Electronically Delivered

September 8, 2026

Licensee
Minn Care Home Health
7215 Fremont Avenue North
Brooklyn Center, MN 55430

RE: Project Number(s) SL37270016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 31, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted no 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.

In accordance with Minn. Stat. § 144G.31, Subd. 4(a)(6), MDH may impose fine amounts of either

$1,000 or $5,000 to licensees who are found to be responsible for maltreatment. MDH may impose a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. MDH also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

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

St - 0 - 0495 - 144g.41 Subdivision. 1 (13) - Minimum Requirements - $1,000.00
St - 0 - 0810 - 144g.45 Subd. 2 (b-F) - Fire Protection And Physical Environment - $1,000.00
St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - $1,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

REQUESTING A HEARING

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

To submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

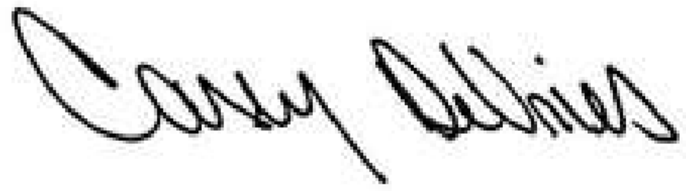
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,



Casey DeVries, Supervisor
State Evaluation Team
Email: Casey.DeVries@state.mn.us
Telephone: 651-201-5917 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37270	A. BUILDING: _____ B. WING _____	07/31/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINN CARE HOME HEALTH	7215 FREMONT AVENUE NORTH BROOKLYN CENTER, MN 55430

(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: SL37227016-0 On July 27, 2026, through July 31, 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 three resident(s); three receiving services under the Assisted Living Facility license. An immediate correction order was identified on July 29, 2026, issued for SL37270016-0, tag identification 0495 and 2310. On July 30, 2026, the licensee replied to the immediate orders for correction, however, did not provide documentation of any actions taken to comply with tag identification 0495.	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.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements	0 470		

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0 470	Continued From page 1 (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a written staffing plan that included an evaluation completed by a registered nurse (RN) (as indicated in Minnesota Administrative Rule 4659.0180) at least twice a year. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 470		

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0 470	Continued From page 2 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On July 28, 2026, at 8:44 a.m., licensed assisted living director (LALD)-A provided the surveyor with a policy titled "2.15 Staffing Plan" in response to a request for the licensee's staffing plan. On July 28, 2026, at 12:18 p.m., LALD-A stated the license utilized the staffing policy as their staffing plan. The licensee's 2.15 Staffing Plan policy lacked documentation of a metric to determine the required staffing level to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis. On July 3, 2026, at 1:55 p.m., clinical nurse supervisor (CNS)-D stated they were aware of the need for a staffing plan and the need for their participation in the development of this plan. CNS-D stated they were under the assumption the staffing plan policy was enough to meet this need. Additionally, CNS-D stated they continuously look at staffing levels with every 90-day assessment or whenever there is a change in condition with residents. No further information was provided.	0 470		

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0 470	Continued From page 3 TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of 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	0 480		

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0 480	Continued From page 4 existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and	0 480		

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0 480	Continued From page 5 Beverage Establishment Inspection Report (FBEIR) dated July 28, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 485 SS=C	144G.41 Subdivision 1.a (a) Minimum requirements; required food services (a) All assisted living facilities must offer to provide or make available at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes. The facility must not require a resident to include and pay for meals in the resident's contract. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to inform residents in advance of changes to the menu and failed to provide residents with a balanced meal that included fresh fruit and vegetables.	0 485		

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0 485	Continued From page 6 This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's posted menu dated Sunday July 26, 2026, to Saturday August 1, 2026, indicated the lunch for the date of July 27, 2026, called for macaroni and cheese with a side of strawberries. On July 27, 2026, at 12:15 p.m., during a tour of the facility, the surveyor observed R3 eating three corndogs for lunch. There were no fruits or vegetables or other sides on R3's plate. The meal provided to R3 was not nutritionally balanced and was not listed on the menu. On July 27, 2026, at 12:15 p.m., when asked if they were consulted about what they would like for lunch, R3 stated "No, I never know what I'm going to have, I just go up there and it's ready for me". R3 stated that he does normally gets fruits and vegetables during dinner. On July 31, 2026, at 10:14 a.m., via email communication, the surveyor requested a policy regarding the meal and menu and inquired what the licensee's expectations were on consulting with residents when there were changes to the menu. On July 31, 2026, at 10:55 a.m., the surveyor called the licensee to verify receipt of the email request. The license did not answer the call. A voice message was left.	0 485		

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0 485	Continued From page 7 On July 31, 2026, at 10:57 a.m., licensed assisted living director (LALD)-A returned the surveyor's call and stated they had received the surveyor's email but was not sure what the surveyor was looking for. LALD-A stated that they were not going to continue digging for documents. LALD-A stated, "you came to the facility and saw the meal and menu, and nobody has any complaints." LALD-A then asked if the surveyor had read the contract as the meal and menu policy was included there. The surveyor explained they had read through the contract but did not see the policy included. LALD-A stated, "read it again". The licensee's contract contained a description of the licensee's meal plan, a description of the fee schedule for meals, and an attachment for the selection of meal plans. The contract did not contain a meal and menu policy. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 495 SS=I	144G.41 Subdivision. 1 (13) Minimum Requirements (13) provide staff access to an on-call registered nurse 24 hours per day, seven days per week. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN) was available 24 hours a day, seven days a week. This had the potential to affect all residents	0 495		

