



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

September 3, 2026

Licensee

We Care Assisted Living

5039 Brent Avenue

Inver Grove Heights, MN 55076

RE: Project Number(s) SL37945017

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 4, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement;

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;

Level 3: a fine of \$1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

Level 4: a fine of \$3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

Level 5: a fine of \$5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this survey:

St - 0 - 0810 - 144g.45 Subd. 2 (b-F) - Fire Protection And Physical Environment - \$500.00

St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required \$1,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$1,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by MDH within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

To submit a hearing request, please visit:

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,

A handwritten signature in black ink, appearing to read "Jodi Johnson", with a stylized, flowing script.

Jodi Johnson, Supervisor

State Evaluation Team

Email: Jodi.Johnson@state.mn.us

Telephone: 507-344-2730 Fax: 1-866-890-9290

KKM

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37945	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/04/2026
NAME OF PROVIDER OR SUPPLIER WE CARE ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 5039 BRENT AVENUE INVER GROVE HEIGHTS, MN 55076			
(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: SL37945017-0 On August 3, 2026, through August 4, 2026, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were four residents; four receiving services under the Assisted Living Facility license. 1290: An immediate correction order was issued on August 4, 2026, at a level 3/Widespread (I). The licensee took immediate action; however, the scope and level remain at I.	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			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the 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	0 480			

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0 480	Continued From page 3 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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post in a conspicuous place, information about the licensee's grievance procedure with the required content. This had the potential to affect the licensee's current 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	0 550			

Minnesota Department of Health

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0 550	Continued From page 4 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On August 3, 2026, at 9:40 a.m. during the facility tour with house manager/unlicensed personnel (HM/ULP)-B, the surveyor observed the licensee's grievance procedure posted on the wall outside of the ULP office. Although the posted grievance procedure included the contact information for the Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, and Minnesota Adult Abuse Reporting Center (MAARC), the two postings had contact information for a previous employee. The postings lacked the name, telephone number and email contact information for individuals who were currently responsible for handling resident grievances. On August 4, 2026, at 12:30 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A reviewed the posted grievance procedure and stated it did not include the name, telephone number, and email contact for the individuals who were currently responsible for handling resident grievances. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550			
0 650 SS=D	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	0 650			

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0 650	Continued From page 5 individual contractor providing services. The records must include the following information: (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 interview and record review, the licensee failed to ensure employee records included all required content for one of two employees (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:	0 650			

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0 650	Continued From page 6 ULP-D was hired on November 4, 2025, to provide direct care and services to the facility's residents. ULP-D's record contained the following Competencies Training dated October 27, 2025: -Hand Washing -Bandage Wrap Application -Blood Glucose Testing -CPAP/BiPAP Care -Foley and Suprapubic Catheter Care -Intake and Output Tracking -Mechanical Lifts -Ear Drops -Eye Drops and Ointment -Liquid Medications -Meter Dose Inhaler -Narcotics Administration -Nasal Sprays -Oral Medications -Rectal Medications -Medication, Exercise and Treatment Reminders -Sublingual Medications -Topical Medications -Topical Patches -Unplanned Time Away Medication Set Up -Assistance with Eating -Basic Nutrition/Food Safety -Modified Diets and Thickened Liquids -Oxygen Use and Oxygen Saturation Levels -Range of Motion Exercises and Positioning -Transfer and Ambulation Techniques -Splint and Brace Application -TED Hose and Compression Stockings -Vital Signs -Wound Care and Dressing Changes -Bathing Assistance ULP-D's competencies listed above were signed	0 650			

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0 650	Continued From page 7 by ULP-D; however, they were not signed by a registered nurse and the area to document if ULP-D passed or failed the competency trainings were all left blank. On August 4, 2026, at 1:04 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A reviewed ULP-D's training and competency documents and stated the competency documents listed above were not completed or signed by him. LALD/CNS-A stated he had trained two ULP at the same time and documented the pass or fail of those ULPs on a later date and must not have completed documenting all the competencies for ULP-D. LALD/CNS-A further stated ULP-D was trained and passed all the competencies listed above. The licensee's Competency Training Evaluations policy dated September 1, 2023, indicated a copy of all education, training, and competency testing shall be kept in each employee's personnel file. 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 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	0 660			

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0 660	Continued From page 8 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 program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included a two-step TST (tuberculin skin test) or other evidence of tuberculosis (TB) screening such as a blood test for one of two employees (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did no harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: ULP-C was hired on January 20, 2026, to provide direct care and services to the licensee's residents. ULP-C's record included the following: -Baseline TB Screening Tool dated January 20, 2026. -a negative quantiferon test dated March 14,	0 660			

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0 660	Continued From page 9 2025; however, the blood test was not completed within 90 days of hire. On August 4, 2026, at 12:54 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated ULP-C had a negative quantiferon test that was completed prior to being hired. LALD/CNS-A stated he was not aware that the test had to be completed within 90 days of hire. The licensee's Tuberculosis Screening policy dated September 1, 2023, indicated baseline (upon hire) screening will be completed, but serial (annual screening will only be required with increased occupational risk or exposure. Screening will be conducted as follows: 1. New staff will be screened for active signs of TB using the Baseline TB Screening Tool 2. New staff will have an IGRA blood test or a two-step Mantoux conducted with results documented on the Baseline TB Screening Tool 3. No staff will be permitted to begin work where the work involves sharing the air space with residents until the negative results of the first Mantoux are read and documented, or a negative IGRA blood test result is received and documented 4. Staff TB screening results will be kept in each employee medical file 5. Staff should be screened for signs and symptoms on an annual basis. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660			

Minnesota Department of Health

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0 680	Continued From page 10	0 680			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an all-hazards risk assessment emergency preparedness (EP) program and plan to include Appendix Z required elements and failed to post the plan prominently. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 680			

Minnesota Department of Health

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0 680	Continued From page 11 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 the residents). The findings include: The licensee's Emergency Preparedness plan dated April 30, 2026, was reviewed and lacked the following: - establish/maintain a comprehensive emergency plan (EP) which describes the facility's approach to meeting health/safety/security needs of staff/residents addressing how they would coordinate with other health care facilities (HCF), as well as community on a whole during emergency or disaster (natural, man-made, facility, etc.) and be reviewed/updated annually; - risk assessment which considered hazards like care related emergencies, cyber-attacks, normal supply of essential resources and medical supplies, should consider duration of interruptions, consider emerging infectious diseases (EIDs); - identification of at-risk population needs like maintaining independence, communication, transportation, supervision, medical care; and qualified person authorized in writing to act in the absence of the administrator; - a process for cooperation and collaboration with local, tribal, regional, State and Federal EP to maintain integrated response; - policy and procedure based on the EP risk assessment and communication plan; - policy and procedure addressing whether evacuated or shelter in place for staff/residents for food, water, medical supplies, pharmaceutical	0 680			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37945	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/04/2026
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0 680	Continued From page 12 supplies; - policy and procedure addressing alternate sources of energy to maintain temperatures to protect resident health/safety, safe and sanitary storage of provisions emergency lighting and sewage and waste disposal; - policy and procedure addressing safe evacuation form facility, including care and treatment needs of evacuees; staff responsibilities; primary/alternate communication means with external sources of assistance; - policy and procedure to shelter in place for residents, staff, and volunteers who remain in the facility; - policy and procedure addressing system of medical documentation that preserves resident information, protects confidentiality, and secures/maintains availability of records; - policy and procedures addressing development of arrangements with other facilities/providers to receive residents in the event of limitations/cessation of operations to maintain the continuity of services to residents; - policy and procedure addressing the role of facility under waiver declared by the Secretary in accordance with section 1135 of the ACT; - develop a written communication plan; - communication plan which includes names/contact information: staff, entities providing services under agreement, residents' physicians, other facilities, volunteers; - communication plan which includes contact information for Federal, State, tribal, regional, and local EP staff; State Licensing and Certification Agency; and other sources of assistance; - communication plan which includes alternate means of communication with facility staff and Federal, State, tribal, regional, and local emergency management agencies; - communication plan which includes method for	0 680			

