Electronically Delivered

September 3, 2026

Licensee
We Do Care LLC
9812 Chicago Avenue South
Bloomington, MN 55420

RE: Project Number(s) SL41558001

Dear Licensee:

This is your **official notice** that you have been **granted your assisted living facility license.** Your license effective and expiration dates remain the same as on your provisional license. Your updated status will be listed on the license certificate at renewal and **this letter serves as proof** in the meantime. If you have not received a letter from us with information regarding renewing your license within 60 days prior to your expiration date, please contact us at (651) 201-5273 or by email at Health.assistedliving@state.mn.us.

The Minnesota Department of Health completed an initial survey on August 5, 2026, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

The Department of Health 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. The Department of Health documents state correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Home Care Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance 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 - 0810 - 144g.45 Subd. 2 (b-F) - Fire Protection And Physical Environment - $500.00

The total amount you are assessed is $500.00. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
Per 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 residents/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 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 the Department of Health 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 MDH 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,

Renee L. Anderson

Renee L. Anderson, Supervisor
State Evaluation Team
Email: Renee.L.Anderson@state.mn.us
Telephone: 651-201-5871 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41558	A. BUILDING: _____ B. WING _____	08/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WE DO CARE LLC	9812 CHICAGO AVE S BLOOMINGTON, MN 55420

(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: SL41558001-0 On August 3, 2026, through August 5, 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 was one resident; one receiving services under the Provisional 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.	
0 460 SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request	0 460		

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0 460	Continued From page 1 assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide a means for residents to request assistance for health and safety needs 24 hours per day, seven days per week. 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:	0 460		

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0 460	Continued From page 2 On August 3, 2026, at 10:17 a.m., during the entrance conference, administrator/unlicensed personnel (A/ULP)-C stated the licensee had a system for the residents to summon staff 24/7, however, the system was not currently being used. A/ULP-C stated all five resident rooms included the same summoning device system (four rooms were unoccupied) and they were also not currently being used. During a facility tour on August 3, 2026, at 11:29 a.m., the surveyor and A/ULP-C observed R1's bedroom and summoning device. R1 stated he had never used the device. R1 pressed his summoning device, and the light did not illuminate on the button and no alarm sounded. A/ULP-C checked the device and stated there were no batteries in place. On August 3, 2026, at 12:23 p.m., during the survey, A/ULP-C installed batteries into R1's summoning device and tested for an audible alarm. When the summoning device was pressed, an audible alarm was heard from a central location in the main living area of the facility. The licensee's 2.01 24-Hour Emergency Response policy, dated September 1, 2024, identified: "1. All residents are given instructions on the use of emergency response systems upon move-in and ongoing, as needed. 2. Pressing the button on the emergency response button or pulling an emergency response cord will activate the response system which will notify a designated staff person. 3. An emergency cell phone will be carried at all times by a designated staff person. All emergency cell phones will be answered	0 460		

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0 460	Continued From page 3 immediately. 4. The system will be tested on a regular basis, and no less than annually by the management staff of [Licensee] 5. The emergency system is to be used for any emergency need." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 460		
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	0 480		

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0 480	Continued From page 4 clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, 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	0 480		

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0 480	Continued From page 5 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: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated August 4, 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		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health.	0 550		

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0 550	Continued From page 6 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to support protection and safety by not posting the licensee's grievance procedure, with the current name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. This had the potential to affect all residents, staff, and visitors of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: On August 3, 2026, at 11:16 a.m., during a tour of the facility with licensed assisted living director (LALD)-A, administrator/unlicensed personnel (A/ULP)-C, and ULP-E, the surveyor observed the licensee's postings. The required grievance posting lacked contact information including the name, email, and phone number for the individual responsible for handling resident grievances. A/ULP-C verified the posting lacked the required information and said she was not aware of this required content. The licensee's 2.10 Complaint / Grievance Posting policy, dated September 1, 2024, identified, "[Licensee] will post, in a conspicuous place, information about our complaint/grievance procedure, and the name, telephone number, and	0 550		

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0 550	Continued From page 7 email contact information for the individual(s) who are responsible for handling resident complaint/grievances." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to engage in and maintain documentation of quality management activity appropriate to the size of the facility and relevant to the type of services provided. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	0 580		

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0 580	Continued From page 8 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: On August 3, 2026, at 10:17 a.m., during the entrance conference, administrator/unlicensed personnel (A/ULP)-C stated they admitted the first resident on December 16, 2025, and they had quality management conversations but lacked documentation for a quality management meeting. The licensee lacked documentation on quality management activities to evaluate quality of care. The licensee's 2.31 Quality Management Project policy, dated September 1, 2024, indicated, "[Licensee] will have at least 2 Quality Improvement (QI) meetings in a year and they will keep the documentation for at least 2 years. The facility will participate in QI management in accordance to the services provided. During the QI meeting the management and staff will address any issues, and determine if changes need to be made for improvement." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 580		
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an	0 630		

