Electronically Delivered

October 30, 2026

Licensee
James Residences
9400 James Avenue North
Brooklyn Park, MN 55444

RE: Project Number(s) SL32622016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 27, 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 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00
St - 0 - 0780 - 144g.45 Subd. 2 (a) (1) - 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,

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

CLN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32622	A. BUILDING: _____ B. WING _____	08/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JAMES RESIDENCES	9400 JAMES AVENUE NORTH BROOKLYN PARK, MN 55444

(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: SL32622016-0 On August 24, 2026, through August 27, 2026, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were two residents; two receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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

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0 480	Continued From page 2 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 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, Food and Beverage Establishment Inspection Report (FBEIR) dated August 24, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.	0 480		

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0 480	Continued From page 3 TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 650 SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records included all required content for two of two unlicensed personnel ((ULP)-A, ULP-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 650		

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0 650	Continued From page 4 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-A ULP-A was hired on November 10, 2021. On August 25, 2026, at 11:23 a.m., the surveyor observed ULP-A assist R1 with medication administration. ULP-A's record included competency evaluations documented on a form titled, Home Health Aide Supervision. The competency evaluations lacked the required documentation for a competency evaluation per Minnesota Administrative Rule 4659.0190, subpart 6, A., as the forms lacked the training methodology, such as classroom style, web-based training, video, or one-to-one training; the total amount of time of the training and competency evaluation; and name and title of the staff person completing the training, and the staff person's signature with a statement attesting that the staff person successfully completed the training as described in the training documentation. ULP-A's employee record lacked evidence of the following required content: - job description; and - competency evaluations related to medication administration when a licensed nurse was not available to provide medications for a resident with an unplanned time away from home.	0 650		

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0 650	Continued From page 5 ULP-B ULP-B was hired on September 12, 2022. On August 24, 2026, at 1:07 p.m., the surveyor observed ULP-B assist R1 with medication administration. ULP-B's record included competency evaluations documented on a form titled, Home Health Aide Supervision. The competency evaluations lacked the required documentation for a competency evaluation per Minnesota Administrative Rule 4659.0190, subpart 6, A., as the forms lacked the training methodology, such as classroom style, web-based training, video, or one-to-one training; the total amount of time of the training and competency evaluation; and name and title of the staff person completing the training, and the staff person's signature with a statement attesting that the staff person successfully completed the training as described in the training documentation. ULP-B's employee record lacked evidence of the following required content: - job description; and - competency evaluations related to medication administration when a licensed nurse was not available to provide medications for a resident with an unplanned time away from home. On August 26, 2026, at 3:18 p.m., ULP-B stated they had to send medications with residents for unplanned time away when the nurse was not available to prepare the medications in the past. ULP-B stated they had returned demonstration to the nurse before they could perform that task. ULP-B stated the nurse also required staff to call them as well when they need to do that task.	0 650		

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0 650	Continued From page 6 On August 27, 2026, at 10:48 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated they were aware of the content required for personnel records. LALD/CNS-C stated the licensee reviewed job descriptions upon hire with each staff. LALD/CNS-C stated the job descriptions were usually in the personnel records, however LALD/CNS-C confirmed ULP-A and ULP-B did not have their job descriptions in the personnel records. LALD/CNS-C stated the licensee had someone transition papers into personnel folders so the records could be more secure, suggesting they may have been lost in the transition. LALD/CNS-C stated they had trained and observed all staff to be competent on medication administration when a licensed nurse was not available to provide medications for a resident with an unplanned time away from home. LALD/CNS-C stated the competency evaluation was written and placed in personnel records, and they should have been in the records that the surveyor reviewed. LALD/CNS-C stated the licensee used the forms titled, Home Health Aide Supervision to document the staff's competency evaluations. LALD-CNS-C stated they were not aware of the specific documentation requirements for competency evaluations; or the need to have staff sign the training document to indicate they had successfully completed the specific training. The licensee's Personnel Records policy dated August 1, 2021, indicated personnel records for each person would include a current signed job description and records of competency evaluations as required. Minnesota Administrative Rule 4659.0190,	0 650		

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0 650	Continued From page 7 subpart 6, A., dated August 11, 2021, indicated the facility must maintain a record of staff training and competency required under this part and Minnesota Statutes, chapter 144G, that documents the following information for each competency evaluation, training, retraining, and orientation topic: - facility name, location, and license number; - name of the training topic or training program, and the training methodology, such as classroom style, web-based training, video, or one-to-one training; - date of the training and competency evaluation, and the total amount of time of the training and competency evaluation; - name and title of the instructor and the instructor's signature, and the name and title of the competency evaluator, if different from the instructor, and the evaluator's signature with a statement attesting that the employee successfully completed the training and competency evaluation; and - name and title of the staff person completing the training, and the staff person's signature with a statement attesting that the staff person successfully completed the training as described in the training documentation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 660 SS=F	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	0 660		

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0 660	Continued From page 8 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 observation, 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 a two-step tuberculin skin test (TST) or other evidence of TB testing such as IGRA (a blood test) and annual TB training for one of two unlicensed personnel ((ULP)-B). This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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:	0 660		