Minnesota Department of Health

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0 680	Continued From page 13 sharing information and medical documentation for residents under the facility's care, as necessary, with other health care personnel to maintain continuity of care; means, in event of evacuation, to release resident information as permitted under 45 CFR 164.510(b)(1)(ii); means of providing information about general condition/location of residents under facility's care as permitted under 45 CFR 164.510(b)(4); - communication plan which includes means to providing information about the facility occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the incident command center, or designee; and - communication plan which includes method for sharing information from the emergency plan, that the facility has determined appropriate, with residents and their families/representatives; - develop and maintain an EP training and testing program; - training program which includes initial training in EP policy and procedure to all new and existing staff, individuals providing services under arrangement, volunteers consistent with their expected role; provide EP training at least annually; maintain documentation of all EP training; demonstrate staff knowledge of EP; - conduct exercises to test EP at least twice per year, including unannounced staff drills using EP, including participating in an annual full-scale exercise community based or annual individual facility based functional exercise or if facility experiences an actual emergency requiring evacuation of plan, facility is exempt from engaging in its next required full scale exercise; conduct an additional annual exercise that may include a second full scale exercise community based or an individual; facility based functional exercise or mock disaster drill or table top exercise.	0 680			

Minnesota Department of Health

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0 680	Continued From page 14 On August 4, 2026, at 1:11 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the EP plan did not include the required content as listed above. LALD/CNS-A stated a few months ago a consultant provided updated documents for the licensee's emergency preparedness manual and it was a work in progress. The licensee's Emergency Preparedness Plan-Appendix Z Compliance policy dated September 1, 2023, indicated the licensee has in place an effective and compliant Emergency Preparedness Plan. The intent is the plan will be aligned with the Centers for Medicare and Medicaid Services State Operation Manual Appendix Z. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680			
0 700 SS=F	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	0 700			

Minnesota Department of Health

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0 700	Continued From page 15 review, the licensee failed to ensure resident's personal health and medical information was kept private. This had the potential to affect all residents residing within 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) 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 3, 2026, at 11:46 a.m., the surveyor observed house manager/unlicensed personnel (HM/ULP)-B prepare to administer medications to R3. HM/ULP-B logged into the laptop and pulled up R3's record, prepared the medications and went to the kitchen to administer R3's medications. HM/ULP-B left R3's record open on the laptop screen, which was visible to others. On August 3, 2026, at 12:17 p.m., the surveyor observed HM/ULP-B prepare to administer medications to R1. HM/ULP-B logged into the laptop and pulled up R1's record, prepared the medications and went to R1's room. HM/ULP-B left R1's record open on the laptop screen, which was visible to others. On August 4, 2026, at 7:05 a.m., the surveyor noted the staff office door was open with no staff present, the medication cart was unlocked with the keys in the lock, and the laptop screen was open with a resident's record open and visible to others.	0 700			

Minnesota Department of Health

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0 700	Continued From page 16 On August 4, 2026, at 7:48 a.m., the surveyor observed HM/ULP-B prepare to administer medications to R1. HM/ULP-B logged into the laptop and pulled up R1's record, prepared the medications and went to R1's room. HM/ULP-B left R1's record open on the laptop screen, which was visible to others. On August 4, 2026, at 12:32 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the laptop screen should be minimized or closed when staff were not using the computer. LALD/CNS-A stated all staff were trained to keep resident records confidential and private from any unauthorized individuals. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 700			
0 775 SS=E	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 775			