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0 630	Continued From page 9 individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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: R1 was admitted on December 16, 2025, and had diagnoses which included anxiety, major depressive disorder, schizoaffective disorder (a mental health disease), traumatic brain injury, opioid dependence, and substance abuse. R1's signed Addendum to Contract - Waiver - MN (service agreement) dated December 17, 2025, indicated R1 received services including	0 630		

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0 630	Continued From page 10 assistance with bathing reminders, dressing, grooming, socialization, behavior management, and medication administration. R1's record included an IAPP dated March 16, 2026. The document lacked the following required content: -the person's risk of abusing other vulnerable adults; and -statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. During a phone interview on August 5, 2026, at 8:00 a.m., clinical nurse supervisor (CNS)-B stated she was not aware of all the requirements for the IAPP or that R1's IAPP was missing an assessment of his risk of abuse to other vulnerable adults and specific interventions for staff. CNS-B stated she would follow up with the licensee's electronic medical record provider to add this additional assessment question. The licensee's 2.44 Vulnerable Adult Maltreatment - Prevention & Reporting policy dated September 1, 2024, identified, "Consistent with the Minnesota Vulnerable Adults Act and Assisted Living licensure regulations, [Licensee] prohibits the maltreatment of residents. To support this prohibition, [Licensee] educates clients, family members, and staff (mandated reporters) about how to report suspected maltreatment internally and to the Minnesota Adult Abuse Reporting Center (MAARC). [Licensee] also develops individualized vulnerable adult abuse prevention plans to identify vulnerability risks and develop measures to minimize maltreatment based on identified information."	0 630		

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0 630	Continued From page 11 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), to include baseline testing (either by a two-step tuberculin skin test (TST) or a single interferon gamma release assay (IGRA) TB blood test) for one of three employees (clinical nurse supervisor (CNS)-B). This practice resulted in a level two violation (a	0 660		

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	41558	A. BUILDING: _____ B. WING _____	08/05/2026

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0 660	Continued From page 12 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: The licensee's TB Facility Risk Assessment worksheet, dated October 25, 2025, indicated the facility was at low risk for TB transmission. CNS-B was hired March 27, 2025, to provide direct nursing care and supervision for the licensee's residents. CNS-B's employee record included a TB history and symptom screening form dated March 15, 2025, a negative TB Gold QuantiFERON blood test dated June 28, 2019, more than 90 days before date of hire, and a chest x-ray dated April 21, 2025, 25 days after date of hire. CNS-B's record and lacked documentation of baseline testing (either by a two-step tuberculin skin test (TST) or a single interferon gamma release assay (IGRA-TB blood test) within 90 days of hire date. CNS-B's record further lacked documentation of a positive TB test correlated with the negative TB chest x-ray. On August 3, 2026, at 1:11 p.m., administrator/unlicensed personnel (A/ULP)-C stated she was not aware a positive test correlating to the chest x-ray was required to be kept in CNS-B's employee file and was not sure CNS-B had a baseline test completed and said	0 660		

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0 660	Continued From page 13 she would check with CNS-B. On August 5, 2026, at 8:00 a.m., CNS-B stated, via phone, she typically would visit the facility every one or two weeks and as needed for resident care needs. CNS-B verbalized she would check to see if she had any records of her positive baseline testing. The licensee's 8.16 Tuberculosis Screening policy dated September 1, 2024, indicated, "Screening will be conducted as follows: 1. New staff will be screened for active signs of TB using the Baseline TB Screening Tool for HCWs. 2. New staff will have an IGRA blood test or a two-step Mantoux conducted with results documented on the Baseline TB Screening Tool for HCWs. 3. No staff will be permitted to begin work where the work involves sharing the air space with residents until the negative results of the first Mantoux are read and documented or a negative IGRA blood test result is received and documented. 4. Staff TB screening results will be kept in each employee medical file. 5. Staff should be screened for signs and symptoms on an annual basis." The CDC's Tuberculosis Screening, Testing, and Treatment of U.S. Health Care Personnel: Recommendations from the National Tuberculosis Controllers Association and CDC dated May 16, 2019, recommended all health care professionals complete a TB screening including a symptom evaluation and an IGRA or TST. Health care workers with written documentation of a previous positive TST or IGRA should have documented in their record:	0 660		

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0 660	Continued From page 14 test results, assessment for current TB symptoms and a related chest x-ray. The Minnesota Department of Health (MDH) Regulations for TB Control in Minnesota Health Care Settings, dated July 2013, indicated baseline TB screening consists of three components: 1. Assessing for current symptoms of active TB disease, 2. Assessing TB history, and 3. Testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step TST or single IGRA. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
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	0 810		

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0 810	Continued From page 15 upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to 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	0 810		