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0 660	Continued From page 9 The licensee's Facility Tuberculosis (TB) Risk Assessment dated July 24, 2026, indicated the TB risk for the facility was low. ULP-B was hired on September 12, 2022. On August 24, 2026, at 1:07 p.m., the surveyor observed ULP-B assist R1 with medication administration. On August 24, 2026, at 1:18 p.m., the surveyor reviewed ULP-B's personnel file and scanned ULP-B's paper records. The surveyor observed ULP-B's record included a blank Consent and Release for TB Screening form with a pink sticky paper/tab attached. The surveyor did not observe any other TB information in ULP-B's personnel record. On August 24, 2026, at 2:40 p.m., ULP-B provided the surveyor with a copy of their TB test results dated March 21, 2021; and stated the TB test results were completed for a prior job. ULP-B stated they did have another TB test, but they needed to wait for the clinic to send those results. ULP-B's TB test dated March 21, 2021, indicated ULP-B had a QuantiFERON-TB Gold Plus (TB blood test) that was negative, however, it was performed five hundred and forty (540) days before ULP-B's hire date and not within ninety (90) days of ULP-B's hire date. ULP-B's Educare (common online training) transcript included TB training completed on October 12, 2023, and February 9, 2025. ULP-B's record lacked evidence of Tb training upon hire and in 2024. On August 26, 2026, at 3:18 p.m., ULP-B stated	0 660		

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0 660	Continued From page 10 they had gone to the clinic on Monday (after the initiation of survey) to get another TB test. ULP-B confirmed they had completed their previous TB testing in March 2021, and they could not get any other TB results from the clinic. On August 27, 2026, at 10:49 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated the licensee usually sent staff to the same clinic for their TB testing upon hire but for some reason the clinic did not have ULP-B's record; so they were not sure how ULP-B's TB test got missed. LALD/CNS-C stated staff received TB training at hire and annually though Educare. LALD/CNS-C stated they also provided the training in person at hire but did not document that training. The licensee's Tuberculosis Screening/Prevention policy dated August 1, 2021, indicated all staff who provided care or visit residents would receive education on TB and ongoing TB education would be proved as part of the infection control training. Also, the policy indicated baseline TB testing would be completed upon hire for all direct care providers and anyone who visited residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that	0 680		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 680	Continued From page 11 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 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 interview and record review, the licensee failed to maintain a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. This had the potential to affect all residents, staff, and visitors. 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).	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32622	A. BUILDING: _____ B. WING _____	08/27/2026

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0 680	Continued From page 12 The findings include: The licensee's undated EPP lacked evidence of the following required content: - maintain and update annually; - process for emergency preparedness (EP) collaboration; - subsistence needs for staff and patients; - procedures for tracking of staff and patients; - policies and procedures for medical documents; - policies and procedures for volunteers; - arrangement with other facilities; - roles under a wavier declared by secretary; - names and contact information; - emergency officials contact information; - primary and alternate means for communication; - methods for sharing information; - sharing information on occupancy/needs; - long term care (LTC) family notifications; and - testing requirements - emergency prep training and testing. On August 25, 2026, at 1:35 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated the licensee had not documented the review of the missing resident plan, but the licensee had reviewed the policy frequently and they had discussed the policy. LALD/CNS-C acknowledged the EPP lacked missing content as indicated above. LALD/CNS-C confirmed the licensee did not have arrangements and/or any agreements with other facilities to receive residents in the event the facility is not able to care for them during an emergency. LALD/CNS-C asked the surveyor if the licensee still needed to have an agreement with other facilities if the licensee owned multiple assisted living facilities, in which the surveyor	0 680		

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0 680	Continued From page 13 explained each facility was under a separate licensure and would require each facility to have its own arrangement. LALD/CNS-C stated the drills the licensee completed were on fire only and had confirmed the licensee had not completed any community-based exercises. The licensee's Emergency Preparedness policy dated August 1, 2021, indicated the licensee would have an identified plan in place and reference CMS (Centers for Medicare and Medicaid Services) State Operations Manual Appendix Z. 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 additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 775 SS=F	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	0 775		

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0 775	Continued From page 14 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 August 26, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 775		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate	0 780		

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0 780	Continued From page 15 sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; 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:	0 780		

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0 780	Continued From page 16 Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated August 26, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, 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	0 800		

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0 800	Continued From page 17 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 August 26, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800		
0 990 SS=D	144G.52 Subd. 2 Prerequisite to termination of a contract (a) Before issuing a notice of termination of an assisted living contract, a facility must schedule and participate in a meeting with the resident and the resident's legal representative and designated representative. The purposes of the meeting are to: (1) explain in detail the reasons for the proposed termination; and (2) identify and offer reasonable accommodations or modifications, interventions, or alternatives to avoid the termination or enable the resident to remain in the facility, including but not limited to securing services from another provider of the resident's choosing that may allow the resident to avoid the termination. A facility is not required to offer accommodations, modifications, interventions, or alternatives that fundamentally alter the nature of the operation of the facility. (b) For a termination pursuant to subdivision 3 or 4, the meeting must be scheduled to take place at least seven days before a notice of termination is issued. The facility must make reasonable	0 990		

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0 990	Continued From page 18 efforts to ensure that the resident, legal representative, and designated representative are able to attend the meeting. (c) For a termination pursuant to subdivision 5, the meeting must be scheduled to take place at least five days before a notice of termination is issued. The facility must make reasonable efforts to ensure that the resident, legal representative, and designated representative are able to attend the meeting. (d) The facility must notify the resident that the resident may invite family members, relevant health professionals, a representative of the Office of Ombudsman for Long-Term Care, a representative of the Office of Ombudsman for Mental Health and Developmental Disabilities, or other persons of the resident's choosing to participate in the meeting. For residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the facility must notify the resident's case manager of the meeting. (e)In the event of an emergency relocation under subdivision 9, where the facility intends to issue a notice of termination and an in-person meeting is impractical or impossible, the facility must use telephone, video, or other electronic means to conduct and participate in the meeting required under this subdivision and rules within Minnesota Rules, chapter 4659. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to conduct a prerequisite to termination of contract meeting with the resident and the resident's representative prior to discharge for one of one resident (R2).	0 990		