Minnesota Department of Health

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0 775	Continued From page 17 resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated August 4, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Two (2) days	0 775			
0 800 SS=D	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements	0 800			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37945	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/04/2026
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0 800	Continued From page 18 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 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: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated August 4, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800			
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37945	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/04/2026
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0 810	Continued From page 19 evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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:	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37945	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/04/2026
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0 810	Continued From page 20 Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated August 4, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
01290 SS=I	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 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 interview and record review, the licensee failed to ensure a background study was submitted and received in affiliation with the assisted living license for two of two employees (unlicensed personnel (ULP)-C and ULP-D). This had the potential to affect all residents residing in the facility. This resulted in an immediate order	01290			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37945	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/04/2026
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01290	Continued From page 21 on August 4, 2026. This practice resulted in a level three violation (a violation that harmed a client/resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On August 4, 2026, at 7:24 a.m., the surveyor reviewed the licensee's NETStudy 2.0 (web-based system used to submit background study requests) roster. The surveyor did not observe ULP-C and ULP-D on the licensee's roster for HFID 37945. ULP-C ULP-C was hired on January 20, 2026, to provide direct care and services to the facility's residents. On August 4, 2026, at 9:54 a.m., a review of NETStudy showed that ULP-C was affiliated with a Housing and Community Based Services license that is no longer active. ULP-C's record lacked a background study affiliated with the licensee. ULP-D ULP-D was hired on November 4, 2025, to provide direct care and services to the facility's residents. On August 4, 2026, at 9:52 a.m., a review of NETStudy showed that ULP-D was affiliated with	01290			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37945	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/04/2026
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01290	Continued From page 22 a Housing and Community Based Services license that is no longer active. ULP-D's record lacked a background study affiliated with the licensee. August 4, 2026, at 9:50 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A reviewed the licensee's NETStudy roster and stated ULP-C and ULP-D were not listed. LALD/CNS-A stated he submitted background studies for both ULP-C and ULP-D and was not sure why they were not included on the roster. LALD/CNS-A stated the only reason he could think of for ULP-C and ULP-D not being on the NETStudy roster was that he was recently directed to close his NETStudy account and set up a new one. LALD/CNS-A states ULP-C and ULP-D were listed on the account that was closed and thought they would transfer to the current NETStudy roster for the facility. LALD/CNS-A stated both ULP-C and ULP-D worked independently providing direct care and services to the residents living in the facility. The licensee's Background Studies policy dated September 1, 2023, indicated the following: 1. The licensee will initial background study on all employees being considered for hire 2. If hired prior to receiving the results of the background study, or the tentative background study results indicate more time is needed requiring supervision, new hires shall not be permitted to interact or provide services to tenants or clients except under the direct supervision (eyesight) of another qualified staff person 3. Once an approved background study has been received, staff may act independently with residents, assuming all other requirements have	01290			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37945	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/04/2026
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01290	Continued From page 23 been met 4. Copies of completed background studies shall be kept in individual employee records No further information was provided. TIME PERIOD FOR CORRECTION: Immediate The licensee took immediate action to mitigate risk; however, the scope and level remains at I.	01290			
01370 SS=F	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating;	01370			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37945	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/04/2026
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01370	Continued From page 24 (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency was completed for two of two employees (unlicensed personnel (ULP)-C, ULP-D) to include all required content. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-C ULP-C was hired on January 20, 2026, to provide direct care and services to the licensee's residents. ULP-C's employee record lacked evidence of	01370			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37945	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/04/2026
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01370	Continued From page 25 training for the following topics: -documentation requirements for all services provided; -training on the prevention of falls; -communication skills that include preserving the dignity of the resident and showing resident for the resident and the resident's preferences, cultural background, and family. -awareness of confidentiality and privacy; -understanding appropriate boundaries between staff and residents and the resident's family; -procedures for handling various emergency situations ULP-D ULP-D was hired on November 4, 2025, to provide direct care and services to the facility's residents. ULP-D's employee record lacked evidence of training for the following topics: -documentation requirements for all services provided; -training on the prevention of falls; -communication skills that include preserving the dignity of the resident and showing resident for the resident and the resident's preferences, cultural background, and family. -awareness of confidentiality and privacy; -understanding appropriate boundaries between staff and residents and the resident's family; -procedures for handling various emergency situations On August 4, 2026, at 12:57 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated ULP-C and ULP-D's record lacked documentation of the training and competency evaluations as listed above. LALD/CNS-A further stated he assigned the	01370			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37945	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/04/2026
NAME OF PROVIDER OR SUPPLIER WE CARE ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 5039 BRENT AVENUE INVER GROVE HEIGHTS, MN 55076			
(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
01370	Continued From page 26 same training and competency evaluations to all staff and thought it met the training requirements. The licensee's Competency Training Evaluations policy dated September 1, 2023, indicated training and competency evaluations for all ULPs will include: -documentation requirements for all services provided -training on the prevention of falls -communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family -awareness of confidentiality and privacy -understanding appropriate boundaries between staff and residents and the residents' family -procedures for handling various emergency situations No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370			
01380 SS=F	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident;	01380			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37945	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/04/2026
NAME OF PROVIDER OR SUPPLIER WE CARE ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 5039 BRENT AVENUE INVER GROVE HEIGHTS, MN 55076			
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01380	Continued From page 27 (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency was completed for two of two employees (unlicensed personnel (ULP)-C, ULP-D) to include all required content. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-C ULP-C was hired on January 20, 2026, to provide direct care and services to the licensee's residents. ULP-C's employee record lacked evidence of training for the following topics: - observing, reporting, and documenting resident status - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel - recognizing physical, emotional, cognitive, and	01380			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37945	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/04/2026
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01380	Continued From page 28 development needs of the resident ULP-D ULP-D was hired on November 4, 2025, to provide direct care and services to the facility's residents. ULP-D's employee record lacked evidence of training for the following topics: - observing, reporting, and documenting resident status - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel - recognizing physical, emotional, cognitive, and development needs of the resident On August 4, 2026, at 12:57 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated ULP-C and ULP-D's record lacked documentation of the training and competency evaluations as listed above. LALD/CNS-A further stated he assigned the same training and competency evaluations to all staff and thought it met the training requirements. The licensee's Competency Training Evaluations policy dated September 1, 2023, indicated training and competency evaluations for all ULP's will include: -observing, reporting, and documenting resident status -basic knowledge of body functioning and changes in body function, injuries or other observed changes that must be reported to appropriate personnel; and - recognizing physical, emotional, cognitive, and development needs of the resident	01380			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37945	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/04/2026
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01380	Continued From page 29 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380			
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure direct supervision of staff performing delegated tasks was provided within 30 calendar days after the date on which the individual begins working for the licensee for	01440			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37945	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/04/2026
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01440	Continued From page 30 two of two unlicensed personnel (ULP-C and 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: ULP-C ULP-C was hired on January 20, 2026, to provide direct care and services to the licensee's residents. ULP-C's employee record lacked documentation of a registered nurse (RN) supervising ULP-C performing a delegated task within 30 days of beginning work with the licensee. ULP-D ULP-D was hired on November 4, 2025, to provide direct care and services to the facility's residents. ULP-D's employee record lacked documentation of a RN supervising ULP-D performing a delegated task within 30 days of beginning work with the licensee. On August 4, 2026, at 1:02 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated ULP-C and ULP-D's record lacked evidence of a 30-day supervision of a delegated task by the RN. LALD/CNS-A stated he was unaware of this requirement and had not	01440			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37945	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/04/2026
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01440	Continued From page 31 completed this for any of the ULP. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440			
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and	01470			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37945	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/04/2026
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01470	Continued From page 32 (9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure two of two employees (unlicensed personnel (ULP)-C and ULP-D) completed an orientation to assisted living facility licensing requirements and regulations before providing services to 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	01470			