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0 495	Continued From page 8 and staff. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted on August 15, 2025, to receive assisted living services. R1's diagnoses included essential hypertension, acquired absence of left and right leg above the knee, alcohol dependence, atherosclerotic heart disease, chronic obstructive pulmonary disease, dissection of renal artery, gastroesophageal reflux disease, hypokalemia, type 2 diabetes, and unspecified dementia. R1's Service Plan - Waiver dated August 15, 2025, indicated R1 received assisted living services to include appointment reminders, transportation, bathing assistance, behavior management, dressing, grooming, incontinence care, laundry, meal reminders, medication administration, repositioning, blood glucose monitoring, safety checks, shopping assistance, symptom screening, and transfer assistance. R1's most recent assessment dated July 18, 2026, indicated R1 needed assistance with medication management including assistance with injectable medications. Additionally, the assessment indicated R1 was at risk for falls.	0 495		

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0 495	Continued From page 9 R2 R2 was admitted on April 21, 2020, and began receiving assisted living services on August 1, 2021. R2's diagnoses included major depressive disorder, alcohol dependence, altered mental status, anemia, essential hypertension, and paralysis of vocal cords and larynx. R2's Service Plan - Waiver dated December 5, 2025, indicated R2 received assistance to include appointment reminders, bathing assistance, behavior management, dressing, grooming, laundry, meal reminders, medication administration, medication setup, vital signs, blood glucose monitoring, safety checks, shopping assistance, and symptom screening. R2's most recent assessment dated July 18, 2026, indicated R2 needed assistance with medication administration, had a history of seizures, had mental health issues controlled with medications, and was at risk for falls. R3 R3 was admitted on August 4, 2022, to receive assisted living services. R3's diagnoses included bipolar disorder, emphysema, and major depressive disorder. R3's Service Plan - Waiver dated August 4, 2022, indicated R3 received assisted living services to include appointment reminders, bathing assistance, behavior management, dressing, grooming, laundry, meal assistance, medication administration, vital signs, and safety checks.	0 495		

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0 495	Continued From page 10 R3's most recent assessment dated July 18, 2026, indicated R3 needed assistance with medication management and administration, is at risk to abuse and has a history of bipolar and major depression. On July 27, 2026, at 10:34 a.m., licensed assisted living director (LALD)-A stated clinical nurse supervisor (CNS)-C worked at a hospital and would not be able to attend the survey that day. On July 27, 2026, at 10:47 a.m., during the entrance conference, LALD-A stated the licensee employed two nurses, CNS-C and registered nurse (RN)-E. LALD-A stated RN-E was currently out of the country. On July 27, 2026, at 10:51 a.m., LALD-A stated they operate three facilities under the same ownership, and CNS-C and RN-E oversaw all three facilities, but CNS-C was responsible for them all while RN-E was absent. On July 27, 2026, at 11:32 a.m., LALD-A stated they were able to contact CNS-C, but that CNS-C would not be able to talk for another 30 minutes. On July 28, 2026, at 12:37 p.m., CNS-C stated they worked at Regions Hospital as a floor nurse on a med-surge unit. CNS-C stated they worked 56 hours every two weeks at the hospital, which was about five days every two weeks, and that they worked 12-hour shifts and were required to work every third weekend. CNS-C stated they were able to respond to calls from the facility while working at the hospital but would not be able to leave the hospital to complete any in-person assessments if needed. CNS-C stated that they were scheduled out for six-week	0 495		

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0 495	Continued From page 11 periods, and they were typically able to able to balance the workload for the facilities between themselves and RN-E. CNS-C stated they believed RN-E was only going to be out of town for this week. On July 29, 2026, at 4:02 p.m., unlicensed personnel (ULP)-D stated they have not had an issue with being able to reach an on-call nurse. ULP-C stated that if they ever had an issue with reaching an on-call nurse, they would reach out to their supervisor, LALD-A. On July 29, 2026, at 4:13 p.m., LALD-A stated the licensee's nurses are able to respond to all calls within a few hours. LALD-A stated that in the event of an emergency, staff would be expected to call 911. The licensee's employee list indicated the only registered nurses employed by the licensee were CNS-C and RN-E. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	0 495		
0 500 SS=F	144G.41 Subd. 2 Policies and procedures Each assisted living facility must have policies and procedures in place to address the following and keep them current: (1) requirements in section 626.557, reporting of maltreatment of vulnerable adults; (2) conducting and handling background studies on employees; (3) orientation, training, and competency evaluations of staff, and a process for evaluating staff performance;	0 500		

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0 500	Continued From page 12 (4) handling complaints regarding staff or services provided by staff; (5) conducting initial evaluations of residents' needs and the providers' ability to provide those services; (6) conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; (7) orientation to and implementation of the assisted living bill of rights; (8) infection control practices; (9) reminders for medications, treatments, or exercises, if provided; (10) conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; (11) ensuring that nurses and licensed health professionals have current and valid licenses to practice; (12) medication and treatment management; (13) delegation of tasks by registered nurses or licensed health professionals; (14) supervision of registered nurses and licensed health professionals; and (15) supervision of unlicensed personnel performing delegated tasks. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement current policies and procedures as required. This practice resulted in a level two violation (a	0 500		

