Electronically Delivered

November 12, 2025

Licensee
Care Partners Healthcare Services LLC
9901 Fallgold Parkway North
Brooklyn Park, MN 55443

RE: Project Number(s) SL41132015

Dear Licensee:

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

The Minnesota Department of Health completed an initial survey on October 16, 2025, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

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

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

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the

correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

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. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

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

CLN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41132	A. BUILDING: _____ B. WING _____	10/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS HEALTHCARE SERVICES LL	9901 FALLGOLD PARKWAY NORTH BROOKLYN PARK, MN 55443

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL41132015-0 On October 13, 2025, through October 16, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there was one resident; one receiving services under the Provisional Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41132	A. BUILDING: _____ B. WING _____	10/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS HEALTHCARE SERVICES LL	9901 FALLGOLD PARKWAY NORTH BROOKLYN PARK, MN 55443

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 480	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A,	0 480		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41132	A. BUILDING: _____ B. WING _____	10/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS HEALTHCARE SERVICES LL	9901 FALLGOLD PARKWAY NORTH BROOKLYN PARK, MN 55443

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 480	Continued From page 2 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 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated October 13, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24	0 480		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41132	A. BUILDING: _____ B. WING _____	10/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS HEALTHCARE SERVICES LL	9901 FALLGOLD PARKWAY NORTH BROOKLYN PARK, MN 55443

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 480	Continued From page 3 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included baseline testing for one of two unlicensed personnel ((ULP)-A). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	0 660		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41132	A. BUILDING: _____ B. WING _____	10/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS HEALTHCARE SERVICES LL	9901 FALLGOLD PARKWAY NORTH BROOKLYN PARK, MN 55443

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 660	Continued From page 4 cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: The licensee's Facility TB Risk Assessment dated July 1, 2025, identified the facility was at a low risk for TB transmission. ULP-A was hired on July 5, 2025, as a house supervisor for direct support personnel. On October 14, 2025, at 12:24 p.m., the surveyor observed ULP-A perform R1's treatment for blood glucose monitoring and medication administration. ULP-A's personnel record included a Tuberculin Skin Test (TST) report dated June 3, 2025, indicated ULP-A had been tested for TB with the results read on May 23, 2025. ULP-A's personnel record lacked TB testing results for a second step TST. On October 14, 2025, at 2:17 p.m., ULP-A asked the surveyor what a two-step TST was and if the first step was when they administered the medication and if the second step was when they read the results. ULP-A stated they were informed by the clinic who had performed their TST, they did not require any further TB testing. On October 15, 2025, at 10:24 a.m., clinical nurse supervisor (CNS)-D stated the licensee required the TB blood test as they felt the TB blood test was the golden standard. CNS-D	0 660		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41132	A. BUILDING: _____ B. WING _____	10/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS HEALTHCARE SERVICES LL	9901 FALLGOLD PARKWAY NORTH BROOKLYN PARK, MN 55443

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 660	Continued From page 5 stated they were told by ULP-A a TB blood test was completed in May and ULP-A had planned to bring those results. On October 15, 2025, at 4:11 p.m., an email from CNS-D, indicated the licensee was not able to obtain ULP-A's lab results as they were informed it would take approximately 24 to 36 hours. CNS-D indicated they would forward the results as soon as available. The licensee's Tuberculosis Screening/Prevention policy dated July 25, 2025, indicated employees would receive baseline TB screening upon hire that included either TST (two-step) or blood assay for M. tuberculosis (BAMT). No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 775 SS=E	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the requirements of Minnesota State Fire Code Rules, Chapter 7511. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 775		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41132	A. BUILDING: _____ B. WING _____	10/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS HEALTHCARE SERVICES LL	9901 FALLGOLD PARKWAY NORTH BROOKLYN PARK, MN 55443

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 775	Continued From page 6 resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On October 14, 2025, at 12:20 p.m., the surveyor toured the facility with clinical nurse supervisor (CNS)-D. During the facility tour, the surveyor observed the following: - Carbon monoxide alarms were not installed within ten feet of sleeping rooms 2 and 3. - A non-operational smoke alarm was installed near the peak of the ceiling in the living room. During the facility tour interview, CNS-D verified the above listed observations. CNS-D stated the living room smoke alarm was battery operated and they had been instructed to remove this alarm during the plan review process as it was installed in a location that could not be readily maintained. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775		
0 780 SS=D	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code:	0 780		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41132	A. BUILDING: _____ B. WING _____	10/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS HEALTHCARE SERVICES LL	9901 FALLGOLD PARKWAY NORTH BROOKLYN PARK, MN 55443