Minnesota Department of Health

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01470	Continued From page 33 resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: ULP-C ULP-C was hired on January 20, 2026, to provide direct care and services to the licensee's residents. ULP-C's training transcript indicated ULP-C completed the following orientation to assisted living on July 10, 2026: -Assisted Living Bill of Rights- Minnesota (MN) -Vulnerable Adult Refresher- MN, ULP-C's employee record lacked evidence of orientation to assisted living regulations for any of the required topics, including: - Overview of Assisted Living statutes; - Review of provider's policies and procedures; - Handling emergencies and using emergency services; - Principles of person-centered planning/service delivery; - Handing of resident complaints, reporting of complaints, where to report; - Consumer advocacy services; and - Review of types of Assisted Living services the employee will provide and provider's scope of license. ULP-D ULP-D was hired on November 4, 2025, to provide direct care and services to the facility's residents.	01470			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37945	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/04/2026
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01470	Continued From page 34 ULP-D's training transcript indicated ULP-D completed the following orientation to assisted living: -Assisted Living Bill of Rights- MN, completed on July 16, 2026 -Vulnerable Adult Refresher-MN, completed on July 3, 2026 ULP-D's employee record lacked evidence of orientation to assisted living regulations for any of the required topics, including: - Overview of Assisted Living statutes; - Review of provider's policies and procedures; - Handling emergencies and using emergency services; - Principles of person-centered planning/service delivery; - Handing of resident complaints, reporting of complaints, where to report; - Consumer advocacy services; and - Review of types of Assisted Living services the employee will provide and provider's scope of license. On August 4, 2026, at 12:58 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated he had a document that he referred to when assigning orientation courses which included Assisted Living Bill of Rights-MN and Vulnerable Adult Refresher-MN, which he thought met the orientation requirements for all staff. LALD/CNS-A stated he was not aware of the additional orientation training required as noted above. The licensee's Orientation and Training policy dated September 1, 2023, indicated orientation must be completed once for each staff person and is not transferable to another home care provider.	01470			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37945	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/04/2026
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01470	Continued From page 35 1. All employees must complete the orientation to assisted living facility requirements before providing assisted living services to residents 2. The materials and/or type of training (i.e. video, lecture, reading, etc.) will be documented for compliance 3. The orientation must contain the following topics: a. An overview of the appropriate Assisted Living statues and rules b. An introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person c. Handling of emergencies and use of emergency services d. Compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC) e. The assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights f. Principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person g. Handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints h. Consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services i. A review of the types of assisted living services the employee will be providing and the facility's category of licensure	01470			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37945	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/04/2026
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01470	Continued From page 36 j. The staff person's job description upon hire and whenever there is a change to the job description that changes the nature of the job or how the job is to be performed k. The facility's organization chart and the roles of staff within the facility, and the services offered by the facility as identified in the uniform checklist disclosure of services l. The identification of incidents of maltreatment as defined under Minnesota Statutes section 626.5572, subdivision 15, including abuse, financial exploitation, and neglect, and an explanation that any act that constitutes maltreatment is prohibited No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01470			
01530 SS=F	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least	01530			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37945	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/04/2026
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01530	Continued From page 37 eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation 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 two of two employees (unlicensed personnel (ULP)-C, ULP-D) received the required amount of dementia, mental illness, and de-escalation training in the required time frame. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	01530			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37945	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/04/2026
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01530	Continued From page 38 or has the potential to affect a large portion or all the residents). The findings include: ULP-C ULP-C was hired on January 20, 2026, to provide direct care and services to the licensee's residents. ULP-C's employee record contained evidence the employee received 2.5 hours of dementia care training, not the required eight hours of training within 160 working hours of the employment start date. ULP-C's employee record contained evidence the employee received 1 hour of mental illness and de-escalation training, not the required two hours of training within 160 working hours of the employment start date. ULP-D ULP-D was hired on November 4, 2025, to provide direct care and services to the facility's residents. ULP-D's employee record contained evidence the employee received 2.5 hours of dementia care training, not the required eight hours of training within 160 working hours of the employment start date. ULP-D's employee record contained evidence the employee received 1 hour of mental illness and de-escalation training, not the required two hours of training within 160 working hours of the employment start date. On August 4, 2026, at 1:01 p.m., licensed	01530			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37945	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/04/2026
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01530	Continued From page 39 assisted living director/clinical nurse supervisor (LALD/CNS)-A stated he was not aware of the eight hours requirement for initial dementia training and thought two hours met the requirements for dementia training. LALD/CNS-A further stated he was not aware of the two hour requirement for initial mental illness/de-escalation training and thought one hour met the requirement for mental illness/de-escalation training. The licensee's Dementia Training policy dated September 1, 2023, indicated direct care employees will complete eight (8) hours of initial training within 160 hours of the employment start date. 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	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37945	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/04/2026
NAME OF PROVIDER OR SUPPLIER WE CARE ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 5039 BRENT AVENUE INVER GROVE HEIGHTS, MN 55076			
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01620	Continued From page 40 conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted timely ongoing nursing	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37945	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/04/2026
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01620	Continued From page 41 assessments 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 September 1, 2023, with diagnoses that included epilepsy (brain disorder defined by recurring, unprovoked seizures). R1's service plan dated March 14, 2026, indicated R1 received services to include grooming, dressing, bathing, incontinence care, toileting reminders, behavior monitoring, twice a day blood pressure checks, daily blood glucose checks, medication setup and medication administration. R1's ongoing nursing assessments dated September 1, 2025, December 1, 2025, March 2, 2026, and June 16, 2026, were reviewed. December 1, 2025, assessment was completed 91 days after the date of the previous assessment. The March 2, 2026, assessment was completed 91 days after the date of the previous assessment and the June 16, 2026, assessment was completed 106 days after the date of the previous assessment, thus all exceeding 90 calendar days. On August 4, 2026, at 12:34 p.m., licensed	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37945	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/04/2026
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01620	Continued From page 42 assisted living director/clinical nurse supervisor (LALD/CNS)-A stated he wasn't aware the comprehensive assessments had to be completed within exactly 90 days, and would complete them in the month that they were due, not by the exact date. LALD/CNS-A stated R1's assessment's were completed late as noted above. The licensee's Assessments, Reviews and Monitoring policy dated September 1, 2023, indicated resident monitoring and review must be conducted as needed based on change in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620			
01710 SS=F	144G.71 Subd. 3 Individualized medication monitoring and reas A registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. 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) conducted a face-to-face	01710			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37945	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/04/2026
NAME OF PROVIDER OR SUPPLIER WE CARE ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 5039 BRENT AVENUE INVER GROVE HEIGHTS, MN 55076			
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01710	Continued From page 43 medication management reassessment at least annually for one of one resident (R1) who received medication management services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on August 3, 2026, at 10:54 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee provided medication management services to the licensee's residents. R1 was admitted on September 1, 2023, with diagnoses that included epilepsy (brain disorder defined by recurring, unprovoked seizures). On August 4, 2026, at 7:48 a.m., the surveyor observed house manager/unlicensed personnel (HM/ULP)-B administer medications to R1. R1's service plan dated March 14, 2026, indicated R1 received services to include medication administration. R1's record included a face-to-face medication assessment completed on September 17, 2023. R1's record lacked an annual face-to-face medication reassessment to include an identification and review of all medications the resident was known to be taking including, a	01710			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37945	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/04/2026
NAME OF PROVIDER OR SUPPLIER WE CARE ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 5039 BRENT AVENUE INVER GROVE HEIGHTS, MN 55076			
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01710	Continued From page 44 review of the indications for use, side effects, contraindications, allergic or adverse reactions, and interventions needed in management of medications to prevent diversion. On August 4, 2026, at 12:38 p.m., LALD/CNS-A stated R1's record lacked an annual medication management assessment. LALD/CNS-A further stated he was not aware that the medication management assessment had to be reassessed annually. The licensee's Medication Management-Assessment, Monitoring and Reassessment policy dated September 1, 2023, indicated the licensee would monitor and reassess the resident's medication management services as needed when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01710			
01730 SS=D	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			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37945	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/04/2026
NAME OF PROVIDER OR SUPPLIER WE CARE ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 5039 BRENT AVENUE INVER GROVE HEIGHTS, MN 55076			
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01730	Continued From page 45 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 with the required content for one of one resident (R1).	01730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37945	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/04/2026
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01730	Continued From page 46 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: R1 was admitted on September 1, 2023, with diagnoses that included epilepsy (brain disorder defined by recurring, unprovoked seizures). R1's service plan dated March 14, 2026, indicated R1 received services to include medication administration. On August 3, 2026, at 12:17 p.m., the surveyor observed house manager/unlicensed personnel (HM/ULP)-B prepare to administer R1's medication. HM/ULP-B removed two 500 milligrams (mg) tablets of acetaminophen from a bottle stored in the medication cart. HM/ULP-B stated R1's family supplied his over-the-counter medications which included acetaminophen, calcium carbonate, Vitamin B12, Vitamin B1 and Aspirin. R1's individualized medication management plan dated June 16, 2026, indicated the following: -licensed nurse responsible for monitoring medication supplies and reordering as needed -Family or responsible party is responsible for monitoring medication and recording as needed: Family to provide mycophenolate	01730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37945	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/04/2026