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0 810	Continued From page 16 August 5, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: twenty-one (21) days	0 810		
01530 SS=D	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	01530		

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01530	Continued From page 17 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 for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure required dementia care training and two hours of initial mental illness and de-escalation training were conducted within 120 working hours of the employment start date for one of two employees (clinical nurse supervisor (CNS)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: CNS-B was hired March 27, 2025, and provided direct nursing care services for the one resident who admitted on December 16, 2025. CNS-B's employee record lacked documentation she completed the required two hours of initial	01530		

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01530	Continued From page 18 training on mental illness and de-escalation topics within 120 hours of start date. On August 5, 2026, at 8:00 a.m., CNS-B stated she thought she had completed all the required training but would look at her online education transcript to see if she could provide the documentation of mental health and de-escalation training by the end of the day. As of August 6, 2026, after the survey concluded, no additional mental health and de-escalation training was submitted to the surveyor for CNS-B. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01620 SS=F	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 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	01620		

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01620	Continued From page 19 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 resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a registered nurse (RN) conducted resident monitoring and reassessment including ongoing reassessments not to exceed 90 days from the previous assessment, for one of one resident (R1).	01620		

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01620	Continued From page 20 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: R1 was admitted on December 16, 2025, and had diagnoses including anxiety disorder, cocaine abuse, major depressive disorder, other schizoaffective disorders (a mental health disease), and history of traumatic brain injury. R1's signed Addendum to Contract - Waiver - MN (service agreement), effective December 16, 2026, indicated R1 received services including assistance with activities of daily living (ADL) reminders, socialization, transportation, managing behavior, and medication administration. On August 3, 2026, at 1:35 p.m., the surveyor observed unlicensed personnel (ULP)-D assist R1 with prepping medication administration to be administered during planned time away from the facility. R1's medical record included a nursing reassessment, dated March 16, 2026, and a subsequent reassessment dated July 19, 2026, greater than 90 days (125 days) after the previous assessment. On August 5, 2026, at 8:00 a.m., clinical nurse supervisor (CNS)-B stated, via phone, R1's	01620		

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01620	Continued From page 21 assessments must have been completed late. CNS-B verbalized she thought the frequency of resident assessments were to be completed every 120 days. The licensee's 6.01 Assessments, Reviews & Monitoring policy, effective September 1, 2024, indicated, "3. Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01690 SS=F	144G.71 Subdivision 1 Medication management services (a) This section applies only to assisted living facilities that provide medication management services. (b) An assisted living facility that provides medication management services must develop, implement, and maintain current written medication management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse, licensed health professional, or pharmacist consistent with current practice standards and guidelines. (c) The written policies and procedures must address requesting and receiving prescriptions for medications; preparing and giving	01690		

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01690	Continued From page 22 medications; verifying that prescription drugs are administered as prescribed; documenting medication management activities; controlling and storing medications; monitoring and evaluating medication use; resolving medication errors; communicating with the prescriber, pharmacist, and resident and legal and designated representatives; disposing of unused medications; and educating residents and legal and designated representatives about medications. When controlled substances are being managed, the policies and procedures must also identify how the provider will ensure security and accountability for the overall management, control, and disposition of those substances in compliance with state and federal regulations and with subdivision 23. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure accountability of controlled substances was maintained by failure to implement the policy for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On August 3, 2026, at 10:17 a.m., during the entrance conference, licensed assisted living	01690		

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01690	Continued From page 23 director (LALD)-A and administrator/unlicensed personnel (A/ULP)-C stated the licensee provided medication management, including controlled substance monitoring and administration for R1. R1 was admitted on December 16, 2025, and had diagnoses which included anxiety, major depressive disorder, schizoaffective disorder (a mental health disease), traumatic brain injury, opioid dependence, and substance abuse. R1's record included a signed Addendum to Contract - Waiver - MN (service agreement), dated December 17, 2025, indicated R1 received services including assistance with bathing reminders, dressing, grooming, socialization, behavior management, and medication administration. R1's medication administration record (MAR) dated August 2026, indicated R1 was administered the following scheduled controlled substance: -buprenorphine and naloxone (Suboxone) (used to treat opioid disorder) 2 milligrams (mg) - 0.5 mg, take one half a film (medication strip), sublingually, three times daily at 9:00 a.m., 3:00 p.m., and 9:00 p.m. R1's record included a report titled "Medications Controlled Recap by Staff," dated July 2, 2026, to August 4, 2026. This report lacked documentation of controlled substance counts in 98 out of 100 controlled medication date entries. R1's record included a "Pill Count History" dated July 1, 2026, to August 4, 2026. The report indicated 11 out of 100 discrepancies on R1's buprenorphine and naloxone 2 mg-0.5 mg, count of remaining medications as highlighted on the	01690		