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0 500	Continued From page 13 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On July 27, 2026, at 8:03 a.m., the surveyor emailed the licensee that an onsite assisted living survey would be initiated on July 27, 2026, at approximately 10:00 a.m. The email indicated the licensee's policies and procedures would need to be available for review. The licensee provided policies that included language for Comprehensive Home Care providers found in MN Statutes 144A, not language for Assisted Living providers found in MN Statutes 144G for the following policies: - 1.13 Complaints Regarding Hoe Care policy dated January 1, 2020; - 3.01 Orientation for Home Care Staff, dated January 1, 2020; - the undated policy titled Requirements for Reporting Maltreatment of Minors and Vulnerable Adults with citations directing the reader to 144A.4795; and - Combined Policy Infection Control dated January 1, 2020. The licensee provided a policy manual titled Minn Care Home Health Policies & Procedures that included language for the PCA Choice care model instead of policies tailored to 144G Assisted Living regulations for the following policies:	0 500		

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0 500	Continued From page 14 - 2.8 Background Study Policy dated December 2023. The licensee failed to provide the following policies: - conducting initial evaluations of residents' needs and the providers' ability to provide those services; - conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; - orientation to and implementation of the assisted living bill of rights; - reminders for medications, treatments, or exercises, if provided; - conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; - ensuring that nurses and licensed health professionals have current and valid licenses to practice; - delegation of tasks by registered nurses or licensed health professionals; - supervision of registered nurses and licensed health professionals; and - supervision of unlicensed personnel performing delegated tasks. On July 28, 2026, at 1:48 p.m., licensed assisted living director (LALD)-A provided the surveyor with a document titled Minn Care Home Health Policies and Procedures dated December 2023. LALD-A stated it was the only policy manual available for the facility. The policy manual	0 500		

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0 500	Continued From page 15 contained no policies related to 144G assisted living, and instead contained policies related to the DHS licensed PCA choice care model. On July 28, 2026, at 2:16 p.m., LALD-A again asserted that the manual provided would have all requested topics. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 500		
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for one of three residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 630		

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0 630	Continued From page 16 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 August 15, 2025, to receive assisted living services. R1's diagnoses included essential hypertension, acquired absence of left and right leg above the knee, alcohol dependence, atherosclerotic heart disease, chronic obstructive pulmonary disease, dissection of renal artery, gastroesophageal reflux disease, hypokalemia, type 2 diabetes, and unspecified dementia. R1's Service Plan - Waiver dated August 15, 2025, indicated R1 received assisted living services to include appointment reminders, transportation, bathing assistance, behavior management, dressing, grooming, incontinence care, laundry, meal reminders, medication administration, repositioning, blood glucose monitoring, safety checks, shopping assistance, symptom screening, and transfer assistance. R1's IAPP dated July 18, 2026, indicated R1 was at risk of being abused by others. R1's IAPP lacked documentation on their risk of abusing other vulnerable adults and contained no information regarding statements of the specific measures to be taken to minimize the risk of abuse. On July 28, 2026, at 1:14 p.m., clinical nurse	0 630		

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0 630	Continued From page 17 supervisor (CNS)-D stated that because R1 is a vulnerable adult their focus during the assessment process was on protecting the resident and they had overlooked the other parts of the assessment. The license failed to provide an individual abuse prevention plan policy. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
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	0 680		

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0 680	Continued From page 18 working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have a written emergency preparedness plan (EPP) with all the required content. Additionally, the licensee failed to post the EPP prominently. This had the potential to affect all residents receiving services under the assisted living license. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The license EPP consisted of PDF's retrieved from the Minnesota Department of Health's Long-Term Care (LTC) Emergency Preparedness page. The license modified some of the PDFs to customize them to the licensee. The licensee's undated EPP lacked the following required content and required further customization in the following topics: -maintain and annual EPP updates; -policies and procedures for subsistence needs for staff and residents; -policies and procedures for tracking staff and residents;	0 680		

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0 680	Continued From page 19 -policies and procedures including evacuation; -policies and procedures for sheltering in place; -policies and procedures for medical documents; -policies and procedures for roles under a waiver declared by secretary; -methods for sharing information; -procedure for sharing information on occupancy and/or needs; On July 30, 2026, at 1:34 p.m., licensed assisted living director (LALD)-A stated the provided documents were the licensee's most up to date EPP available for use but they would adjust them as needed to ensure the documents meet the standards. The licensee's Emergency Preparedness policy dated January 1, 2020, indicated the licensee would have in place a written plan of action to facilitate the management of clients care and services in response to a natural disaster or other emergencies that may disrupt their ability to provide care or service. Minnesota Administrative Rule 4659.0100 dated August 11, 2021, indicated assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations title 42, section 483.72, or successor requirements. This part referenced documents, specifications, methods, and standards in State Operations Manual Appendix Z - Emergency Preparedness for All Provider and Certified Supplier Types: Interpretive Guidance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		

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0 700 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 and interview, 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, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On July 28, 2026, at 7:30 a.m., the surveyor arrived on site for the second day of survey. Upon arrival, the surveyor was able to see into the facility through a window at the front door. Visible from the front door was an unlocked and unsecured computer logged into the license's electronic medical record. This computer was located in the main living area of the facility	0 700		

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0 700	Continued From page 21 directly adjacent to the kitchen. The surveyor was able to visibly see that a resident's record was displayed. On July 28, 2026, at 7:42 a.m., the surveyor observed the licensee's computer monitor unlocked, unsecured, and unattended during the morning medication administration from 7:44 a.m. to 8:00 a.m. At the same time, the surveyor observed a resident in the kitchen of the facility directly adjacent to the unlocked computer. On July 28, 2026, at 12:58 p.m., licensed assisted living director (LALD)-A stated staff are trained and expected to close the computer when not in use. Additionally, LALD-A argued that even though the records were visible from the front door, they were still behind a locked door, and a person would need to be let into the house in order to obtain the resident records. The licensee's 1.06 Client Record - Confidentiality policy dated January 1, 2020, indicated client records will be kept confidential and locked in a secure area where only home care staff of license will have access to. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 700		
0 810 SS=I	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	0 810		