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01730	Continued From page 47 On August 4, 2026, at 12:40 p.m., licensed assisted living/clinical nurse supervisor (LALD/CNS)-A stated R1's family ordered and provided R1's acetaminophen, calcium carbonate, Vitamin B12, Vitamin B1 and Aspirin. LALD/CNS-A stated he would update R1's medication management plan to reflect this change. R1's individualized medication management plan did not include the family ordering and supplying R1's over-the-counter medications. The licensee's Medication management Individualized Plan policy dated September 1, 2023, indicated the licensee would 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 instructions relating to the administration of medications d. identification of persons responsible for monitoring medications 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,	01730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37945	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/04/2026
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01730	Continued From page 48 verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730			
01750 SS=D	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 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 interview and record review, the licensee failed to specify in writing, specific instructions for as needed (PRN) medications and documented those instructions for one of one resident (R1) for medication administration delegated to unlicensed personnel (ULP). 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	01750			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37945	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/04/2026
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01750	Continued From page 49 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: R1 was admitted on September 1, 2023, with diagnoses that included epilepsy (brain disorder defined by recurring, unprovoked seizures). On August 4, 2026, at 7:48 a.m., the surveyor observed house manager/unlicensed personnel (HM/ULP)-B administer medications to R1. R1's service plan dated March 14, 2026, indicated R1 received services to include medication administration. CONSTIPATION R1's medication administration record (MAR) dated August 2026, included the following PRN medications for constipation: -bisacodyl 10 milligrams (mg) suppository; unwrap and insert one suppository rectally once daily as needed for constipation if no stool in three days -bisacodyl 4 mg; give one tablet by mouth once daily if no BM (bowel movement) for three days -milk of magnesia 30 milliliter (ml); give 30 ml by mouth once daily as needed for constipation -milk of magnesia; give 30-50 ml by to relieve constipation - house stock -polyethylene glycol 3350 power; mix one capful in liquid and take by mouth once daily as needed if no BM in two days -Senna-S 8.6-50 mg; take two tablets by mouth as needed if no bowel movement in last 24 hours up to one time per day	01750			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37945	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/04/2026
NAME OF PROVIDER OR SUPPLIER WE CARE ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 5039 BRENT AVENUE INVER GROVE HEIGHTS, MN 55076			
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01750	Continued From page 50 The licensee failed to provide instructions for the ULP to understand which PRN medication for constipation should be used in which order. Further the licensee failed to provide instructions for the ULP on when to administer 30, 40 or 50 ml of milk of magnesia. HEARTBURN/ACID REFLUX -calcium carbonate 500 mg; chew and swallow one tablet by mouth up to four times daily as needed -liquid antacid 30 ml by mouth up to four times daily as needed The licensee failed to provide instructions for the ULP to understand which PRN medication for heartburn/acid reflux should be used in which order. PAIN R1's MAR dated August 2026, included the following PRN medications for pain: -acetaminophen 500 mg; give two tablets by mouth every four hours as needed (pain or fever) -ibuprofen 200 mg; take 800 mg up to three times a day for pain -Tizanidine 4 mg; take one-half tablet by mouth at night as needed for pain -Voltaren 1% gel; apply two grams topically to bilateral shoulders three times a day as needed for pain The licensee failed to provide instructions for the ULP to understand which PRN medication for pain should be used in which order. On August 4, 2026, at 12:42 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated there were no written	01750			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37945	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/04/2026
NAME OF PROVIDER OR SUPPLIER WE CARE ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 5039 BRENT AVENUE INVER GROVE HEIGHTS, MN 55076			
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01750	Continued From page 51 instructions regarding which PRN medications should be given in which order for R1's PRN medications as listed above. The licensee's Medication and Treatment Orders policy dated September 1, 2023, indicated an an order for medication or treatment must contain the name of the resident, a description of the medication, treatment or therapy to be provided and the frequency, duration, and other information needed to carry out the order. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750			
01820 SS=D	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 current written or electronically recorded prescriptions were obtained for all medications the licensee managed 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 an isolated scope (when one or a	01820			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37945	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/04/2026
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01820	Continued From page 52 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: R1 was admitted on September 1, 2023, with diagnoses that included epilepsy (brain disorder defined by recurring, unprovoked seizures). On August 4, 2026, at 7:48 a.m., the surveyor observed house manager/unlicensed personnel (HM/ULP)-B administer medications to R1. R1's service plan dated March 14, 2026, indicated R1 received services to include medication administration. R1's medication administration record (MAR) dated August 2026, included the following medications: -famotidine 20 milligram (mg); take one tablet by mouth twice a day before meals (acid reflux) -oxcarbazepine 150 mg; take three tablets by mouth twice daily (anticonvulsant) -oxybutynin 15 mg; take one tablet by mouth once daily (bladder spasms) -propranolol 40 mg; take one tablet by mouth two times a day. Hold for SBP <100 and P <55 -tamsulosin 0.4 mg; take one capsule by mouth once daily (prostate) -tizanidine 2 mg; give one tablet by mouth twice daily (pain) -topiramate 25 mg; take three tablets by mouth once a day (seizures) -venlafaxine 150 mg capsule; take one capsule by mouth once daily (depression) -Vitamin B1 100 mg; take one tablet by mouth once daily (supplement) -melatonin 3 mg; give one tablet by mouth at	01820			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37945	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/04/2026
NAME OF PROVIDER OR SUPPLIER WE CARE ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 5039 BRENT AVENUE INVER GROVE HEIGHTS, MN 55076			
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01820	Continued From page 53 bedtime (insomnia) -amlodipine 5 mg; take one table by mouth once at bedtime. Do not give if SBP < 110 (blood pressure) -Aspirin 81 mg; give one tablet by mouth once daily (supplement) -acetaminophen 500 mg; give two tablets by mouth every four hours as needed (pain or fever) -benzonatate capsule 100 mg; one capsule three times daily as needed for cough, may take an additional capsule (total dose of 200 mg) -bisacodyl 10 mg suppository; unwrap and insert one suppository rectally once daily as needed for constipation if not stool in three days -bisacodyl 4 mg; give one tablet by mouth once daily if no BM (bowel movement) for three days -calcium carbonate 500 mg; chew and swallow one tablet by mouth up to four times daily as needed (heartburn) -guaifenesin 400 mg; give 20 milliliters (ml) every four hours as needed for cough -ibuprofen 200 mg; take 800 mg up to three times a day for pain -liquid antacid 30 milliliter (ml) by mouth up to four times daily as needed (acid reflux) -loperamide 2 mg; take one capsule after each loose stool. Maximum of 16 mg per day (diarrhea) -milk of magnesia 30 ml; give 30 ml by mouth once daily as needed for constipation -milk of magnesia; give 30-50 ml by to relieve constipation - house stock -polyethylene glycol 3350 power; mix one capful in liquid and take by mouth once daily as needed if no BM in two days -preparation H; one application per package instructions up to four times daily for hemorrhoid pain -Senna-S 8.6-50 mg; take two tablets by mouth as needed if no bowel movement in last 24 hours	01820			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37945	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/04/2026
NAME OF PROVIDER OR SUPPLIER WE CARE ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 5039 BRENT AVENUE INVER GROVE HEIGHTS, MN 55076			
(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
01820	Continued From page 54 up to one time per day -tizanidine 4 mg; take one-half tablet by mouth at night as needed for pain -Voltaren 1% gel; apply two grams topically to bilateral shoulders three times a day as needed for pain On August 4, 2026, at 12:45 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated he was not able to locate signed prescriber orders for the medications listed above. LALD/CNS-A stated he would contact R1's provider to request a signed medication list for all medications R1 is known to be taking. The license's Medication and Treatment Orders policy dated September 1, 2023, indicated that the registered nurse (RN) is responsible for assuring that a current, authorized prescriber orders for medications or treatments administered by the staff are kept on files in the residents' records. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820			
01830 SS=F	144G.71 Subd. 14 Renewal of prescriptions Prescriptions must be renewed at least every 12 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter 152. This MN Requirement is not met as evidenced by:	01830			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37945	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/04/2026
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01830	Continued From page 55 Based on interview and record review, the licensee failed to renew prescriptions at least every 12 months 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) 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 September 1, 2023, with diagnoses that included epilepsy (brain disorder defined by recurring, unprovoked seizures). On August 4, 2026, at 7:48 a.m., the surveyor observed house manager/unlicensed personnel (HM/ULP)-B administer medications to R1. R1's service plan dated March 14, 2026, indicated R1 received services to include medication administration. R1's medication administration record (MAR) dated August 2026, included the following medications: -ketoconazole 2% cream, apply topically to armpits twice a day (rash), prescriber order dated December 21, 2023. -diclofenac sodium 1% gel; apply topically to affected joints of shoulder and hips twice a day (pain), prescriber order dated March 6, 2024. -atorvastatin 80 milligram (mg); take one tablet by mouth at bedtime (cholesterol), prescriber order dated July 11, 2024. -Vitamin B12 1,000 micrograms (mcg); take one	01830			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37945	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/04/2026
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01830	Continued From page 56 tablet by mouth once daily (supplement), prescriber order dated October 24, 2024. -acetaminophen 500 mg; take two tablets by mouth three times a day (pain), prescriber order dated November 29, 2024. -calcium carbonate 500 mg; chew one tablet by mouth once daily, prescriber order dated November 29, 2024. -losartan 25 mg; take one tablet by mouth once daily (blood pressure), prescriber order dated November 29, 2024. R1's record lacked evidence of prescriber orders being renewed annually for the above medications. On August 4, 2026, at 12:45 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated R1's record lacked annual orders for the medications listed above. LALD/CNS-A stated he was not aware of this requirement until a couple months ago. LALD/CNS-A stated he was working on requesting annual orders for all the residents that received medication management services. The license's Medication and Treatment Orders policy dated September 1, 2023, indicated the licensed nurse will communicate with the prescriber to assure that the prescriber renews a medication or treatment/ therapy order at least every 12 months, or more frequently as needed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01830			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37945	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/04/2026
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01880	Continued From page 57	01880			
