical nurse supervisor (CNS)-A stated that R2 and R3 were impatient to allow CNS-A enough time to complete an assessment once it was started. CNS-A also stated they always waited 90 days to complete resident assessments which made it difficult to complete assessments timely. The licensee's undated Comprehensive Client Assessment indicated ongoing resident monitoring and reassessment must be conducted as needed based on changes in the needs of the client and cannot exceed 90 days from the last date of the assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	01620		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	Continued From page 25 (21) days	01620		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plan included all required content for three of three residents	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36973	A. BUILDING: _____ B. WING _____	09/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW HOPE CARE LLC	7949 ORCHARD AVENUE NORTH BROOKLYN PARK, MN 55443

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01650	Continued From page 26 (R2, R3, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2 R2 was admitted to the licensee on August 24, 2026, for assisted living services. R2's Service Plan dated August 24, 2026, indicated R2 received services for assistance with dressing, self-care, oral hygiene, hair care, grooming, toileting, bathing, medication reminders, laundry, meal preparation, and okay checks. R3 R3 was admitted to the licensee on September 4, 2025, for assisted living services. R3's Service Plan dated September 4, 2025, lacked the services R3 received. R3's Services Delivered - One Resident dated September 28, 2026, indicated R3 received services for behavior management, medication administration, safety check, socialization, and grooming. R4 R4 was admitted to the licensee on May 17,	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36973	A. BUILDING: _____ B. WING _____	09/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW HOPE CARE LLC	7949 ORCHARD AVENUE NORTH BROOKLYN PARK, MN 55443

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01650	Continued From page 27 2024, for assisted living services. R4's Service Plan dated May 17, 2024, indicated R4 received services for assistance with dressing, assistance with self-care, assistance with oral hygiene, assistance with hair care, grooming, toileting, bathing, stand by assistance, medication reminders, medication administration, laundry, meal preparation, housekeeping, linen change, and okay checks. R2, R3, and R4's service plan lacked the following required content: - the frequency; - the schedule and methods of monitoring staff providing services; - a contingency plan that includes: - information and a method to contact the facility; and - the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency. On September 30, 2026, at 1:55 p.m., licensed assisted living director (LALD)-D stated they thought their resident service plan had all required content. LALD-A also stated the service plans' pages may have been misplaced in their off-location office as they prepared to bring documents for survey. The licensee's undated Service Plan policy indicated assisted living services will be provided according to a suitable and current written service plan. The policy also indicated the service plan will include: a. a description of the home care services to be	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36973	A. BUILDING: _____ B. WING _____	09/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW HOPE CARE LLC	7949 ORCHARD AVENUE NORTH BROOKLYN PARK, MN 55443

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01650	Continued From page 28 provided b. the staff or categories of staff that will provide the services. c. the type and frequency of visits/services proposed to be furnished according to the client's current review/assessment and client preferences d. the fees for services. e. the schedule and methods of monitoring reviews or assessments of the client f. the frequency of sessions of supervision of staff and type of personnel who will supervise staff. g. plan for contingency action shall include: a. the action to be taken by the home care provider and by the client or client's representative if scheduled services cannot be provided. b. information and a method for a client or client's representative to contact the home care provider c. name and contact information of persons the client wishes to have notified in an emergency or if there is a significant change in the client's condition, including identification of person(s) who has authority to sign for the client in an emergency; d. the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the client under those chapters. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		

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

NEW HOPE CARE LLC
7949 ORCHARD AVENUE NORTH
Brooklyn Park, MN 55443
Hennepin County
Parcel:

Phone:

License Info

License: HFID 36973

Risk:
License:
Expires on:
CFPM: Chukwuemeka Joe Agbagbuo
CFPM #: CFPM-64937; Exp: 2/16/2029

Inspection Info

Report Number: F1039261268
Inspection Type: Full - Single
Date: 9/29/2026 Time: 1:00 PM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 1
Total Priority 2 Orders: 0
Total Priority 3 Orders: 1
Delivery: Emailed

New Order: 3-300C Protection from Contamination: equipment/utensils, consumers
3-304.14B *Priority Level: Priority 3 CFP#: 41*
MN Rule 4626.0285B Wiping cloths used for wiping counters and other equipment surfaces must be held in an approved sanitizing solution and laundered daily.
COMMENT: SOILED WIPING CLOTH HELD ON COUNTER BESIDE SINK. STAFF SENT CLOTH FOR LAUNDERING. INSTRUCTED STAFF TO STORE ANY WIPING CLOTH IN SANITIZER SOLUTION.
Comply By: 9/29/2026 Originally Issued On: 9/29/2026