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0 810	Continued From page 22 rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level three violation (a violation that harmed a resident's health or safety,	0 810		

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0 810	Continued From page 23 or a violation that had the potential to cause more than minimal harm to the resident) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated July 28, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor	01500		

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01500	Continued From page 24 blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, 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	01500		

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	37270	A. BUILDING: _____ B. WING _____	07/31/2026

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01500	Continued From page 25 licensee failed to ensure employees received at least eight (8) hours of annual training for each 12 months of employment for one of three employees (clinical nurse supervisor (CNS)-C). 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: CNS-C was hired October 4, 2020, to provide clinical oversite. CNS-C's employee record lacked any documentation of having completed the following required annual training topics: - effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders. On July 30, 2026, at 2:00 p.m., CNS-C stated they did not receive the missing training from the licensee but thought they did receive similar training from their hospital job. The documentation was not provided during the survey process. The licensee's 3.08 Required Annual Staff Training policy, dated January 1, 2020, indicated that all staff that perform direct home care services will complete a minimum of eight hours	01500		

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01500	Continued From page 26 of annual training for each 12 months of employment. This policy lacked inclusion of all required annual training components, and appeared to be a policy tailored to home care licensure as evidenced by the inclusion of the following language: "Annual training may be obtained from the home care provider or another source and must include topics relevant to the provision of home care services. The following training elements MUST be included every 12 months to all staff who perform direct home care services: 1. Training on reporting of maltreatment of minors under section 626.556 and maltreatment of vulnerable adults under section 626.557, whichever is applicable to the services provided (Minnesota Adult Abuse Reporting Center - MAARC) 2. A review of the appropriate version of the home care bill of rights 3. A review of infection control techniques used in the home and implementation of infection control standards including: - Hand-washing techniques; - The need for and use of protective gloves, gowns, and masks - appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades - cleaning and disinfecting reusable or shared equipment - Disinfecting environmental surfaces; and reporting of communicable diseases 4. A review of the home care provider's policies and procedures relating to the provision of home care services and how to implement those policies and procedures." No further information was provided.	01500		

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01500	Continued From page 27 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
01530 SS=F	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for	01530		

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01530	Continued From page 28 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 complete two hours of initial training on mental illness and de-escalation for employees hired prior to July 1, 2025, for three of three employees (clinical nurse supervisor (CNS)-C, unlicensed personnel (ULP)-D, ULP-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: CNS-C was hired October 4, 2020, to provide clinical oversite. ULP-D was hired July 18, 2022, to provide assisted living services. On July 28, 2026, from 7:30 a.m. to 8:22 a.m., the surveyor observed ULP-D provide medications and assisted living services to residents.	01530		

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01530	Continued From page 29 ULP-F was hired June 9, 2023, to provide assisted living services. CNS-D, ULP-D, and ULP-F's employee records lacked documentation of the required two hours of initial mental health training. On July 30, 2026, at 1:32 p.m. licensed assisted living director (LALD)-A stated all annual trainings were completed around October every year and that they thought this training requirement was completed at that time. LALD-A stated going foward, they would ensure the required training was completed by staff and would be added to their annual training courses. The licensee's 3.01 Orientation for Home Care Staff policy dated January 1, 2020, indicated all staff providing and supervising direct home care services must complete an orientation to home care licensing requirements and regulations before providing home care services to clients. The policy failed to address all assisted living orientation requirements regarding required mental health training. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01610 SS=D	144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a	01610		

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01610	Continued From page 30 nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to a conduct a nursing assessment by a registered nurse (RN) of the physical and cognitive needs for one of two residents (R1) on or before the admission date. 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 August 15, 2025, to receive assisted living services. R1's diagnoses included essential hypertension, acquired absence of left and right leg above the	01610		

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01610	Continued From page 31 knee, alcohol dependence, atherosclerotic heart disease, chronic obstructive pulmonary disease, dissection of renal artery, gastroesophageal reflux disease, hypokalemia, type 2 diabetes, and unspecified dementia. R1's Service Plan - Waiver dated August 15, 2025, indicated R1 received assisted living services to include appointment reminders, transportation, bathing assistance, behavior management, dressing, grooming, incontinence care, laundry, meal reminders, medication administration, repositioning, blood glucose monitoring, safety checks, shopping assistance, symptom screening, and transfer assistance. R1's record contained an admission assessment dated August 21, 2025. The admission assessment was completed six days after R1's admission to the licensee. On July 30, 2026, at 2:01 p.m., clinical nurser supervisor (CNS)-D stated R1's admission assessment was completed on the licensee's electronic medical record (EMAR) system on the date of admission, but it had not been finalized and submitted until the date noted on the assessment. CNS-D stated that they were unaware the assessments would be documented like this when submitted late. On July 28, 2026, at 1:48 p.m., licensed assisted living director (LALD)-A provided the surveyor with a document titled Minn Care Home Health Policies and Procedures dated December 2023. LALD-A stated it was the only policy manual available for the facility. The policy manual contained no policies related to 144G assisted living, and instead contained policies related to the DHS licensed PCA choice care model. This	01610		

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01610	Continued From page 32 policy manual lacked inclusion of policies related to admission assessments. On July 28, 2026, at 2:16 p.m., LALD-A again asserted that the provided manual would have all requested topics. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01610		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered 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	01620		