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure all medications were securely locked in substantially constructed compartments and permitted only authorized personnel to have access. 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) 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 3, 2026, at 11:46 a.m., the surveyor observed house manager/unlicensed personnel (HM/ULP)-B prepare to administer medications to R3. HM/ULP-B logged into the laptop and pulled up R3's record, prepared the medications and went to the kitchen to administer R3's medications. HM/ULP-B left the medication cart unlocked with the keys still in the lock and unattended. On August 3, 2026, at 12:17 p.m., the surveyor observed HM/ULP-B prepare to administer	01880			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37945	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/04/2026
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01880	Continued From page 58 medications to R1. HM/ULP-B logged into the laptop and pulled up R1's record, prepared the medications and went to R1's room. HM/ULP-B left the medication cart unlocked with the keys still in the lock and unattended. On August 4, 2026, at 7:48 a.m., the surveyor observed HM/ULP-B prepare to administer medications to R1. HM/ULP-B logged into the laptop and pulled up R1's record, prepared the medications and went to R1's room. HM/ULP-B left the medication cart unlocked with the keys still in the lock and unattended. On August 4, 2026, at 12:30 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the medication cart should be locked when not in use and when staff are not present at the cart. LALD/CNS-A stated the staff should always keep the keys on them. The licensee's Medication Storage policy dated September 1, 2023, indicated medications will be kept securely locked and stored per manufacturer's directions. Only authorized staff will have access to stored medications. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880			
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written	01940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37945	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/04/2026
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01940	Continued From page 59 statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all 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	01940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37945	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/04/2026
NAME OF PROVIDER OR SUPPLIER WE CARE ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 5039 BRENT AVENUE INVER GROVE HEIGHTS, MN 55076			
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01940	Continued From page 60 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: R1 was admitted on September 1, 2023, with diagnoses that included epilepsy (brain disorder defined by recurring, unprovoked seizures). On August 4, 2026, at 7:48 a.m., the surveyor observed house manager/unlicensed personnel (HM/ULP)-B check R1's blood pressure and pulse. The surveyor noted a CPAP (device that uses mild air pressure to keep your airway open while you sleep) machine on R1's bedside table. R1 stated the staff assisted him with the CPAP every night. HM/ULP-B stated the evening shift turned the CPAP machine on and applied it every night when R1 went to bed. R1's service plan dated March 14, 2026, indicated R1 received services to include grooming, dressing, bathing, incontinence care, toileting reminders, behavior monitoring, twice a day blood pressure checks, daily blood glucose checks, medication setup and medication administration. R1's service plan did not include twice daily pulse checks and CPAP management. CPAP R1's signed prescriber orders dated December 4, 2023, indicated: -CPAP every HS (bedtime) R1's medication administration record (MAR) dated August 2026, did not include CPAP services.	01940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37945	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/04/2026
NAME OF PROVIDER OR SUPPLIER WE CARE ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 5039 BRENT AVENUE INVER GROVE HEIGHTS, MN 55076			
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01940	Continued From page 61 R1's service recap summary dated August 2026, did not include CPAP services. R1's record lacked documentation of CPAP services provided by the ULP. BLOOD PRESSURE/PULSE CHECKS R1's record lacked signed prescriber orders for propranolol, amlodipine, twice daily blood pressure and pulse checks. R1's MAR dated August 2026, included the following: -Propranolol 40 milligrams (mg); take one tablet by mouth two times a day. Hold for SBP less than 100 and pulse less than 55. -amlodipine 5 mg; take one table by mouth once at bedtime. Do not give if SPB < 110 (blood pressure). R1's treatment management plan dated September 1, 2023, failed to include the following required content: - statement of the type of service that will be provided (CPAP, Blood Pressure Checks, Pulse Checks) - documentation of specific resident instructions relating to the treatments or therapy administration; - identification of treatment or therapy tasks that will be delegated to unlicensed personnel; - procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and - any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed and monitoring of treatment or therapy to prevent possible	01940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37945	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/04/2026
NAME OF PROVIDER OR SUPPLIER WE CARE ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 5039 BRENT AVENUE INVER GROVE HEIGHTS, MN 55076			
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01940	Continued From page 62 complications or adverse reactions. In addition, R1's service plan did not include a written statement of the treatment or therapy services that will be provided to the resident (CPAP and twice daily pulse checks). On August 4, 2026, at 12:51 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A reviewed R1's record and stated it lacked a individualized treatment management plan for R1's CPAP, blood pressure checks and pulse checks. The licensee's Treatment and Therapy Management Plan policy dated September 1, 2023, indicated the licensee will develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: a. a statement of the type of services that will be provided b. documentation of specific resident instructions relating to the treatments or therapy administration c. identification of treatment or therapy tasks that will be delegated to unlicensed personnel d. procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services e. any resident-specific requirements relating to documentation of treatments and therapy received f. verification that all treatment and therapy was administered as prescribed g. monitoring of treatment or therapy to prevent possible complications or adverse reactions No further information was provided.	01940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37945	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/04/2026
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01940	Continued From page 63	01940			
	TIME PERIOD FOR CORRECTION: Seven (7) days				
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure treatment or therapies were administered as prescribed, or to document the reason they were not provided, 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 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:	01960			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37945	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/04/2026
NAME OF PROVIDER OR SUPPLIER WE CARE ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 5039 BRENT AVENUE INVER GROVE HEIGHTS, MN 55076			
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01960	Continued From page 64 R1 was admitted on September 1, 2023, with diagnoses that included epilepsy (brain disorder defined by recurring, unprovoked seizures). On August 4, 2026, at 7:48 a.m., the surveyor observed house manager/unlicensed personnel (HM/ULP)-B check R1's blood pressure and pulse. The surveyor noted a CPAP (device that uses mild air pressure to keep your breathing airway open while you sleep) machine on R1's bedside table. R1 stated the staff assisted him with the CPAP every night. HM/ULP-B stated the evening shift turned the CPAP machine on and applied it every night when R1 went to bed. R1's service plan dated March 14, 2026, indicated R1 received services to include grooming, dressing, bathing, incontinence care, toileting reminders, behavior monitoring, twice a day blood pressure checks, daily blood glucose checks, medication setup and medication administration. R1's service plan did not include twice daily pulse checks and CPAP management. CPAP R1's signed prescriber orders dated December 4, 2023, indicated: -CPAP every HS (bedtime) R1's medication administration record (MAR) dated August 2026, did not include CPAP services. R1's service recap summary dated August 2026, did not include CPAP services. R1's record lacked documentation of CPAP services provided by the ULP. On August 4, 2026, at 12:52 p.m., licensed	01960			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37945	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/04/2026
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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
01960	Continued From page 65 assisted living director/clinical nurse supervisor (LALD/CNS)-A stated CPAP management had not been added to R1's service plan so it did not get included with the services that the ULP document. LALD/CNS-A stated he would update R1's service plan which will then add an area for the ULP to document assisting R1 with the CPAP every night. The licensee's Treatment and Therapy Management Plan policy dated September 1, 2023, indicated the licensee will develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: a. a statement of the type of services that will be provided b. documentation of specific resident instructions relating to the treatments or therapy administration c. identification of treatment or therapy tasks that will be delegated to unlicensed personnel d. procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services e. any resident-specific requirements relating to documentation of treatments and therapy received f. verification that all treatment and therapy was administered as prescribed g. monitoring of treatment or therapy to prevent possible complications or adverse reactions No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37945	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/04/2026
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01970	Continued From page 66	01970			
01970 SS=F	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure up-to-date written or electronically recorded orders were renewed at least every 12 months for one of one resident (R1) receiving treatments. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 was admitted on September 1, 2023, with diagnoses that included epilepsy (brain disorder defined by recurring, unprovoked seizures). On August 4, 2026, at 7:48 a.m., the surveyor observed house manager/unlicensed personnel (HM/ULP)-B check R1's blood pressure and pulse. The surveyor noted a CPAP (device that uses mild air pressure to keep your airway open	01970			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37945	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/04/2026
NAME OF PROVIDER OR SUPPLIER WE CARE ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 5039 BRENT AVENUE INVER GROVE HEIGHTS, MN 55076			
(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
01970	Continued From page 67 while you sleep) machine on R1's bedside table. R1 stated the staff assisted him with the CPAP every night. HM/ULP-B stated the evening shift turned the CPAP machine on and applied it every night when R1 went to bed. R1's service plan dated March 14, 2026, indicated R1 received services to include grooming, dressing, bathing, incontinence care, toileting reminders, behavior monitoring, twice a day blood pressure checks, daily blood glucose checks, medication setup and medication administration. R1's service plan did not include twice daily pulse checks and CPAP management. R1's MAR dated August 2026, included the following: -Propranolol 40 milligrams (mg); take one tablet by mouth two times a day. Hold for SBP less than 100 and pulse less than 55. -amlodipine 5 mg; take one table by mouth once at bedtime. Do not give if SBP < 110 (blood pressure). R1's record lacked signed prescriber orders for twice daily blood pressure and pulse checks. R1's signed prescriber orders dated December 4, 2023, indicated: -CPAP every HS (bedtime) On August 4, 2026, at 12:52 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated R1's record lacked current prescriber orders for R1's twice daily blood pressure and pulse checks and CPAP management. LALD/CNS-A stated he was not aware of this requirement until a couple months ago. LALD/CNS-A stated he was working on requesting annual orders for all the residents that	01970			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37945	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/04/2026
NAME OF PROVIDER OR SUPPLIER WE CARE ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 5039 BRENT AVENUE INVER GROVE HEIGHTS, MN 55076			
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01970	Continued From page 68 received treatment management services. The license's Medication and Treatment Orders policy dated September 1, 2023, indicated that the registered nurse (RN) is responsible for assuring that a current, authorized prescriber orders for medications or treatments administered by the staff are kept on files in the residents' records. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970			