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 780	Continued From page 7 (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that complied with fire protection requirements. 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).	0 780		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41132	A. BUILDING: _____ B. WING _____	10/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS HEALTHCARE SERVICES LL	9901 FALLGOLD PARKWAY NORTH BROOKLYN PARK, MN 55443

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 780	Continued From page 8 The findings include: On October 14, 2025, at 12:20 p.m., the surveyor toured the facility with clinical nurse supervisor (CNS)-D. During the facility tour, the surveyor observed an interconnected smoke alarm was not installed outside and in the immediate vicinity of occupied resident sleeping room 2. During the facility tour interview, CNS-D verified the above listed observation. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 800 SS=A	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This practice resulted in a level one violation (a	0 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41132	A. BUILDING: _____ B. WING _____	10/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS HEALTHCARE SERVICES LL	9901 FALLGOLD PARKWAY NORTH BROOKLYN PARK, MN 55443

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 800	Continued From page 9 violation that will cause only minimal impact on the resident and does not affect health or safety) 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 October 14, 2025, at 12:20 p.m., the surveyor toured the facility with clinical nurse supervisor (CNS)-D. During the facility tour, the surveyor observed the following: - A privacy lock was not installed on the door leading into the shared bathroom for unoccupied resident room 3. - The bottom of the door was dragging along the carpet, making it difficult to open, for unoccupied resident room 5. - A knob or handle was not installed for the supply closet on the upper floor. During the facility tour interview, CNS-D verified the above listed observations. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41132	A. BUILDING: _____ B. WING _____	10/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS HEALTHCARE SERVICES LL	9901 FALLGOLD PARKWAY NORTH BROOKLYN PARK, MN 55443

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 810	Continued From page 10 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, record review, and interview, the licensee failed to develop the fire safety and evacuation plan with required content, This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41132	A. BUILDING: _____ B. WING _____	10/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS HEALTHCARE SERVICES LL	9901 FALLGOLD PARKWAY NORTH BROOKLYN PARK, MN 55443

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 810	Continued From page 11 cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On October 14, 2025, clinical nurse supervisor (CNS)-D provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee FSEP floor plan failed to clearly identify the main exit for the building evident by the following: On October 14, 2025, at 12:20 p.m., the surveyor toured the facility with clinical nurse supervisor (CNS)-D. During the facility tour, the surveyor observed an exit sign was posted at the front door/primary exit for the building. The posted floor plans, dated March 20, 2024, did not label the front door as an exit. Exit labels are required to be included on the floor plan in order to direct occupants to the designated main exit in the event of an emergency. Record review of the available documentation indicated the licensee failed to develop and maintain the FSEP with site specific procedures for the facility and building occupants evident by the following: - The FSEP had been created using templates from third party providers. The plan included procedures developed for a building with life safety systems and fire resistant construction	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41132	A. BUILDING: _____ B. WING _____	10/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS HEALTHCARE SERVICES LL	9901 FALLGOLD PARKWAY NORTH BROOKLYN PARK, MN 55443

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 810	Continued From page 12 type that were not applicable to a residential home. Pull fire alarms, smoke compartments, magnetic door holders, illuminated exit signs, elevators, and automatic spinklers were inaccurately referenced. - The FSEP included standard employee procedures, but 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 FSEP failed to include fire safety and evacuation instructions for residents evident by a lack of these procedures in the plan. - The FSEP failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents evident by a lack of these procedures in the plan. During an interview on October 14, 2025, at 2:15 p.m., CNS-D verified the FSEP was lacking site specific information and procedures. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, a registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must prepare and include in the service plan a	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41132	A. BUILDING: _____ B. WING _____	10/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS HEALTHCARE SERVICES LL	9901 FALLGOLD PARKWAY NORTH BROOKLYN PARK, MN 55443

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01730	Continued From page 13 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 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.	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41132	A. BUILDING: _____ B. WING _____	10/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS HEALTHCARE SERVICES LL	9901 FALLGOLD PARKWAY NORTH BROOKLYN PARK, MN 55443