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01620	Continued From page 33 (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 RN conducted ongoing resident assessment and reassessment, not to exceed 90 calendar days from the last date of the assessment for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems	01620		

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01620	Continued From page 34 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 R1 was admitted on August 15, 2025, to receive assisted living services. R1's diagnoses included essential hypertension, acquired absence of left and right leg above the knee, alcohol dependence, atherosclerotic heart disease, chronic obstructive pulmonary disease, dissection of renal artery, gastroesophageal reflux disease, hypokalemia, type 2 diabetes, and unspecified dementia. R1's Service Plan - Waiver dated August 15, 2025, indicated R1 received assisted living services to include appointment reminders, transportation, bathing assistance, behavior management, dressing, grooming, incontinence care, laundry, meal reminders, medication administration, repositioning, blood glucose monitoring, safety checks, shopping assistance, symptom screening, and transfer assistance. R1's record contained a 90-day assessment dated January 14, 2026, with their next assessment occurring on April 17, 2026. This indicated 93 days had lapsed between assessments. R1's next assessment date occured on July 18, 2026, indicating 92 days had lapsed between assessment dates. R2 R2 was admitted on April 21, 2020, and began receiving assisted living services on August 1, 2021.	01620		

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01620	Continued From page 35 R2's diagnoses included major depressive disorder, alcohol dependence, altered mental status, anemia, essential hypertension, and paralysis of vocal cords and larynx. R2's Service Plan - Waiver dated December 5, 2025, indicated R2 received assistance to include appointment reminders, bathing assistance, behavior management, dressing, grooming, laundry, meal reminders, medication administration, medication setup, vital signs, blood glucose monitoring, safety checks, shopping assistance, and symptom screening. R2's record contained a 90-day assessment dated January 14, 2026, with their next assessment occurring on April 17, 2026. This indicated 93 days had lapsed between assessments. R2's next assessment date occured on July 18, 2026, indicating 92 days had lapsed between assessment dates. On July 28, 2026, at 1:17 p.m., clinical nurse supervisor (CNS)-C stated they do assessments every 90 days or when there is a change in condition. On July 30, 2026, at 2:03 p.m., CNS-C stated that when there is a 90-day assessment due within the facility, they complete a 90-day assessment on all residents within the facility so that everyone is on the same schedule. CNS-C stated there were times when residents were not available when the assessments were due. CNS-C stated going forward, they would attempt to complete assessments earlier than when they were due. On July 28, 2026, at 1:48 p.m., licensed assisted living director (LALD)-A provided the surveyor	01620		

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01620	Continued From page 36 with a document titled Minn Care Home Health Policies and Procedures dated December 2023. LALD-A stated it was the only policy manual available for the facility. The policy manual contained no policies related to 144G assisted living, and instead contained policies related to the DHS licensed PCA choice care model. This policy manual lacked infomration related to the timeline of assessments for assisted living residents. On July 28, 2026, at 2:16 p.m., LALD-A again asserted that the provided manual would have all requested topics. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, a registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (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	01730		

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01730	Continued From page 37 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 record with the required content for two of two residents (R1 and R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	01730		

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01730	Continued From page 38 cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 was admitted on August 15, 2025, to receive assisted living services. R1's diagnoses included essential hypertension, acquired absence of left and right leg above the knee, alcohol dependence, atherosclerotic heart disease, chronic obstructive pulmonary disease, dissection of renal artery, gastroesophageal reflux disease, hypokalemia, type 2 diabetes, and unspecified dementia. R1's Service Plan - Waiver dated August 15, 2025, indicated R1 received assisted living services to include appointment reminders, transportation, bathing assistance, behavior management, dressing, grooming, incontinence care, laundry, meal reminders, medication administration, repositioning, blood glucose monitoring, safety checks, shopping assistance, symptom screening, and transfer assistance. R1's record contained documentation of a medication management plan dated July 25, 2026. The medication management plan lacked the following required content: - medication management services that would be provided by the nurse and unlicensed personnel (ULP) (included PRN); - type of medication storage system, based on resident's needs; - specific written instructions for resident's medication administration;	01730		

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	37270	A. BUILDING: _____ B. WING _____	07/31/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINN CARE HOME HEALTH	7215 FREMONT AVENUE NORTH BROOKLYN CENTER, MN 55430

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01730	Continued From page 39 - person responsible for monitoring medication supplies and refills; - medication management tasks that may be delegated to ULPs; and - procedures for staff to notify an RN when problems arose. R2 R2 was admitted on April 21, 2020, and began receiving assisted living services on August 1, 2021. R2's diagnoses included major depressive disorder, alcohol dependence, altered mental status, anemia, essential hypertension, and paralysis of vocal cords and larynx. R2's Service Plan - Waiver dated December 5, 2025, indicated R2 received assistance to include appointment reminders, bathing assistance, behavior management, dressing, grooming, laundry, meal reminders, medication administration, medication setup, vital signs, blood glucose monitoring, safety checks, shopping assistance, and symptom screening. R2's record contained documentation of a medication management plan dated July 25, 2026. The medication management plan lacked the following required content: - medication management services that would be provided by the nurse and unlicensed personnel (ULP) (included PRN); - person responsible for monitoring medication supplies and refills; - medication management tasks that may be delegated to ULPs; and - procedures for staff to notify an RN when problems arose.	01730		