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01690	Continued From page 24 report. On August 3, 2026, from 1:35 p.m. to 1:45 p.m., during continuous observation, the surveyor observed unlicensed personnel (ULP)-D prepare R1's medications to be administered outside of the facility for an appointment ULP-D planned to attend with R1. ULP-D opened R1's mediset (medication cartridge system) section labeled Monday midday and emptied the medication into a clear baggy. Next, ULP-D obtained an unlabeled baggy in the locked cabinet that included five packaged Suboxone medication strips. ULP-D took out one of the Suboxone strips and cut it in half, placed it into a medication cup, and then placed it into the clear baggy with the oral medication. When asked, ULP-D stated after he administered the medications, he would document them in R1's electronic medical record, which he could access using a cell phone. Without counting the controlled substances or labeling the medications in baggy for R1's time away, ULP-D locked the medication cabinet and then left the facility with R1 and the medications in the clear unlabeled baggy to go to the appointment. On August 3, 2026, at 1:50 p.m., A/ULP-C stated the narcotics were counted during every change of shift. On August 4, 2026, from 9:01 a.m. to 9:35 a.m., during continuous observation, the surveyor observed A/ULP-C assist R1 with medication administration, which included the Suboxone medication. A/ULP-C counted and documented the controlled substance quantity during this medication administration. The Suboxone controlled substance count was 79.5 strips remaining at the time of the observation.	01690		

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01690	Continued From page 25 On August 4, 2026, at 9:40 a.m., A/ULP-C stated, the licensee had used a narcotic logbook for documenting controlled substance counts but no longer used the narcotic logbook. A/ULP-C verbalized the employees were trained by the nurse to document the controlled substance counts with each controlled medication administration in the electronic medical record (EMR). The surveyor requested the licensee print a controlled substance count report from the EMR and to review the narcotic logbook the licensee previously used. On August 4, 2026, at approximately 11:30 a.m., A/ULP-C provided a Patient Narcotic's Logbook used for R1's Suboxone controlled substance. Counts were documented from February 5, 2026, to April 10, 2026, at 3:00 p.m., and included no further documentation of Suboxone quantities. The log also lacked signatures or initials of who completed the counts on multiple dates each month. A/ULP-C verbalized she planned to re-implement the use of the narcotic logbook to monitor R1's controlled substance. A/ULP-C stated she planned to have the nurse complete additional education and oversight on the controlled medications. On August 4, 2026, at 2:01 p.m., A/ULP-C stated, via email, "Residex (electronic medical record provider) got back to me and sent me how to get the report you wanted. Please see attached report. I can see mistakes clearly." On August 5, 2026, at 8:00 a.m., clinical nurse supervisor (CNS)-B stated she was not aware of the employees not routinely counting and documenting the controlled substances.	01690		

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01690	Continued From page 26 R1's controlled substance monitoring lacked narcotic log records according to the licensee's policy. The licensee's 7.26 Narcotic Log policy dated September 1, 2024, indicated, "Staff at [Licensee] who administer Schedule II controlled substances must participate in recording Schedule II medications in the bound narcotic log book." In addition, included, "4. All Schedule II controlled substances will be counted and recorded on the narcotic count sheet and compared with the quantities listed in the Narcotic Log Book. This will occur at the start of the day shift and during the evening shift. This count will only be recorded in the narcotic count sheet and not on the MAR. The MAR will only reflect the initials of the staff that administered the medication." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01690		
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, a registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following:	01730		

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01730	Continued From page 27 (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and maintain an individualized medication management plan for each resident to include all required content for one of one resident (R1).	01730		

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01730	Continued From page 28 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 was admitted on December 16, 2025, and had diagnoses which included anxiety, major depressive disorder, schizoaffective disorder (a mental health disease), traumatic brain injury, opioid dependence, and substance abuse. R1's record included a signed Addendum to Contract - Waiver - MN (service agreement), dated December 17, 2025. The service agreement indicated R1 received services including assistance with bathing reminders, dressing, grooming, socialization, behavior management, and medication administration. On August 3, 2026, at 1:35 p.m., the surveyor observed unlicensed personnel (ULP)-D prepare R1's medications to be administered outside of the facility for an appointment ULP-D planned to attend with R1. R1's record included a nursing assessment and Individualized Medication Management Plan both dated July 19, 2026, but the medication plan lacked the following required content: -a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's	01730		

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01730	Continued From page 29 directions; -procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and -any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. On August 5, 2026, from 8:00 a.m. to 8:52 a.m., during a phone call with clinical nurse supervisor (CNS)-B, CNS-B stated she was not aware the IMMP plan for R1 did not include all the required content. CNS-B verbalized she planned to follow up with the licensee's electronic medical record provider to include the additional required content for medication assessments. The licensee's 7.03 Medication Management Individualized Plan policy dated September 1, 2024, indicated, "1. [Licensee] will develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: a. A statement describing the medication management services that will be provided b. A description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions c. Documentation of specific resident	01730		