! **New Order: 4-600 Cleaning Equipment and Utensils**
4-602.11A *Priority Level: Priority 1 CFP#: 16*
MN Rule 4626.0845A Clean and sanitize food-contact surfaces of equipment and utensils: 1. before each use with a different type of raw animal food; 2. each time there is a change from working with raw foods to working with ready-to-eat foods; 3. between uses with raw fruits and vegetables and TCS foods; 4. before using or storing a food temperature measuring device; 5. at any time during the operation when contamination may have occurred.
COMMENT: STORED DIGITAL THERMOMETER IS SOILED ON PROBE. INSTRUCTED PERSON-IN-CHARGE TO CLEAN AND SANITIZE PROBE AFTER AND BEFORE USE. PROBE CLEANED AND SANITIZED.
Comply By: Complied On Site Originally Issued On: 9/29/2026

Food & Beverage General Comment

PICKLE - HOLD, COOLER - 41 DEGREES F
FREEZERS - FROZEN

This inspection was completed as part of MDH HRD assisted living facility survey. The inspection was conducted with the person-in-charge and reviewed with MDH HRD nurse evaluator Benard Nyangena.

The kitchen is of residential build and should serve food for same-day service only.

The kitchen has wood cabinets with hollow base and faux-stone countertops, tiled floor, painted walls and ceiling. These kitchen finishes and surfaces are in good repair, clean and well maintained.

A 2-compartment sink is present in kitchen. 1 compartment is designated for handwashing only.

A residential dishwashing machine is present in the kitchen.

Verified hand sink correctly set-up, gloves, illness policy, probe thermometer, UST measuring device.

Discussed the following with the person-in-charge: minimum cook temps for animal proteins, food source, foodborne illness symptoms and exclusion of ill employees, avoiding bare hand contact with ready to eat foods, handwashing, cleaning/sanitizing, vomit clean-up procedures, all orders on this report.

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 F1039261268 from 9/29/2026

Chukwuemeka Joe Agbagbuo
person-in-charge

Aron Goodner,
Public Health Sanitarian
651-201-4910
aron.goodner@state.mn.us

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

Sanitizer Observations/Recordings

Establishment Info

NEW HOPE CARE LLC
Brooklyn Park
County/Group: Hennepin County

Inspection Info

Report Number: F1039261268
Inspection Type: Full
Date: 9/29/2026
Time: 1:00 PM

Sanitizing Chemical: Product: Hot Water**; Sanitizing Process:** Dish Machine
Location: Greater Than 160 PPM
Comment: BY THERMO TEST STRIP LOG MAINTAINED BY ESTABLISHMENT. LAST TEST DATED 9/22.
Violation Issued?: No

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL36973016-0	**Date:** September 28, 2026
Facility Name: New Hope Care LLC	
Facility Address: 7949 Orchard Avenue North, Brooklyn Park, MN 55443	

☒ **TAG IDENTIFICATION: 0775**

SCOPE/ SEVERITY: Level 2; Pattern **TIME PERIOD OF CORRECTION:** Two (2) days

1. Each assisted living facility must comply with the provisions of the Minnesota State Fire Code (MSFC) in Minnesota Rules chapter 7511. [Minn. Stat. 144G.45 subd. 2]

2. A means of egress shall be free from obstructions that would prevent its use, including the accumulation of snow and ice. [Minn. Stat. 144G.45 subd. 2; MSFC 1031.3]

   Comments:
   - In occupied resident bedroom two, the egress window was obstructed by the headboard attached to the bed.
   - In occupied resident bedroom three, the egress window was obstructed by the storage of boxes in front of the window.
   These obstructions would delay exiting through an egress window in the event of a fire or similar emergency.

3. Lighted matches, cigarettes, cigars or other burning objects shall not be discarded in such a manner that could cause ignition of other combustible material. [Minn. Stat. 144G.45 subd. 2; MSFC 310.7]

   Comments: On the exterior of the building, in the designated smoking area on the back deck, ashes and several burnt cigarettes had been discarded on the top surfaces of the wood deck. Licensed assisted living director (LALD)-D stated two designated smoking areas were provided with disposal containers for smoking materials. LALD-D explained two residents were unable to use the stairs to access the smoking area in the backyard and these residents used the deck. LALD-D stated they believed the ashes on the deck were from a recent spill and they were not unaware of the burnt cigarettes on the deck surfaces. Improper smoking material disposal creates a fire hazard.

4. Relocatable power taps (power strips) shall be directly connected to a permanently installed receptacle. [Minn. Stat. 144G.45 subd. 2; MSFC 604.4.2]

   Comments: Two power strips were daisy chained together in occupied resident bedroom four, creating an electrical fire hazard.