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01730	Continued From page 40 On July 30, 2026, at 2:45 p.m., clinical nurse supervisor (CNS)-C stated they were under the assumption the medication management plan only needed to contain information on what was being completed for the resident and that they were unaware of the other requirements. On July 28, 2026, at 2:31 p.m., via email, the surveyor requested a policy regarding medication management services. On July 28, 2026, at 4:14 p.m., in an email communication, licensed assisted living director (LALD)-A provided a document titled "4.06 Medication Assessment & Management Plan" which consisted of a blank assessent form. The assessment form was dated January 2020 indicating the form was developed prior to the implementation of assisted living licensure on August 1, 2021, however, included all required contents of a medication management plan. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01820 SS=F	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure written or	01820		

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01820	Continued From page 41 electronically recorded prescriptions were obtained for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted on August 15, 2025, to receive assisted living services. R1's diagnoses included essential hypertension, acquired absence of left and right leg above the knee, alcohol dependence, atherosclerotic heart disease, chronic obstructive pulmonary disease, dissection of renal artery, gastroesophageal reflux disease, hypokalemia, type 2 diabetes, and unspecified dementia. R1's Service Plan - Waiver dated August 15, 2025, indicated R1 received assisted living services to include appointment reminders, transportation, bathing assistance, behavior management, dressing, grooming, incontinence care, laundry, meal reminders, medication administration, repositioning, blood glucose monitoring, safety checks, shopping assistance, symptom screening, and transfer assistance. R1's Medication Administration Record (MAR) dated July 27, 2026, indicated R1 took the following medications:	01820		

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01820	Continued From page 42 - acetaminophen 500mg caplet, 1 tablet by mouth 4 times a day; - aspirin 81mg tab chew, chew and swallow 1 tablet by mouth daily; - atorvastatin Calcium F/C 40mg tablet, 1 tablet by mouth daily; - folic acid 1mg tablet, 1 tablet by mouth daily; - gabapentin 100mg capsule, 2 capsules by mouth three times a day; - insulin glargine-100unit/1ml insulin pen, inject 25 units subcutaneously daily; - Jardiance F/C 10mg tablet, 1 tablet by mouth daily; - magnesium oxide 400mg tablet, 2 tablets by mouth daily with meal; - omeprazole 20mg capsule DR, 2 capsules by mouth daily 1 hour before a meal; - sertraline HCL 100mg tablet, 1 tablet by mouth daily; - vitamin B1 100mg tablet, 1 tablet by mouth daily; - Xarelto 20mg tablet, 1 tablet by mouth daily with meal; - metformin HCL ER 500mg tab ER 24h, 4 tablets by mouth once daily with evening meal; and - Metoprolol Succ ER 100mg tab ER 24h, 1 tablet by mouth daily. R1's record contained an unsigned after-visit summary (AVS) dated July 6, 2026. R1's record lacked inclusion of signed physician orders. R2 R2 was admitted on April 21, 2020, and began receiving assisted living services on August 1, 2021. R2's diagnoses included major depressive disorder, alcohol dependence, altered mental status, anemia, essential hypertension, and	01820		

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01820	Continued From page 43 paralysis of vocal cords and larynx. R2's Service Plan - Waiver dated December 5, 2025, indicated R2 received assistance to include appointment reminders, bathing assistance, behavior management, dressing, grooming, laundry, meal reminders, medication administration, medication setup, vital signs, blood glucose monitoring, safety checks, shopping assistance, and symptom screening. R2's Medication Administration Record (MAR) with dated July 27, 2026, indicated R2 took the following medications: - amlodipine besylate 5mg tablet, 1 tablet by mouth per day; - ferrous gluconate 324mg tablet, take 1 tablet by mouth every 48 hours; - fluoxetine HCL 20mg capsule, take 1 capsule daily; - folic acid 1mg tablet , 1 tablet by mouth daily; - levetiracetam 1000mg tablet, 2 tablets by mouth every 12 hours; - vitamin B1 100mg tablet , 1 tablet by mouth daily; - trazodone HCL 100mg tablet take 1 tablet by mouth at bedtime; - acetaminophen 500mg caplet, take 1 tablet by mouth every 6 hours as needed for moderate pain or mild pain; - geri-Tussin 100mg/5ml liquid, take 5ml (100mg) by mouth every 4 hours as needed for cough; - guaifenesin 100/ml liquid, take 5ml (100mg) by mouth every 4 hours as needed for cough; - Senexon-S 8.6-50mg tablet, take 1 tablet by mouth daily as needed for constipation. R2's record contained an unsigned AVS dated May 12, 2026. R2's record lacked documentation of signed physician orders.	01820		

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01820	Continued From page 44 On July 29, 2026, at 2:27 p.m., licensed assisted living director (LALD)-A stated the AVS' provided for R1 and R2 were the most current and up to date AVS' on record for the residents. LALD-A stated the residents will come back from their appointments with this documentation, and "We do not get signed orders. They do not send them to us". On July 30, 2026, at 2:11p.m., clinical nurse supervisor (CNS)-C stated the licensee utilizes AVS' for all orders for all residents. Additionally, CNS-C asked the surveyor whether orders needed to be updated on an annual basis. The licensee's 5.01 Medication & Treatment Orders policy dated January 1, 2020, indicated an order for medication or treatment must be dated, signed by the prescriber, and must be current and consistent with the client's nursing assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by:	01890		