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01730	Continued From page 30 instructions relating to the administration of medications d. Identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis e. Identification of medication management tasks that may be delegated to unlicensed personnel f. Procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services, and g. Any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions 2. The medication management record will be current and updated when there are any changes. 3. Medication reconciliation will be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01750 SS=F	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated	01750		

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01750	Continued From page 31 the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure delegated procedures were followed for one of one resident (R1) observed during medication observation. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 was admitted on December 16, 2025, and had diagnoses which included anxiety, major depressive disorder, schizoaffective disorder (a mental health disease), traumatic brain injury, opioid dependence, and substance abuse. R1's signed Addendum to Contract - Waiver - MN (service agreement) dated December 17, 2025, indicated R1 received services including assistance with bathing reminders, dressing, grooming, socialization, behavior management, and medication administration. On August 3, 2026, from 1:35 p.m. to 1:45 p.m.,	01750		

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01750	Continued From page 32 the surveyor observed unlicensed personnel (ULP)-D prepare R1's afternoon medications to be administered outside of the facility on an appointment ULP-D was attending with R1. Without performing the six rights of medication administration and comparing the medications to the electronic medical record, ULP-D opened R1's mediset (medication cartridge system) labeled Monday midday and emptied one pill into a clear baggy. Next, ULP-D obtained another baggy in locked cabinet that included five unlabeled packaged Suboxone (for opioid disorder) medication strips. ULP-D took out one of the Suboxone strips and cut it in half and placed it into a medication cup and then placed it into the clear baggy with the oral medications. When asked, ULP-D stated he was trained by the nurse on medication administration and he should have compared R1's medications to the electronic medical record (EMR) before administration, but he forgot this step today. R1's medication administration record (MAR) dated August 2026, indicated R1 received assistance with administration of the following: -Aspirin (for pain and blood thinner) 81 milligrams (mg), by mouth daily; -buprenorphine and naloxone (for opioid disorder) 2 mg-0.5 mg, take 1/2 film sublingual, three times daily; -fluoxetine (for depression) 20 mg, take one capsule by mouth daily together with 40 mg; -folic acid (a supplement) 1 mg, take one tablet by mouth, three times daily; -gabapentin (for nerve pain) 600 mg, take one tablet by mouth, three times daily; -multiple vitamin (a supplement) capsule, take one tablet by mouth daily; -omeprazole (to decrease stomach acid) 40 mg, take one capsule daily before a meal;	01750		

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01750	Continued From page 33 -senna docusate sodium (for constipation) 8.6 - 50 mg, take one tablet by mouth, twice daily; -baclofen (a muscle relaxant) 5 mg, take one tablet, three times daily; -Caplyta (an atypical antipsychotic) 42 mg, take one tablet by mouth every bedtime; -Flomax (treats weak urine flow) 0.4 mg, take two capsules by mouth, every evening; -rosuvastatin (for high cholesterol) 20 mg, take one tablet by mouth, daily at bedtime; and -Seroquel (an anti-psychotic) 200 mg, take one tablet by mouth, daily at bed. On August 3, 2026, at 2:10 p.m., clinical nurse supervisor (CNS)-B stated, via phone, she set up R1's medications into a mediset every one to two weeks and then she instructed the ULPs to choose the correct mediset section for day and time of medications to be administered and to place those medications into a medication cup and administer to the resident. CNS-B stated she believed this process was adequate and they had not found a way to compare the medications in the mediset to the medication administration record. On August 3, 2026, at 2:28 p.m., administrator/ULP (A/ULP)-C stated she planned to work with the nurse to create a new medication administration process to ensure ULPs followed the six rights of medication administration. The licensee's 7.08 Medication Management - Administration & Setup policy, dated September 1, 2024, indicated, "8. A licensed nurse will set up medications in dosage boxes for the resident, usually on a weekly basis, and will make or direct changes between set ups when necessary. ULP will verify medications are set up correctly in the dosage box before administration to the resident	01750		

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01750	Continued From page 34 by use of the medication profile. If any question of medication accuracy in the dosage box arises, the unlicensed staff will contact the licensed nurse and receive direct instructions on handling any necessary changes at that time, while in direct contact with the nurse." The licensee's 7.15 Medication & Treatment - Administration & Delegation policy, dated September 1, 2024, indicated, "I. Performing medication management services, medication reminders, assistance, or administration. When medication management is delegated to a ULP, the RN will: i. Instruct the unlicensed personnel in the proper methods to administer the medications ii. Verify the unlicensed personnel has demonstrated the ability to competently follow the procedures iii. Specify, in writing, specific instructions for each resident and document those instructions in the resident's record iv. Communicate with the unlicensed personnel about the individual needs of the resident." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01790 SS=D	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days;	01790		