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0 990	Continued From page 19 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: The licensee's letter from the [City] police department dated July 17, 2026, indicated the city had passed a new City Ordinance §137 in August 2025, in which the police department had sent out letters in July 2025 to inform residents and facilities of the new city ordinance and potential consequences for failure to comply. The licensee was notified that they violated City Ordinance § 137.03, subd. (A)(1) by allowing R2 to enter and reside at the facility; and was placed on notice that mandatory compliance with Brooklyn Park City Ordinance § 137 had to be in effect by 8:00 a.m. on July 31, 2026. R2 was admitted to the licensee on December 26, 2025. R2's Service Plan dated December 26, 2025, indicated R2 received assistance with medication administration. R2's Discharge Summary dated July 30, 2026, indicated R2 was discharged from the licensee on July 30, 2026, due to R2's residency near public areas where R2 was not allowed. The discharge summary indicated R2 had an emergency relocation to another facility owned by the same owner.	0 990		

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0 990	Continued From page 20 R2's record lacked evidence of a prerequisite to termination of contract meeting with R2 and R2's representative prior to discharge. On August 25, 2026, at 12:51 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated R2 was supposed to have registered their place of residency but did not. LALD/CNS-C stated the licensee had a visit from the Sheriff's Office the same day the licensee registered R2's place of residence; and the licensee had received a notice that indicated R2 needed to move due to a violation of a city ordinance. LALD/CNS-C stated they had received an email in addition from the city and the police department which indicated they were going to shut the facility down. LALD/CNS-C stated they had contacted the Ombudsman, but the Ombudsman had informed the licensee that R2 and/or their case manager needed to make the decision for R2 to move. LALD/CNS-C stated the licensee could not put R2 in a hotel as that would have been a safety concern to the public as well. LALD/CNS-C stated R2's case manager was looking for another placement for R2 but had a hard time due to the locations of the facilities and their proximity to other public areas where R2 was not allowed to be near. LALD/CNS-C stated they have continued to work with R2's case manager. On August 26, 2026, at 9:23 a.m., LALD/CNS-C stated the licensee did not go through the termination process due to the letter they had received from the city that indicated R2 needed to be out of the facility. LALD/CNS-C stated the licensee never provided a termination letter or had a documented meeting with R2 or R2's case manager. LALD/CNS-C stated the whole process	0 990		

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0 990	Continued From page 21 was very short; there was no way to have all those specifics completed in the time frame they were given. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 990		
01040 SS=D	144G.52 Subd. 7 Notice of contract termination required (a) A facility terminating a contract must issue a written notice of termination according to this section. The facility must also send a copy of the termination notice to the Office of Ombudsman for Long-Term Care and, for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, to the resident's case manager, as soon as practicable after providing notice to the resident. A facility may terminate an assisted living contract only as permitted under subdivisions 3, 4, and 5. (b) A facility terminating a contract under subdivision 3 or 4 must provide a written termination notice at least 30 days before the effective date of the termination to the resident, legal representative, and designated representative. (c) A facility terminating a contract under subdivision 5 must provide a written termination notice at least 15 days before the effective date of the termination to the resident, legal representative, and designated representative. (d) If a resident moves out of a facility or cancels services received from the facility, nothing in this section prohibits a facility from enforcing against the resident any notice periods with which the	01040		

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01040	Continued From page 22 resident must comply under the assisted living contract. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written termination notice before the effective date of an expedited termination to the resident, legal representative, and designated representative for one of one resident (R2) who had an expedited termination. 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: The licensee's letter from the [City] police department dated July 17, 2026, indicated the city had passed a new City Ordinance §137 in August 2025, in which the police department had sent out letters in July 2025 to inform residents and facilities of the new city ordinance and potential consequences for failure to comply. The licensee was notified that they violated City Ordinance § 137.03, subd. (A)(1) by allowing R2 to enter and reside at the facility; and was placed on notice that mandatory compliance with Brooklyn Park City Ordinance § 137 had to be in effect by 8:00 a.m. on July 31, 2026. R2 was admitted to the licensee on December 26, 2025.	01040		

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01040	Continued From page 23 R2's Service Plan dated December 26, 2025, indicated R2 received assistance with medication administration. R2's Discharge Summary dated July 30, 2026, indicated R2 was discharged from the licensee on July 30, 2026, due to R2's residency near public areas where R2 was not allowed. The discharge summary indicated R2 had an emergency relocation to another facility owned by the same owner. R2's Notice of Emergency Relocation dated July 30, 2026, indicated R2 was emergently relocated to a different facility due to the violation of the City Ordinance. Also, indicated approximate date of return to the facility was pending change of condition. R2's record lacked evidence of a written termination notice that was provided to R2, R2's legal representative, and R2's designated representative. On August 25, 2026, at 12:51 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated R2 was supposed to have registered their place of residency but did not. LALD/CNS-C stated the licensee had a visit from the Sheriff's Office the same day the licensee registered R2's place of residency; and the licensee had received a notice that indicated R2 needed to move due to a violation of a city ordinance. LALD/CNS-C stated they had received an email in addition from the city and the police department which indicated they were going to shut us down. LALD/CNS-C stated they had contacted the Ombudsman but had been informed R2 and /or their case manager had	01040		