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01890	Continued From page 45 Based on observation, interview, and record review, the licensee failed to ensure time sensitive medications were labeled with the date opened for one of two residents (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: On July 27, 2026, at 12:08 p.m., during an audit of the licensee's medication storage closet, the surveyor observed the following undated time sensitive medications: - insulin Glargine 100units/ml insulin pen belonging to R1. The insulin pen had a sticker placed on the cap of the injection pen for the labeling of the date in which the pen was started. As of the time of the surveyor's observation, the opened-on-date sticker had not been labeled. On July 27, 2026, at 12:15p.m., unlicensed personnel (ULP)-D stated staff were trained to label insulin pens when starting a new pen. ULP-D stated they were not sure of why the pen had not been labeled, but R1 would be starting a new pen today, and they would be sure to label the new pen. On July 28, 2026, at 12:56 p.m., clinical nurse supervisor (CNS)- C stated staff are trained to	01890		

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01890	Continued From page 46 label insulin pens when starting a new pen. The licensee lacked policy or procedure on the labeling of time sensitive medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the care and services were provided according to acceptable health care, and medical, or nursing standards for one of one resident (R1) with bed rails. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On July 27, 2026, at 11:59 a.m., during a tour of	02310		

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02310	Continued From page 47 the facility, the surveyor observed an adjustable hospital style bed with bilateral bed rails placed and in the upright position on the upper portion of R1's bed. Licensed assisted living director (LALD)-A stated R1 admitted with the bed. R1 was admitted on August 15, 2025, to receive assisted living services. R1's diagnoses included essential hypertension, acquired absence of left and right leg above the knee, alcohol dependence, atherosclerotic heart disease, chronic obstructive pulmonary disease, dissection of renal artery, gastroesophageal reflux disease, hypokalemia, type 2 diabetes, and unspecified dementia. R1's Service Plan - Waiver dated August 15, 2025, indicated R1 received assisted living services to include appointment reminders, transportation, bathing assistance, behavior management, dressing, grooming, incontinence care, laundry, meal reminders, medication administration, repositioning, blood glucose monitoring, safety checks, shopping assistance, symptom screening, and transfer assistance. R1's most recent 90-day assessment dated July 18, 2026, indicated R1's bed type was a low bed. Additionally, the assessment indicated the bed safety zone assessment was not applicable, as the bed had no bed rails in use or had portable bed rails that were installed on a consumer bed. The assessment contained no additional information related to R1's bed rail. R1's record contained a separate document titled "Bed Rail Assessment" dated May 8, 2026. The assessment form contained information on the following required components:	02310		

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02310	Continued From page 48 - the purpose and intention of the bed rail; - the residents need/use assessment; - documentation of the risk vs. benefits discussion; - the residents' safety preferences; - whether the bed rail has the effect of being an improper restraint, and - any necessary information related to interventions to mitigate safety risk or negotiated risk agreements. The assessment form lacked the following required information for a hospital style bed rail: - a physical description of the bed rail; - documentation to show the bed rail has not shifted and is securely attached to the bed frame per manufacturer's recommendations; - information about the manufacturer's instructions; - measurements of zones of entrapment; - physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; - documentation as to whether the bed rails were FDA compliant. No further assessments were provided by the licensee. On July 28, 2026, at 12:43 p.m., clinical nurse supervisor (CNS)-C stated the bed rail assessment is completed on a separate paper form. CNS-C stated they were under the assumption that bed rail assessments need only be completed on an annual basis, but after completing R1's most recent 90-day assessment last week they were informed by licensed assisted living director (LALD)-B that the bed rail assessment needed to be completed more frequently. CNS-C stated they questioned the need as the bed rail does not change.	02310		

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02310	Continued From page 49 On July 28, 2026, at 12:47 p.m., CNS-C asked the surveyor how often bed rail assessments needed to be completed. On July 28, 2026, at 1:58 p.m., LALD-A stated they would look into adding missing information into an assessment form and would look into what was available on their online medical record system. The licensee's Bed Rail/Side Rail policy dated June 1, 2025, lacked information on the frequency of assessments as well as information describing the contents of a consumer or hospital bed rail assessment. The FDA's, A Guide to Bed Safety, dated October 2000, and revised April 2010, indicated following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients." The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." The FDA's, Guidance for Industry and FDA Staff Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment dated March 10, 2006, indicated the following information: "FDA is recommending dimensional limits for zones 1 through 4 at this time because we believe the majority of the entrapments reported to FDA have occurred in these zones.	02310		

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02310	Continued From page 50 We based these recommended limits upon the body parts entrapped in these individual zones identified through adverse event reports and entrapment scenarios described in the reports." The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Best practice for documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail - Measurements - The resident's bed rail use/need assessment - Risk vs. benefits discussion (individualized to each resident's risks) - The residents' preferences - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". Additionally, the FAQ indicated hospital bed rail assessments should include information to consider whether the bed rail has the effect of being an improper restraint, and that the bed rail has not shifted and is securely attached to the	02310		

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02310	Continued From page 51 bed frame per manufacturer recommendations. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	02310		

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

Food & Beverage Inspection Report

Establishment Info

MINN CARE HOME HEALTH
7215 Fremont Ave N
Brooklyn Center, MN 55430
Hennepin County
Parcel:

Phone:

License Info

License: HFID 37270

Risk:
License:
Expires on:
CFPM: Ikenna C. Dijeh
CFPM #: 107375; Exp: 07/28/2027

Inspection Info

Report Number: F1021261211
Inspection Type: Full - Single
Date: 7/28/2026 Time: 1:13:06 PM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 1
Total Priority 3 Orders: 2
Delivery: Emailed