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

Page: 1

Establishment Info

We Care Assisted Living
5039 BRENT AVENUE
inver grove heights, MN 55076
Dakota County
Parcel:

Phone:

License Info

License: HFID 37945

Risk:
License:
Expires on:
CFPM: Maydeu Ly
CFPM #: FM119050; Exp: 9/27/2026

Inspection Info

Report Number: F1004261207
Inspection Type: Full - Single
Date: 8/4/2026 Time: 10:00:00 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 2
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

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

3-302.11A(1) Priority Level: Priority 1 CFP#: 15

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

COMMENT: (ORIGINALLY ISSUED 4/30/24): RAW GROUND BEEF FOUND STORED OVER READY-TO-EAT ITEMS IN THE REFRIGERATOR. DISCUSSED STORAGE ORDER REQUIREMENTS WITH PERSON IN CHARGE ON SITE. RAW BEEF WAS MOVED TO LOWEST DRAWER WITH OTHER RAW ANIMAL PRODUCTS. REISSUED 8/4/26.

Comply By: 4/30/2024 Originally Issued On: 8/4/2026

! New Order: 4-700 Sanitizing Equipment and Utensils

4-702.11 Priority Level: Priority 1 CFP#: 16

MN Rule 4626.0900 Sanitize utensils and food contact surfaces of equipment before use, after cleaning.

COMMENT: STAFF STATED THAT SOME DISHES ARE WASHED BY HAND IN THE KITCHEN SINK.

ESTABLISHMENT DOES NOT HAVE A 3-COMPARTMENT WAREWASHING SINK. ENSURE ALL DISHES ARE WASHED USING THE DISH MACHINE WITH THE SANITIZE CYCLE TO FULLY WASH, RINSE, AND SANITIZE ALL DISHES AS REQUIRED.

Comply By: 8/4/2026 Originally Issued On: 8/4/2026

Food & Beverage General Comment

INSPECTION WAS CONDUCTED BY MOLLY DOUGHERTY (FPLS) IN CONJUNCTION WITH A HEALTH REGULATIONS DIVISION (HRD) SURVEY CONDUCTED BY KASSIE MARKING.

DISCUSSED:

- EMPLOYEE ILLNESS POLICY AND LOG
- HANDWASHING
- PREVENTING BAREHAND CONTACT
- SANITIZER USE
- CLEANING/SANITIZING FOOD CONTACT SURFACES AND UTENSILS
- HIGH TEMPERATURE SANITIZING DISH MACHINE TEMPERATURE VERIFICATION
- DATE MARKING PROCEDURES
- THERMOMETER USE AND CALIBRATION
- SERVING A HIGHLY SUSCEPTIBLE POPULATION (NO RAW/UNDERCOOKED ANIMAL FOODS, NO UNPASTEURIZED JUICE, MILK, ETC)
- VOMIT/FECAL INCIDENT CLEAN UP PROCEDURES
- FOOD SOURCE
- RECEIVING DELIVERIES PROCEDURES

-FOOD SERVICE PROCEDURES (SAME-DAY SERVICE ONLY)

-PEST CONTROL

-LOGS

-PHYSICAL FACILITIES AND MAINTENANCE

*CURRENT RESIDENT HAS A DOG ON SITE. DOG IS ONLY ALLOWED IN BASEMENT (WITH SEPARATE ENTRANCE), AND DOES NOT ENTER THE KITCHEN AREA.