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01040	Continued From page 24 needed to make the decision for R2 to move. LALD/CNS-C stated the licensee could not put R2 in a hotel as that would have been a safety concern to the public as well. LALD/CNS-C stated R2's case manager was looking for other placements for R2 but had a hard time due to the locations of the facilities and their proximity to other public areas where R2 was not allowed to be near. LALD/CNS-C stated they have continued to work with R2's case manager. On August 26, 2026, at 9:23 a.m., LALD/CNS-C stated the licensee did not go through the termination process due to the letter they had received from the city that indicated R2 needed to be out of the facility. LALD/CNS-C stated the licensee never provided a termination letter or had a documented meeting with R2's case manager. LALD/CNS-C stated the whole process was very short; there was no way to have all those specifics completed in the time frame they were given. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01040		
01290 SS=D	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be	01290		

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01290	Continued From page 25 classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a background study was affiliated with the licensee's health facility identification number (HFID) for one of eleven employees (unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: On August 24, 2026, at 1:07 p.m., the surveyor observed ULP-B assist R1 with medication administration. ULP-B was hired on September 12, 2022. ULP-B's Background Study Clearance dated September 7, 2022, indicated ULP-B was associated with HFID 34949. ULP-B's record lacked a background study for HFID 32622.	01290		

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	32622	A. BUILDING: _____ B. WING _____	08/27/2026

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01290	Continued From page 26 On August 25, 2026, at 10:21 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated the licensee was aware of the need to have all employees affiliated to the facility's HFID of where the employee provided resident care. LALD/CNS-C stated the licensee missed affiliating ULP-B to the licensee's HFID 32622; and they did not know how ULP-B got missed. LALD/CNS-C stated usually ULP-B worked at another facility with a different HFID owned by the same owner; and seldomly worked at the location with HFID 32622. The licensee's Personnel Records policy dated August 1, 2021, indicated licensee would maintain results of background studies in each employee's personnel record. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in	01500		

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01500	Continued From page 27 the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated 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,	01500		

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01500	Continued From page 28 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 annual training included all required topics for each 12 months of employment, for one of two unlicensed personnel ((ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: On August 24, 2026, at 1:07 p.m., the surveyor observed ULP-B assist R1 with medication administration. ULP-B was hired on September 12, 2022. ULP-B's personnel record lacked evidence of the following required topics of annual training in 2024: - Assisted Living Bill of Rights; - infection control techniques; and - principles of person-centered planning/service delivery. On August 27, 2026, at 10:48 a.m., licensed assisted living director/clinical nurse supervisor	01500		

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01500	Continued From page 29 (LALD/CNS)-C stated the licensee assigned annual training according to the requirements in Statute 144G; and if there was another training that would benefit the staff or resident, the licensee would also provide that training. LALD/CNS-C acknowledged ULP-B had missing annual training from 2024. LALD/CNS-C stated the licensee did check to verify if assigned courses were completed for online training, but ULP-B must have been missed. The licensee's Staff Orientation and Education policy dated August 1, 2021, indicated all staff that provided assisted living services would complete at least eight (8) hours of education for every twelve (12) months of employment. The policy indicated the annual training must include topics on Assisted Living Bill of Rights; infection control techniques; and the principles of person-centered planning and service delivery. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
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	01730		

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01730	Continued From page 30 assessment that must contain the following: (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 an individualized medication management plan (IMMP) with the required content for one of one	01730		

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01730	Continued From page 31 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: On August 24, 2026, at 1:07 p.m., the surveyor observed unlicensed personnel (ULP)-B assist R1 with medication administration. R1 was admitted to licensee on February 1, 2024. R1's Service Plan dated February 1, 2024, indicated R1 received assistance with medication administration. R1's record lacked evidence of a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with instructions per manufacturer; and identification of medication management tasks that may be delegated to unlicensed personnel. On August 27, 2026, at 10:48 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated they were aware of the required content needed for an IMMP. LALD/CNS-C acknowledged the missing content for R1's IMMP but did not indicate a reason for the missing content. The licensee's Service Plan for Medication	01730		

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01730	Continued From page 32 Management policy dated August 1, 2021, indicated the licensee would prepare and document a medication management plan as part of the service plan for each resident who received medication management services. Also, the policy indicated the written medication management plan would include a description of storage of medications based on the resident's assessment, preferences, risk of diversion, and instructions per manufacturer; and description of medication management tasks to be delegated to unlicensed personnel. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01760 SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	01760		

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01760	Continued From page 33 review, the licensee failed to ensure medications were administered as prescribed; and failed to document the reason why medication administration was not completed as prescribed 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: On August 25, 2026, at 11:23 a.m., the surveyor observed unlicensed personnel (ULP)-A assist R1 with medication administration. R1 was admitted to the licensee on February 1, 2024. R1's Service Plan dated February 1, 2024, indicated R1 received assistance with medication administration. R1's Medication Administration Record (MAR) dated August 2026, indicated the following medications lacked documentation as noted below: - Adapalene 0.1 percent (%) cream at 8:00 a.m., had four omitted entries; - amlodipine besylate 10 milligrams (mg) at 8:00 a.m., had three omitted entries; - aripiprazole 15 mg at 8:00 p.m., had two omitted entries; - bupropion 150 mg at 8:00 a.m., had three	01760		