New Order: 4-600 Cleaning Equipment and Utensils
4-601.11C *Priority Level: Priority 3 CFP#: 49*
MN Rule 4626.0840C Clean non-food contact surfaces of equipment and maintain free of accumulations of dust, dirt, food residue, and other debris.
COMMENT: GREASE ACCUMULATION OBSERVED UNDER MICROWAVE AND ON VENTILATION FILTERS ABOVE THE STOVE. CLEAN AND MAINTAIN CLEAN.
Comply By: 7/30/2026 Originally Issued On: 7/28/2026

New Order: 6-300 Physical Facility Numbers and Capacities
6-301.12 *Priority Level: Priority 2 CFP#: 10*
MN Rule 4626.1445 Provide and maintain a supply of individual disposable towels, a continuous towel system, a heated-air hand drying device, or an approved ambient air temperature hand drying device at each handwashing sink or group of adjacent handwashing sinks.
COMMENT: NO PAPER TOWELS AT THE KITCHEN HANDWASHING SINK. STAFF PROVIDED A NEW ROLL OF PAPER TOWELS DURING THE INSPECTION. CORRECTED ONSITE. MAINTAIN A SUPPLY OF PAPER TOWELS AT ALL HANDWASHING SINKS DURING ALL HOURS OF OPERATION.
Comply By: Complied On Site Originally Issued On: 7/28/2026

New Order: 6-300 Physical Facility Numbers and Capacities
6-301.14A *Priority Level: Priority 3 CFP#: 10*
MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands.
COMMENT: HANDWASHING SINK IN THE KITCHEN IS MISSING A HANDWASHING SIGN/POSTER THAT REMINDS FOOD EMPLOYEES TO WASH HANDS BEFORE RETURNING TO WORK. PROVIDE AS DESCRIBED IN RULE ABOVE.
Comply By: 7/29/2026 Originally Issued On: 7/28/2026

Food & Beverage General Comment

All findings on this report were discussed with Assistant Licensed Director (ALD), Celestine Okonkwo and Health Regulation Division Nurse Evaluator, Zachary Morth.

This facility is a residential home. They currently have 3 clients and the facility can accommodate up to 5 clients.

Food is for same-day service. Leftovers are discarded at the end of service.

A two basin sink is located in the kitchen. One basin is designated for hand washing.

A temperature indicator was available on site to verify that the dishwasher reaches a utensil surface temperature of at least 160F.

Discussed hand washing, ware washing, staff illness policy, temperature control, final cook temperatures, cleaning, serving highly susceptible populations, food storage, and food handling procedures.

The kitchen has residential equipment, vinyl floor, popcorn ceiling, wood cabinets and painted drywall. Physical facility items will be monitored during future inspections.

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 F1021261211 from 7/28/2026

Melissa Ramos

Celestine Okonkwo
ALD

Melissa Ramos,
Public Health Sanitarian 3
651-201-4495
melissa.ramos@state.mn.us

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

Temperature Observations/Recordings

Establishment Info

MINN CARE HOME HEALTH
Brooklyn Center
County/Group: Hennepin County

Inspection Info

Report Number: F1021261211
Inspection Type: Full
Date: 7/28/2026
Time: 1:13:06 PM

Food Temperature: Product/Item/Unit: Milk **; Temperature Process:** Cold-Holding
Location: Kitchen Refrigerator at 41 Degrees F.
Comment:
Violation Issued?: No

Equipment Temperature: Product/Item/Unit: Kitchen Refrigerator **; Temperature Process:** Ambient Air
Location: Kitchen at 40 Degrees F.
Comment:
Violation Issued?: No

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

Sanitizer Observations/Recordings

Establishment Info

MINN CARE HOME HEALTH
Brooklyn Center
County/Group: Hennepin County

Inspection Info

Report Number: F1021261211
Inspection Type: Full
Date: 7/28/2026
Time: 1:13:06 PM

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Residential Dish Machine
Location: Kitchen **Equal To** 180 Degrees F.
Comment: Establishment had a previous thermolabel from when they ran the dish machine.
Violation Issued?: No

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL3727016-0	**Date:** July 28, 2026
Facility Name: Minn Care Home Health	
Facility Address: 7215 Fremont Ave N, Brooklyn Center, MN 55430	

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 3; 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 include employee actions to be taken in the event of a fire or similar emergency. [Minn. Stat. 144G.45 subd.2]

   Comments: Licensed assisted living director (LALD)-A provided what they stated was their FSEP labeled Annex G: Fire Guidance for the surveyor to review. The surveyor confirmed several times that what LALD-A provided was the facilities FSEP. LALD-A affirmed every time that the document provided was the FSEP for the facility. After the surveyor had completed the record review LALD-A stated that the document that they had provided was not the licensees FSEP but rather a broader guidance for in the event of a fire. Both documents have been evaluated for this tag.

   The FSEP labeled Annex G: Fire Guidance failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine and Extinguish or Evacuate) but failed to include procedures for how staff are to complete each step.

   The FSEP provided after the surveyor exited with the LALD-A labeled 7.05 Fire, failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate) but the plan was designed for a building with life safety systems such as fire doors and smoke compartments. The policy had not been updated to provide complete actions for employees to take in the event of a fire or similar emergency at the licensed facility which did not have life safety systems or a fire-resistant construction type.

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

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

3. 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: LALD-A was unable to provide any written documentation that staff received training on the FSEP.

4. 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: LALD-A stated that residents are offered training on the FSEP every six months. LALD-A lacked written documentation that residents were offered training on the FSEP.

5. 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: LALD-A provided documentation that drills were conducted on all three shifts in October of 2025, and April of 2026. No additional documentation was provided.