*REPORT WAS DISCUSSED WITH THE PERSON IN CHARGE AND WITH THE NURSE EVALUATOR ON SITE AT THE CONCLUSION OF THE INSPECTION.

*FLOORS ARE LAMINATE PLANK TILES, WALLS ARE SMOOTH PAINTED DRYWALL, AND CEILING IS "ORANGE PEEL" TEXTURE. COUNTERTOPS ARE SOLID, SMOOTH STONE, AND CABINETS ARE LAMINATE WITH HALLOW BASE. ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT SUCH A TIME THEY ARE FOUND TO BE A CONCERN OR RISK OF CONTAMINATION, THEY WILL BE ORDERED TO BE REPLACED AND BROUGHT UP TO CODE.

*KITCHEN HAS A 2-BASIN SINK. ONE BASIN IS DESIGNATED AS THE HANDWASHING SINK. THIS BASIN MAY ONLY BE USED FOR HANDWASHING PURPOSES.

*KITCHEN HAS RESIDENTIAL GRADE EQUIPMENT. ALL FOOD MUST BE PREPARED AND SERVED SAME-DAY.

*IF ANY RESIDENT COMPLAINS OF ILLNESS, CONTACT THE MINNESOTA DEPARTMENT OF HEALTH AND PROVIDE THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER TO THE RESIDENT. THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER IS 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 F1004261207 from 8/4/2026

Tawana Henderson
Person in Charge

Molly Dougherty
Molly Dougherty,
Public Health Sanitarian 3
651-201-3978
molly.dougherty@state.mn.us



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

Temperature Observations/Recordings

Page: 1

Establishment Info	Inspection Info
We Care Assisted Living inver grove heights County/Group: Dakota County	Report Number: F1004261207 Inspection Type: Full Date: 8/4/2026 Time: 10:00:00 AM

Food Temperature: **Product/Item/Unit:** chicken salad; **Temperature Process:** Cold-Holding

Location: Refrigerator at 40 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: **Product/Item/Unit:** cut lettuce; **Temperature Process:** Cold-Holding

Location: Refrigerator at 40 Degrees F.

Comment:

Violation Issued?: No



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

Sanitizer Observations/Recordings

Page: 1

Establishment Info

We Care Assisted Living
inver grove heights
County/Group: Dakota County

Inspection Info

Report Number: F1004261207
Inspection Type: Full
Date: 8/4/2026
Time: 10:00:00 AM

Sanitizing Equipment: Product: Hot Water; **Sanitizing Process:** Dish Machine

Location: Kitchen **Equal To** 186 Degrees F.

Comment: *per establishment's irreversible temperature indicator

Violation Issued?: No

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL37945017-0	Date: August 4, 2026
Facility Name: We Care Assisted Living	
Facility Address: 5039 Brent Avenue, Inver Grove Heights, MN 55076	

☒ **TAG IDENTIFICATION: 0775**

SCOPE/ SEVERITY: Level 2; Pattern

TIME PERIOD OF CORRECTION: Two (2) days

1. Each assisted living facility must comply with the provisions of the Minnesota State Fire Code (MSFC) in Minnesota Rules chapter 7511. [Minn. Stat. 144G.45 subd. 2]
2. Lighted matches, cigarettes, cigars or other burning objects shall not be discarded in such a manner that could cause ignition of other combustible material. [Minn. Stat. 144G.45 subd. 2; MSFC 310.7]

Comments: On the exterior of the building, outside the front door, burnt cigarettes had been disposed of inappropriately inside a ceramic planter containing potting soil.

3. Extension cords and flexible cords shall not be a substitute for permanent wiring, nor shall such cords be subject to environmental damage or physical impact. [Minn. Stat. 144G.45 subd. 2; MSFC 604.5]

Comments: Extension cords were used in resident room C and in the main floor living room to supply power to electronics. Additionally, in the basement living room, two extension cords were plugged into wall outlets and stored on the floor where they were exposed to foot traffic.

☒ **TAG IDENTIFICATION: 0800**

SCOPE/ SEVERITY: Level 2; Isolated

TIME PERIOD OF CORRECTION: Seven (7) days

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:

- In resident room A, the cover plate and switch for the closet light were loose.
- The chairs on the back deck were in disrepair.
- In the main floor bathroom, the cover was missing from one ceiling light fixture and there was wheelchair damage on wall surfaces in several locations.

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Twenty One (21) days

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

Comments: The surveyor requested the fire safety and evacuation plan (FSEP) from licensed assisted living director (LALD)-A. LALD-A provided an emergency binder with undated fire emergency procedures. The LALD-A also printed an electronic copy of a FSEP that they stated had been updated in April 2026. The FSEP in the binder did not match the electronic copy of the FSEP dated April 30, 2026.

2. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that include the location and number of resident rooms. [Minn. Stat. 144G.45 subd.2]

Comments:

- Letters were posted at the doors for bedrooms B, C, and D on the main floor. The emergency evacuation floor plans displayed in the building lacked these resident room letter identifiers. Resident room identifiers (letters) are required to be included on the floor plans to provide efficient communication for exiting in the event of a fire or similar emergency.
- The letter A was posted at the door for the resident bedroom in the basement. The emergency evacuation floor plans displayed in the building labeled this room as "bedroom #6". Accurate resident room identifiers shall be included on the emergency evacuation floor plans.
- A room identifier was not posted on or at the door for the resident bedroom adjacent to the kitchen. Identifiers for all resident bedrooms need to be posted and correspond with the bedroom labels on the emergency evacuation floor plans.

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

Comments: The fire safety and evacuation plan 2.11 employee actions, dated April 30, 2026, inappropriately directed employees to evacuate residents to an area of refuge inside the facility, in a building without fire resistant construction or life safety systems.

4. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that include procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. [Minn. Stat. 144G.45 subd.2]

Comments: The fire safety and evacuation plans provided by licensed assisted living director (LALD)-A failed to include evacuation procedures for the individualized unique needs of residents.

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

Comments: The surveyor requested records for employee training on the fire safety and evacuation plan (FSEP) completed at the time of hire and in the last year from licensed assisted living director (LALD)-A . Employee FSEP training records were not provided for review when requested. The licensee stated employees were trained on the FSEP at the time of hire and before each fire drill. LALD-A stated records had not been created to document employee FSEP training.

6. Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. [Minn. Stat. 144G.45 subd.2]

Comments: The surveyor requested records for resident training on fire safety and evacuation completed in the last year from licensed assisted living director (LALD)-A. Resident training records were not provided for review when requested. LALD-A stated residents were trained but records had not been created to document this training.

7. Evacuation drills are required for employees 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. [Minn. Stat. 144G.45 subd.2]

Comments: The surveyor requested records for evacuation drills completed in the past year from licensed assisted living director (LALD)-A. Fire drill reports indicated six fire drills were completed in the last year, and the licensee had inappropriately required all employees to participate in each drill. These fire drills lacked actual employee staffing levels during each shift to accurately test response capabilities. Additionally, the reports lacked simulated fire locations and drill conditions; information needed to evaluate regulatory compliance.