5. Extension cords and flexible cords shall not be a substitute for permanent wiring. [Minn. Stat. 144G.45 subd. 2; MSFC 604.5]

   Comments: On the main floor level, an extension cord was attached to the wall and used to supply power to the security camera system.

☒ **TAG IDENTIFICATION: 0790**

SCOPE/ SEVERITY: Level 1; Pattern **TIME PERIOD OF CORRECTION:** Seven (7) days

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1. Portable fire extinguishers installed and maintained to MN State Fire Code. [Minn. Stat. 144G.45 subd.2]

   Comments: Inspections were not recorded on the back of the tag attached to the portable fire extinguisher mounted on the dining room wall. Licensed assisted living director (LALD)-D verified these inspections were lacking. Fire extinguisher inspections shall be conducted and documented every month to ensure each extinguisher is in its designated place, it has not been tampered with, and there is no obvious physical damage or condition that would interfere with its use or operation.

☒ **TAG IDENTIFICATION: 0800**

SCOPE/ SEVERITY: Level 2; Pattern **TIME PERIOD OF CORRECTION:** Seven (7) days

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1. The physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment are 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. [Minn. Stat. 144G.45 subd.2]

   Comments:
   - The knob was missing from one side of the closet door in the entryway.
   - In the main floor shared resident bathroom, two light bulbs were missing from the light fixture above the sink, and one bulb in this fixture was burnt out. Additionally, a wall mounted towel bar was broken.
   - In the basement shared resident bathroom, one light bulb was missing from the light fixture above the sink vanity.

- The area under the basement stairs was used inappropriately for storage. There was a hole in the wall where drywall was missing and there were gaps between the drywall and metal ductwork.
- On the exterior of the garage door, one section of weatherstripping was missing.
- The exterior fence that enclosed the backyard was in disrepair. One fence panel was not securely attached with a broken board, creating a safety risk to residents. Both fence gates were dragging on the ground making these gates difficult to operate.

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Twenty One (21) days

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1. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that are readily available at all times within the facility. [Minn. Stat. 144G.45 subd.2]

   Comments:
   - Licensed assisted living director (LALD)-D stated the individualized evacuation procedures for three residents were kept in the files at the main office. These procedures were not readily available in the event of an emergency to all building occupants and emergency responders.
   - The licensee emailed the surveyor a copy of a fire safety and evacuation plan (FSEP) that did not match the FSEP displayed on the wall in the main floor living room. All FSEP procedures shall be maintained as readily available onsite at the facility.

2. 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 fire safety and evacuation plan (FSEP) was not developed and maintained with site specific employee actions to take in the event of a fire or similar emergency. Record review of the available documentation indicated the following:
   - Portable fire extinguisher locations were not accurately identified on the safety information document displayed on the wall in the main floor living room.
   - The FSEP included general employee actions but failed to include procedures relative to the facility's building layout and environmental risks.
   - A third party RACE (Remove, Alarm, Confine, Extinguish/Evacuate) template was displayed on the wall in the main floor living room that inaccurately directed employees to use pull fire alarms.
   - The FSEP provided to the surveyor by email was a template from a third party and lacked site specific employee actions.

3. 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: Licensed assisted living director (LALD)-D stated the fire safety and evacuation plan was posted on the wall in the main floor living room. Record review indicated the licensee failed to develop site specific fire safety and evacuation instructions for residents evident by the lack of these procedures in this plan. Additionally, there were no written procedures for use of emergency escape and rescue openings (egress windows) in resident bedrooms.

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

   Comments:
   - Licensed assisted living director (LALD)-D stated the fire safety and evacuation plan (FSEP) was posted on the wall in the main floor living room. This FSEP failed to include evacuation procedures for the individualized unique needs of residents and lacked instructions on where this information was maintained.
   - LALD-D provided a personalized emergency evacuation plan for one resident, dated September 4, 2025. This plan indicated the resident required supervision during an evacuation but lacked information on what type of assistance would be needed.

5. Employees of assisted living facilities shall receive training on the fire safety and evacuation plans (FSEP) upon hiring and at least twice per year thereafter. [Minn. Stat. 144G.45 subd.2]

   Comments: The surveyor requested records for employee training on the fire safety and evacuation plan (FSEP) completed at the time of hire and in the past year from the licensee. Employee FSEP training records were not provided for review when requested. The licensee stated these records were not available. Employee training on the FSEP was not completed at the required frequency.

6. 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. [Minn. Stat. 144G.45 subd.2]

   Comments: The surveyor requested records for resident training on fire safety and evacuation completed in 2025 and 2026 from the licensee. Resident training records were not provided for review when requested. The licensee stated these records were not available. Resident training was not completed at the required frequency.