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01760	Continued From page 34 omitted entries; - buspirone 10 mg at 8:00 a.m.; had three omitted entries; - buspirone 10 mg at 8:00 p.m.; had two omitted entries; - carvedilol 25 mg at 8:00 a.m., had three omitted entries; - carvedilol 25 mg at 8:00 p.m., had one omitted entries; - doxazosin mesylate 1 mg at 8:00 p.m., had two omitted entries; - drysol solution 2% solution was to be applied on Mondays, Wednesdays, and Fridays at 8:00 p.m. had two omitted entries on Fridays (August 14, 2026, and August 21, 2026), and an entry that indicated it was administered on Saturday, August 1, 2026; - gabapentin 100 mg at 8:00 a.m., had three omitted entries; - gabapentin 100 mg at 8:00 p.m., had two omitted entries; - lokelma powder packet 5 grams (gm) on non-dialysis days (Mondays, Wednesdays, Fridays, and Sundays) at 8:00 a.m., had seven omitted entries, and one entry on Saturday August 15, 2026, which did not follow the medication directions; - mycophenolate 250 mg at 8:00 a.m., had three omitted entries; - mycophenolate 250 mg at 8:00 p.m., had two omitted entries; - pantoprazole 40 mg at 8:00 a.m., had three omitted entries; - pantoprazole 40 mg at 8:00 p.m., had two omitted entries; - prednisone 5 mg at 8:00 p.m., had two omitted entries; - sertraline 50 mg at 8:00 a.m., had three omitted entries; - sevelamer carbonate 800 mg at 8:00 a.m., had	01760		

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01760	Continued From page 35 five omitted entries; - sevelamer carbonate 800 mg at 12:00 p.m., had thirteen omitted entries; and - sevelamer carbonate 800 mg at 8:00 p.m., had two omitted entries. R1's MAR dated August 2026, indicated R1 had cinacalcet 90 mg at noon but this was supplied and administered by the dialysis clinic staff (Tuesdays, Thursdays, and Saturdays). R1's MAR indicated this medication was administered on August 1, 2026, and August 15, 2026, by the licensee's staff. On August 26, 2026, at 1:20 p.m., licensed assisted living director/clinical nurse supervisor (CNS/LALD)-C stated the licensee's electronic medical record system did not allow staff to document medication administration if it was late; and gave an example of when a resident had slept in an hour later. LALD/CNS-C stated they call and check in with staff daily at each facility owned by the licensee's owner to ask staff about medications, late medication administration, and medication refusals. LALD/CNS-C stated they have been actively working to correct this problem. LALD/CNS-C stated the licensee also had issues with staff logging in. LALD/CNS-C stated the licensee plans to transition to a different electronic system for the documentation. LALD/CNS-C stated they planned to have a staff meeting to teach staff how to document medication administration on a paper MAR until the licensee could work out the kinks with the electronic medical record system. The licensee's Medication Documentation policy dated August 1, 2021, indicated each medication administered would be documented in the resident's clinical record. The policy indicated if	01760		

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01760	Continued From page 36 the administration of one or more medications were not completed, staff would document the reason why the medication administration was not administered and follow up procedures to meet the residents' needs. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide documentation in the	01910		

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01910	Continued From page 37 resident's record regarding the disposition of medication to include quantity and names of staff and other individuals involved in the disposition of medications for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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: R2 was admitted to the licensee on December 26, 2025. R2's Service Plan dated December 26, 2025, indicated R2 received assistance with medication administration. R2's Discharge Summary dated July 30, 2026, indicated R2 was discharged from the licensee on July 30, 2026, due to R2's residency near public areas where R2 was not allowed. The discharge summary indicated R2 had an emergency relocation to another facility owned by the same owner. R2's record lacked a disposition of medications to include the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. On August 25, 2026, at 10:38 a.m., licensed	01910		

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01910	Continued From page 38 assisted living director/clinical nurse supervisor (LALD/CNS)-C confirmed R2 had been discharged from the licensee on July 30, 2026. LALD/CNS-C stated the licensee did not have documentation of a medication disposition for R2 as the licensee had moved the resident to another facility (different license) that was owned by the same owner of the license and did not think of the move as a discharge. The licensee's Disposition and Disposal of Medications policy dated August 1, 2021, upon disposition, the licensee would document in the residents record the disposition of the medication to include the medication name, strength, prescription number, quantity, to whom the medications were given, date of disposition, and the names of staff and other individuals involved in the disposition. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01910		
02290 SS=F	144G.91 Subd. 2 Legislative intent The rights established under this section for the benefit of residents do not limit any other rights available under law. No facility may request or require that any resident waive any of these rights at any time for any reason, including as a condition of admission to the facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee limited the rights of residents when the licensee required residents to sign and	02290		

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JAMES RESIDENCES	9400 JAMES AVENUE NORTH BROOKLYN PARK, MN 55444

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02290	Continued From page 39 follow house rules for two of two residents (R1, 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 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 24, 2026, at 11:31 a.m., during a facility tour, the surveyor observed a post in the common dining room and in the entryway of the facility that was labeled, "[licensee name] House Rules." The posts indicated guests were not allowed to be in the resident rooms; all guests must visit residents in the common living areas; alcohol was not allowed; and if engaged in alcohol use, they would be asked to leave the premises. R1 was admitted to the licensee on February 1, 2024. R1's Assisted Living Contract dated June 28, 2026, indicated the resident would comply with all rules and regulations of the licensee regarding resident conduct, which could be amended as the licensee determined to be appropriate; and the resident had the right to choose the resident's visitor and the times of visits but restrictions would be communicated by the licensee. On August 25, 2026, at 12:00 p.m., unlicensed personnel (ULP)-A stated the licensee normally	02290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32622	A. BUILDING: _____ B. WING _____	08/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JAMES RESIDENCES	9400 JAMES AVENUE NORTH BROOKLYN PARK, MN 55444