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01790	Continued From page 35 (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the	01790		

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01790	Continued From page 36 registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) trained the unlicensed staff and determined the unlicensed staff was competent to follow the procedures for giving medications to residents during unplanned times away as required for one of two unlicensed personnel (ULP-D). 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: ULP-D was hired on December 15, 2025, to provide direct care services to the licensee's residents.	01790		

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01790	Continued From page 37 On August 3, 2026, from 1:35 p.m. to 1:45 p.m., the surveyor observed unlicensed personnel (ULP)-D prepare R1's afternoon medications to be administered outside of the facility for an appointment ULP-D was attending with R1. Without performing the six rights of medication administration and comparing the medications to the electronic medical record, ULP-D opened R1's mediset (medication cartridge system) labeled Monday midday and emptied one pill into a clear baggy. Next, ULP-D obtained another baggy in locked cabinet that included five unlabeled packaged Suboxone (for opioid disorder) 2 milligrams (mg) -0.5 mg, medication strips. ULP-D took out one of the Suboxone strips and cut it in half and placed it into a medication cup and then placed it into the clear baggy with the oral medications. The remaining medication strips were locked back up in the medication cabinet. Finally, without labeling the baggy with medications, ULP-D left the facility with R1 and the afternoon medications in a baggy. The medications lacked a label with the resident's name and the dates and times that the medications were scheduled to be administered. On August 3, 2026, at 2:10 p.m., clinical nurse supervisor (CNS)-B stated, via phone, that she trained the unlicensed personnel on the licensee's unplanned time away medication administration policy. CNS-B verbalized ULP-D must have forgotten to label R1's medications when he took the medications for R1 to be administered outside of the facility. CNS-B stated she planned to provide education for all staff. The licensee's 7.10 Medication Management - Planned & Unplanned Time Away policy dated September 1, 2024, indicated, "2. The registered nurse has developed written procedures for the	01790		

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01790	Continued From page 38 unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: a. the type of container or containers to be used for the medications appropriate to the provider's medication system b. how the container or containers must be labeled c. the written information about the medications to be given to the resident or resident's representative d. how the unlicensed staff must document in the resident's record that medications have been given to the resident or the resident's representative, including documenting the date the medications were given to the resident or the resident's representative and who received the medications, the person who gave the medications to the resident, the number of medications that were given to the resident, and other required information e. how the registered nurse shall be notified that medications have been given to the resident or resident's representative and whether the registered nurse needs to be contacted before the medications are given to the resident or the resident's representative f. a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel g. how the unlicensed staff must document in the resident's record any unused mediations that are returned to the provider, including the name of each medication and the doses of each returned medication." No further information was provided.	01790		

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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
01790	Continued From page 39 TIME PERIOD FOR CORRECTION: Seven (7) days	01790		
01820 SS=F	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure there were current written or electronically recorded prescriptions as defined in section 151.01, subdivision 16 a, for all prescribed medications that the assisted living facility was managing for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 was admitted on December 16, 2025, and had diagnoses which included anxiety, major depressive disorder, schizoaffective disorder (a mental health disease), traumatic brain injury, opioid dependence, and substance abuse.	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41558	A. BUILDING: _____ B. WING _____	08/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WE DO CARE LLC	9812 CHICAGO AVE S BLOOMINGTON, MN 55420

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01820	Continued From page 40 R1's signed Addendum to Contract - Waiver - MN (service agreement) dated December 17, 2025, indicated R1 received services including assistance with bathing reminders, dressing, grooming, socialization, behavior management, and medication administration. R1's medication administration record (MAR) dated August 2026, indicated R1 received assistance with administration of the following scheduled medications: -Aspirin (for pain and blood thinner) 81 milligrams (mg), by mouth daily; -buprenorphine and naloxone (for opioid disorder) 2 mg-0.5 mg, take 1/2 film sublingual, three times daily; -fluoxetine (for depression) 20 mg, take one capsule by mouth daily together with 40 mg; -folic acid (a supplement) 1 mg, take one tablet by mouth, three times daily; -gabapentin (for nerve pain) 600 mg, take one tablet by mouth, three times daily; -multiple vitamin (a supplement) capsule, take one tablet by mouth daily; -omeprazole (to decrease stomach acid) 40 mg, take one capsule daily before a meal; -senna docusate sodium (for constipation) 8.6 - 50 mg, take one tablet by mouth, twice daily; -baclofen (a muscle relaxant) 5 mg, take one tablet, three times daily; -Caplyta (an atypical antipsychotic) 42 mg, take one tablet by mouth every bedtime; -Flomax (treats weak urine flow) 0.4 mg, take two capsules by mouth, every evening; -rosuvastatin (for high cholesterol) 20 mg, take one tablet by mouth, daily at bedtime; and -Seroquel (an anti-psychotic) 200 mg, take one tablet by mouth, daily at bed. R1's record included signed provider orders,	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41558	A. BUILDING: _____ B. WING _____	08/05/2026