(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
02290	Continued From page 40 did not want visitors during certain times of the day except nurses who worked with the residents could come any time. ULP-A stated visitors could not come between 7:00 a.m. to 8:00 a.m.; 10:00 a.m. to 1:00 p.m.; and 5:00 p.m. to 6:00 p.m., since they would get busy with mealtimes and medications. ULP-A stated the residents could only have family in their room since it was their right but could not have a friend in their room as they would be expected to stay in the common living areas. ULP-A stated the residents were not allowed to have alcohol in the facility as "that is a no, no." ULP-A stated they remind the residents they could not buy or bring any alcohol into the facility especially on Tuesdays and Thursdays when they go shopping with the residents. On August 25, 2026, at 12:18 p.m., during an interview, R3 stated they could only have their friends in the living room (common area of the facility); and they would not be allowed to have a friend come into their room to play video games. R3 stated they had to sign house rules for the licensee. On August 25, 2026, at 12:43 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated the licensee only had visitor restrictions in place during covid. LALD/CNS-C stated the licensee did not encourage residents to have friends in their rooms; and often asked if they could stay in the living room or common areas as they don't know the friends. LALD/CNS-C stated the residents' friends could bring drugs or weapons into the facility; which staff could then monitor them. LALD/CNS-C stated there are no restrictions as for the time of day of when a visitor could come to the facility. LALD/CNS-C stated if the residents were to bring any alcohol into the facility, they	02290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32622	A. BUILDING: _____ B. WING _____	08/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JAMES RESIDENCES	9400 JAMES AVENUE NORTH BROOKLYN PARK, MN 55444

(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
02290	Continued From page 41 would not fight with the residents or take the alcohol away but would go by whatever the doctor said regarding alcohol. LALD/CNS-C stated they used to have residents sign house rules but that was in the beginning under a different license as house rules are not allowed under the 144G Statutes; so, it would have been prior to August 2021. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02290		
02310 SS=F	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care standards, medical or nursing standards with regards to safely storing oxygen. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32622	A. BUILDING: _____ B. WING _____	08/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JAMES RESIDENCES	9400 JAMES AVENUE NORTH BROOKLYN PARK, MN 55444

(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
02310	Continued From page 42 failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On August 24, 2026, at 11:31 a.m., during a facility tour, the surveyor observed one oxygen cylinder tank that was not secured in a stand in a corner of a common hallway leading from the entrance area to the common dining room area. On August 25, 2026, at 1:00 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated the oxygen company was supposed to pick up the oxygen tanks; however, they were here today to pick the tanks. LALD/CNS-C stated the oxygen tanks should be stored in a cool place; and the licensee usually stored the oxygen tanks in the closet in an oxygen stand. Minnesota Department of Health Oxygen Cylinder Storage Requirements dated April 16, 2020, indicated cylinders must be secured (chains or racks) to prevent them from falling over. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		
02430 SS=F	144G.91 Subd. 15 Confidentiality of records (a) Residents have the right to have personal, financial, health, and medical information kept private, to approve or refuse release of information to any outside party, and to be advised of the assisted living facility's policies and procedures regarding disclosure of the	02430		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32622	A. BUILDING: _____ B. WING _____	08/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JAMES RESIDENCES	9400 JAMES AVENUE NORTH BROOKLYN PARK, MN 55444

(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
02430	Continued From page 43 information. Residents must be notified when personal records are requested by any outside party. (b) Residents have the right to access their own records. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure residents' personal health and medical information was kept private when the licensee used Whats App to communicate in a group chat for changes in residents' condition, medications, and treatment needs. This had the potential to affect all residents residing at the assisted living facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: On August 24, 2026, at 10:27 a.m., during the entrance conference, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated the licensee used Whats App for staff to contact the on-call nurse. LALD/CNS-C stated if the resident presented a new medication or new order to the staff, then the staff were to take a picture of a medication and the section of the provider order to send it via Whats App to communicate to the nurse. LALD/CNS-C stated unlicensed personnel (ULPs) would communicate	02430		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32622	A. BUILDING: _____ B. WING _____	08/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JAMES RESIDENCES	9400 JAMES AVENUE NORTH BROOKLYN PARK, MN 55444

(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
02430	Continued From page 44 with each other and the nurse regarding changes in the residents' condition or events on their shifts by phone, text or Whats App; and the nurse may use Whats App to communicate to ULPs regarding changes in residents' condition, medications, or treatments. LALD/CNS-C stated the licensee had a secured Whats App Connection. LALD/CNS-C stated the Whats App was run by the administrator, so anyone else trying to get in the group chat, had to be let in by the administrator only. On August 26, 2026, at 3:18 p.m., ULP-B stated the licensee used an app called, Whats App, for communications on residents and house information such as any appointments, police calls, events and behaviors. ULP-B stated the app was used to communicate on everything. ULP-B stated the Whats App did not have a password or passkey to access the app. ULP-B stated it was a group chat used for all of the facilities owned by the same owner and everyone was included in the group chat. The licensee's Privacy of Protected Health Information policy dated August 1, 2021, indicated the licensee would protect the privacy of its residents' personal health information. Also, the policy indicated protected health information would not be discussed on cell phones in public areas. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02430		

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

Food & Beverage Inspection Report

Establishment Info

JAMES RESIDENCES
9400 JAMES AVENUE NORTH
Brooklyn Park, MN 55444
Hennepin County
Parcel:

Phone:
thecaringcrewllc@gmail.com

License Info

License: HFID 32622

Risk:
License:
Expires on:
CFPM:
CFPM #: ; Exp:

Inspection Info

Report Number: F1031261255
Inspection Type: Full - Single
Date: 8/24/2026 Time: 1pm
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 3
Total Priority 2 Orders: 3
Total Priority 3 Orders: 3
Delivery: Emailed

New Order: 2-100 Supervision
2-102.12AMN *Priority Level: Priority 3 CFP#: 2*
MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.
COMMENT:
ESTABLISHMENT DOES NOT HAVE A CERTIFIED FOOD PROTECTION MANAGER (CFPM) THAT IS ENTERING FACILITY AND CONDUCTING CFPM CHECKS AS REQUIRED.
ENSURE 1 FULL-TIME EMPLOYEE HAS TAKEN AN APPROVED FOOD SAFETY COURSE AND AFTER COMPLETION APPLIES WITH STATE FOR CFPM.
LINKS PROVIDED IN EMAIL WITH REPORT.

Comply By: 8/24/2026 Originally Issued On: 8/24/2026

! **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:
ESTABLISHMENT DID NOT HAVE ILLNESS LOG ON SITE.
COPY OF LOG SENT WITH REPORT.
PRINT AND KEEP ILLNESS LOG ON SITE.
FILL OUT LOG WHENEVER SOMEONE CALLS IN OR GOES HOME SICK.

Comply By: 8/24/2026 Originally Issued On: 8/24/2026

! **New Order: 3-500B Microbial Control: hot and cold holding**
3-501.16A2 *Priority Level: Priority 1 CFP#: 22*
MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.
COMMENT:
THE FOLLOWING COOLERS ARE NOT KEEPING FOOD 41F OR BELOW:

1. MAIN REFRIGERATOR (MILK 44F, SR CREAM 50F, MAYO 48F)
2. OFFICE REFRIGERATOR (SODA 43F, WATER 43F)

DISCONTINUE USE OF MAIN REFRIGERATOR UNTIL REPAIRED.
MAIN REFRIGERATOR TCS ITEMS MOVED TO OFFICE REFRIGERATOR OR DISCARDED.
MONITOR TEMPERATURES.

Comply By: 8/24/2026 Originally Issued On: 8/24/2026

New Order: 4-300 Equipment Numbers and Capacities
4-302.13B *Priority Level: Priority 2 CFP#: 48*
MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.
COMMENT:
ESTABLISHMENT MISSING IRREVERSIBLE MEASURING DEVICE.
PROVIDE IRREVERSIBLE MEASURING DEVICE AND MEASURE UTENSIL TEMPERATURE (160F REQUIRED) AT REGULAR INTERVALS.

Comply By: 8/28/2026 Originally Issued On: 8/24/2026

New Order: 4-300 Equipment Numbers and Capacities
4-302.14 *Priority Level: Priority 2 CFP#: 48*
MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.
COMMENT:
ESTABLISHMENT DOES NOT HAVE SANITIZER TESTING KIT ON SITE.
PURCHASE KIT AND TEST SANI CONCENTRATION (50-200PPM BLEACH, 150-400PPM QUAT) ON REGULAR BASIS.

Comply By: 8/28/2026 Originally Issued On: 8/24/2026

New Order: 4-500 Equipment Maintenance and Operation
4-501.11AB *Priority Level: Priority 3 CFP#: 47*
MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.
COMMENT:
BOTH MAIN AND OFFICE REFRIGERATORS ARE NOT KEEPING FOOD 41F OR BELOW.

HAVE BOTH REFRIGERATORS REPAIRED OR REPLACED.

CONTACT INSPECTOR ONCE REPAIRS ARE COMPLETE.

Comply By: 8/24/2026 Originally Issued On: 8/24/2026

! **New Order: 4-700 Sanitizing Equipment and Utensils**
4-703.11B *Priority Level: Priority 1 CFP#: 16*
MN Rule 4626.0905B Sanitize food contact surfaces of equipment and utensils after cleaning by using mechanical hot water operations that achieve a utensil surface temperature of 160 degrees F (71 degrees C) and are set up and maintained in accordance with the specifications of NSF International and the manufacturer's data plate.
COMMENT:
UTENSIL TEMPERATURE DISH MACHINE MEASURED < 150F.

DISCONTINUE USE OF DISH MACHINE FOR SANITIZING UNTIL REPAIRED.

CAN BE USED FOR WASH/RINSE.
FILL SINK BASIN WITH BLEACH WATER (50-200PPM) AND SANI DIP DISHES AFTER WASHING.
ALLOW DISHES TO AIR DRY

Comply By: 8/24/2026 Originally Issued On: 8/24/2026

New Order: 5-200C Plumbing: Maintenance, fixture location
5-205.11AB *Priority Level: Priority 2 CFP#: 10*
MN Rule 4626.1110AB The handwashing sink must be accessible at all times for employee use, and must be used only for handwashing.
COMMENT:
HANDWASH SINK BLOCKED BY PLATE AND UTENSILS IN BASIN.
HANDWASH BASIN CLEARED.
KEEP HANDWASH SINK CLEAR OF ALL ITEMS AND AVAILABLE FOR HANDWASHING AT ALL TIMES.