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01820	Continued From page 41 dated February 23, 2026, but lacked a signed provider order for the following scheduled medications from the list above: -Aspirin 81 mg, by mouth daily; -fluoxetine 20 mg, take one capsule by mouth daily together with 40 mg; -baclofen 5 mg, take one tablet, three times daily; -Caplyta 42 mg, take one tablet by mouth every bedtime; -Flomax 0.4 mg, take two capsules by mouth, every evening; -rosuvastatin 20 mg, take one tablet by mouth, daily at bedtime; -Seroquel 200 mg, take one tablet by mouth, daily at bed. On August 3, 2026, at 2:10 p.m., clinical nurse supervisor (CNS)-B stated, via phone, she set up all R1's medications routinely and believed she had signed provider orders for each of the medications administered to R1. On August 5, 2026, from 8:00 a.m. to 8:52 a.m., during a phone call, CNS-B stated she reviewed and set up R1's medications every one to two weeks at the facility. CNS-B verbalized she was not aware some of R1's medications did not contain a legal signed or electronically signed provider order. Education provided. The Office of the Revisor of Statutes defined 151.01 Subd. 16 a., "Prescription. "Prescription" means a prescription drug order that is written or printed on paper, an oral order reduced to writing by a pharmacist, or an electronic order. To be valid, a prescription must be issued for an individual patient by a practitioner within the scope and usual course of the practitioner's practice, and must contain the date of issue, name and address of the patient, name and	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01820	Continued From page 42 quantity of the drug prescribed, directions for use, the name and address of the practitioner, and a telephone number at which the practitioner can be reached. A prescription written or printed on paper that is given to the patient or an agent of the patient or that is transmitted by fax must contain the practitioner's manual signature. An electronic prescription must contain the practitioner's electronic signature." The licensee's 7.17 Medication & Treatment Orders - Receiving policy, dated September 1, 2024, indicated, "PROCEDURE: 1. All orders for medications and treatments must be dated and signed by the prescriber, and must be current and consistent with the nursing assessment. 2. Content of medication orders must contain the name of the drug, dosage, frequency, route, indication and directions for use. 3. Verbal orders received from a prescriber must have the RN/LPN: a. Record and sign the order. b. A record of the verbal order will be kept in the resident record c. All verbal orders received will be written and then forwarded to the prescriber for the prescriber's signature. 4. Electronically transmitted orders: a. An order received by facsimile machine, or other electronic means must be received and kept confidential. b. An order received by facsimile machine, or other electronic means must be communicated to a licensed nurse within 1 hour of receipt. c. An order received by electronic means, not including facsimile machines, must be immediately recorded or placed in the resident's record by a nurse and must be countersigned by the prescriber if not already	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01820	Continued From page 43 done so. d. An order received by email or facsimile machine must have been signed by the prescriber and must be immediately recorded or a usable copy must be placed in the resident's record by a person authorized by the RN. 5. When appropriate, changes will be made to the resident's Service Plan." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure expired medications were disposed of for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01890	Continued From page 44 affect a large portion or all of the residents). The findings include: R1 was admitted on December 16, 2025, and had diagnoses which included anxiety, major depressive disorder, schizoaffective disorder (a mental health disease), traumatic brain injury, opioid dependence, and substance abuse. R1's signed Addendum to Contract - Waiver - MN (service agreement) dated December 17, 2025, indicated R1 received services including assistance with bathing reminders, dressing, grooming, socialization, behavior management, and medication administration. On August 3, 2026, at 1:46 p.m., the surveyor observed the locked medication cabinet with administrator/unlicensed personnel (A/ULP)-C. The cabinet contained all R1's medications, including one unopened box of Narcan (to rapidly reverse life-threatening opioid overdoses) 4 milligrams (mg) nasal spray expired on July 21, 2026. A/ULP-C confirmed the expiration date and stated she did not realize this medication was expired and would notify the nurse to obtain a replacement. On August 5, 2026, from 8:00 a.m. to 8:52 a.m., during a phone call, clinical nurse supervisor (CNS)-B stated, she reviewed and set up medications for R1 every one to two weeks at the facility. CNS-B verbalized she had not noticed the Narcan was expired. The Narcan Over the Counter (OTC) Fact Sheet dated July 2023, indicated under Frequently Asked Questions (FAQS); "Please adhere to the expiration date as printed on the package."	01890		

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01890	Continued From page 45 The licensee's 7.23 Medication Disposal policy, dated September 1, 2024, indicated, "Expired Prescription Drugs: -Expired medications managed by [Licensee] will disposed of according to the accepted practices of the Minnesota board of Pharmacy and the labels from the containers will be destroyed. -Upon disposition, the facility must document in the resident's record the disposition of the expired medication including the medication's name, strength, prescription number as applicable, quantity, date of disposition, and names of the staff and other individuals involved in the disposition." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

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

We Do Care LLC
9812 CHICAGO AVE S
Bloomington, MN 55420
Hennepin County
Parcel:

Phone:

License Info

License: HFID 41558

Risk:
License:
Expires on:
CFPM: Hodo F. Osman
CFPM #: 31371; Exp: 3/29/2027

Inspection Info

Report Number: F1043261224
Inspection Type: Full - Single
Date: 8/4/2026 Time: 3:37:56 PM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 1
Total Priority 2 Orders: 1
Total Priority 3 Orders: 1
Delivery:

! New Order: 2-200 Employee Health
2-201.11C *Priority Level: Priority 1 CFP#: 3*
MN Rule 4626.0040C The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority at the specific request of the regulatory authority.
COMMENT: NO ILLNESS LOG IN USE. ADVISED STAFF TO RECORD FOR STAFF WHO GOES HOME SICK OR CALLS IN SICK. LOG MUST BE AVAILABLE FOR REVIEW UPON REQUEST. LOG PROVIDED WITH REPORT. COMPLY WITH ABOVE RULE.
Comply By: 8/4/2026 Originally Issued On: 8/4/2026

New Order: 3-500C Microbial Control: date marking
3-501.17A *Priority Level: Priority 2 CFP#: 23*
MN Rule 4626.0400A Mark the refrigerated, ready-to-eat, TCS food prepared and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded.
COMMENT: NO DATE MARKING OBSERVED ON OPENED PACKAGES OF DELI MEAT. STAFF CONFIRMED PACKAGES WERE OPENED ON A PREVIOUS DAY. ADVISED STAFF TO DATE MARK AND DISCARD LEFTOVERS AFTER 7 DAYS. FACT SHEET PROVIDED WITH REPORT. COMPLY WITH ABOVE RULE.
Comply By: 8/4/2026 Originally Issued On: 8/4/2026

New Order: 4-200 Equipment Design and Construction
4-201.11GMN *Priority Level: Priority 3 CFP#: 47*
MN Rule 4626.0506G Discontinue serving TCS foods that are held for more than same-day service in an adult or child care center or boarding establishment or provide equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.
COMMENT: PASTA DATE MARKED 8/1 AND CHICKEN RICE DATE MARKED 7/31. STAFF CONFIRMED LEFTOVERS ARE KEPT FOR ADDITIONAL DAYS. ADVISED STAFF TO DISCONTINUE PRACTICE AND TO DISCARD FOODS COOKED IN HOUSE BY END OF EACH MEAL SERVICE/DAY. COMPLY WITH ABOVE RULE.
Comply By: 8/4/2026 Originally Issued On: 8/4/2026

Food & Beverage General Comment

Inspection was completed with Sara Freking and Dede Hinnendael as the lead Health Regulation Division Nurse Evaluators completing the site survey.

TEMPERATURE (F)
KITCHEN FRIDGE: CHEESE 41, DELI MEAT 38, MILK 41

UTENSIL SURFACE TEMPERATURE (F)
DISH MACHINE: FACILITY USES TEMPERATURE STRIPS WEEKLY TO VERIFY THAT THE DISHWASHER IS PROPERLY SANITIZING AND HAS PAST STICKERS ON FILE SHOWING THAT THE DISHWASHER IS PROVIDING A UTENSIL SURFACE TEMPERATURE OF AT LEAST 160 DEGREES F. THE LAST STICKER WAS RUN ON 8/2/26.

Discussed highly susceptible populations, date marking, illness policy, sanitizer use, ware washing, temperature control, same day food service, cleaning, pest control, vomit/fecal procedures, test kits, food storage, and food handling procedures.

This facility has a residential kitchen with residential equipment, laminated cabinetry, tiled flooring, smooth walls, and textured ceilings, dish machine with sanitizing option. Conditions of equipment and physical facility will be monitored during future inspections – must be brought up to code if at such time they are found to be a concern or risk of contamination.

Contact Health Regulation Division for plan review approval when facility/kitchen undergoes remodeling, major equipment additions, or changes of equipment due to a menu change.

***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.

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

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 F1043261224 from 8/4/2026

Asha Mohamud, Fatima Mohamud
PIC

Blia Lor,
Public Health Sanitarian 1
651-355-0641
blia.lor@state.mn.us

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL41558001-0	**Date:** August 5, 2026
Facility Name: WE DO CARE LLC	
Facility Address: 9812 Chicago Ave S, Minneapolis, Minnesota 55420	

☒ **TAG IDENTIFICATION: 0810**

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

1. 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 licensee failed to provide proof that residents capable of assisting in their own evacuation received training on the proper actions to take in the event of a fire to include movement, evacuation, or relocation.