Comply By: 8/26/2026 Originally Issued On: 8/24/2026

New Order: 6-500 Physical Facility Maintenance/Operation and Pest Control
6-501.11 *Priority Level: Priority 3 CFP#: 55*
MN Rule 4626.1515 Maintain the physical facilities in good repair.
COMMENT:
THE FOLLOWING AREAS NEED TO BE REPAIRED OR REPLACED:

1. LAMINATE COUNTER IS DAMAGED AND COVERED WITH TAPE (UNCLEANABLE).
REMOVE TAPE AND REPAIR COUNTER DAMAGE.

2. WOOD CABINETRY BELOW SINK HAS BLACK SUBSTANCE COVERING FRONT OF MILLWORK AND INSIDE OF LOWER DOOR COVERS.
REMOVE ALL BLACK SUBSTANCE AND RESEAL WOOD.
REPLACE WOOD IF UNABLE TO CLEAN.

3. MULTIPLE CUPBOARD INTERIORS ARE DAMAGED (NO LONGER SMOOTH, DURABLE, CLEANABLE, AND NON-ABSORBENT).
CLEAN INTERIOR OF CUPBOARDS AND COVER DAMAGED CUPBOARD SURFACES WITH CONTACT PAPER OR SIMILAR PRODUCT.

Comply By: 9/21/2026 Originally Issued On: 8/24/2026

Food & Beverage General Comment

Nurse Evaluator on site: Rhawnie Quinehan

All violations discussed with PIC during the inspection.

NOTES:
Facility has a residential kitchen with the following finishes:
Laminate wood flooring
Wood cabinetry
Laminate countertops
Textured ceiling
2-comp sink with right basin designated for handwashing.

Since establishment has a residential kitchen (4626.0506(G)(2)) Same-day service only. No saving and reheating of foods or preparation of foods the day prior to eating. Any remaining food from meals to be removed/discarded at end of day.

Discussed the following with pic:
Hand washing
Ware washing and dish machine temp (160F or greater)
Illness and illness log
No undercooked foods and cooking temps
Pasteurized egg use

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 F1031261255 from 8/24/2026

Natalia Campbell
Person in Charge

Chris Foster, REHS/RS
Public Health Sanitarian 3
651-201-4728
chris.j.foster@state.mn.us

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

Temperature Observations/Recordings

Establishment Info

JAMES RESIDENCES
Brooklyn Park
County/Group: Hennepin County

Inspection Info

Report Number: F1031261255
Inspection Type: Full
Date: 8/24/2026
Time: 1pm

Food Temperature: Product/Item/Unit: Milk**; Temperature Process:** Cold-Holding
Location: Refrigerator (main) at 44 Degrees F.
Comment:
Violation Issued?: Yes

Food Temperature: Product/Item/Unit: Sour Cream**; Temperature Process:** Cold-Holding
Location: Refrigerator (main) at 50 Degrees F.
Comment:
Violation Issued?: Yes

Food Temperature: Product/Item/Unit: Mayo**; Temperature Process:** Cold-Holding
Location: Refrigerator (main) at 48 Degrees F.
Comment:
Violation Issued?: Yes

Food Temperature: Product/Item/Unit: Soda**; Temperature Process:** Cold-Holding
Location: Refrigerator (office) at 43 Degrees F.
Comment:
Violation Issued?: Yes

Food Temperature: Product/Item/Unit: Water**; Temperature Process:** Cold-Holding
Location: Refrigerator (office) at 43 Degrees F.
Comment:
Violation Issued?: Yes

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

Sanitizer Observations/Recordings

Establishment Info

JAMES RESIDENCES
Brooklyn Park
County/Group: Hennepin County

Inspection Info

Report Number: F1031261255
Inspection Type: Full
Date: 8/24/2026
Time: 1pm

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Kitchen **Less Than** 150 Degrees F.
Comment:
Violation Issued?: Yes

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL32622016-0	**Date:** August 26, 2026
Facility Name: JAMES RESIDENCES	
Facility Address: 9400 JAMES AVE N, Brooklyn Park, MN, 55444	

☒ **TAG IDENTIFICATION: 0775**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Seven (7) 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. Single- and multiple-station smoke alarms shall be replaced when they fail to respond to operability tests or exceed ten years from the date of manufacture. Smoke alarms shall be replaced with smoke alarms having the same type of power supply. [Minn. Stat. 144G.45 subd. 2; MSFC 1103.8.1]

   Comments: The hard-wired smoke alarm in lower-level hallway was over 10 years past the manufacturer date. All smoke alarms shall be replaced with smoke alarms having the same type of power supply.

☒ **TAG IDENTIFICATION: 0780**

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

1. Smoke alarms interconnected so that actuation of one alarm causes all alarms in the individual dwelling or sleeping unit to operate where more than one smoke alarm is required within an individual dwelling or sleeping unit. [Minn. Stat. 144G.45 subd.2]

   Comments: Existing hardwired (receiving power from the building electrical system) smoke alarms were removed from the facility or were not being maintained. Hard-wired smoke alarms are required to be maintained as installed previously and interconnected to additional battery-operated alarms, so activation of one alarm activates all alarms throughout the facility.

2. Smoke Alarm power supply complies with MN State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated. [Minn. Stat. 144G.45 subd.2]

   Comments: The existing hardwired smoke alarms were removed from the facility and replaced with battery powered smoke alarms. Existing hardwired smoke alarms are required to be maintained as installed previously and shall be replaced with smoke alarms having the same type of power supply.

☒ **TAG IDENTIFICATION: 0800**

SCOPE/ SEVERITY: Level 2; Widespread **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: Basement occupied resident room four egress window frame was breaking away from the opening/closing hardware.

   In unoccupied resident room 1, there was a wasp hive and wasps inside the window.

   In occupied resident room 2 the egress window screen was torn away.

   In the upper bathroom shower, there was a tile that had broken away from the wall.