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01730	Continued From page 14 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an individualized medication management plan with the required content for one of one resident (R1). 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 October 14, 2025, at 12:24 p.m., the surveyor observed unlicensed personnel (ULP)-A administer R1's Insulin Lispro medication subcutaneously (between the skin and muscle) into R1's abdomen. The surveyor did not observe ULP-A ask R1 where the previous injection site was; and did not observe ULP-A document the site of the injection upon documentation on R1's medication administration record. R1 was admitted on June 30, 2025, with diagnoses of type 1 diabetes and bilateral below knee amputation. R1's Service Agreement/Service Plan dated June 30, 2025, indicated R1 received assistance with medication administration. R1's Individualized Medication Management Plan	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41132	A. BUILDING: _____ B. WING _____	10/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS HEALTHCARE SERVICES LL	9901 FALLGOLD PARKWAY NORTH BROOKLYN PARK, MN 55443

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01730	Continued From page 15 (IMMP) completed on August 20, 2025, and on October 11, 2025, indicated R1 was not able to correctly administer subcutaneous injections or manage their own medications due to being unable to keep track of medication administration. R1's IMMP indicated staff were to review medication instructions via MAR for specific instructions related to the administration, monitoring, and documentation of medication. R1's Med Admin Summary - Month (MAR) dated October 2025, indicated the following: - Insulin Lispro 100 units (u)/milliliter (ml) at 8:00 a.m., 12:00 p.m., and 6:00 p.m., inject 2 u with meal plus correction scale of 1 u for every 50 over, total daily dose (TDD) 21u, blood glucose (bs) under 200 = 2 u, 201-250=3 u, 251-300=4 u, 301-350=5 u, 351-400=6 u, greater than 401=7 u; if bs less than 100, give the patient 15 grams of glucose, 4 ounce glass of juice or regular, 1 tablespoon of honey, sugar or corn syrup. Recheck bs in 15 minutes; for sliding scale, document the amount of insulin administered; and - Lantus (daily) inject 7 u SQ every evening for diabetes mellitus due to underlying condition with diabetic nephropathy. R1's record lacked any resident-specific requirements related to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. On October 15, 2025, at 3:20 p.m., ULP-A stated they were told by the nurse to only inject into the lower abdomen. The surveyor asked ULP-A if they were aware of rotating injection sites. ULP-A	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41132	A. BUILDING: _____ B. WING _____	10/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS HEALTHCARE SERVICES LL	9901 FALLGOLD PARKWAY NORTH BROOKLYN PARK, MN 55443

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01730	Continued From page 16 stated they were aware of a need to rotate injections site due to previous employment as they were told never to inject in the same spot. ULP-A stated they always ask the resident where they had been poked last. The manufacturer's instructions for the use of Insulin Lispro KwikPen dated July 2023, indicated to change (rotate) injections sites within the area chosen with each dose to reduce risk of getting lipodystrophy (pits in skin or thickened skin) and localized cutaneous amyloidosis (skin lumps) at the injection sites. The manufacturer's instructions for the use of Lantus Solostar insulin pens dated June 2023, indicated to change (rotate) injections sites within the area chosen with each dose to reduce risk of getting lipodystrophy (pits in skin or thickened skin) and localized cutaneous amyloidosis (skin lumps) at the injection sites. The licensee's Service Plan for Medication Management policy dated July 25, 2025, indicated the written medication management plan would include any resident-specific requirements related to documenting medication administration. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01760 SS=E	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41132	A. BUILDING: _____ B. WING _____	10/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS HEALTHCARE SERVICES LL	9901 FALLGOLD PARKWAY NORTH BROOKLYN PARK, MN 55443

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01760	Continued From page 17 resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the license failed to ensure medication administration was documented accurately for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 was admitted on June 30, 2025, with diagnoses of type 1 diabetes and bilateral below knee amputation. R1's Service Agreement/Service Plan dated June 30, 2025, indicated R1 received assistance with	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41132	A. BUILDING: _____ B. WING _____	10/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS HEALTHCARE SERVICES LL	9901 FALLGOLD PARKWAY NORTH BROOKLYN PARK, MN 55443

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01760	Continued From page 18 medication administration. R1's Med Admin Summary - Month (MAR) dated October 2025, indicated R1 received insulin Lispro 100 units (u)/milliliter (ml) 2 u with meal plus correction scale of 1 u for every 50 over, total daily dose (TDD) 21u, blood glucose (bs) under 200 = 2 u, 201-250=3 u, 251-300=4 u, 301-350=5 u, 351-400=6 u, greater than 401=7 u; if bs less than 100, give the patient 15 grams of glucose, 4 ounce glass of juice or regular, 1 tablespoon of honey, sugar or corn syrup. Recheck bs in 15 minutes; for sliding scale, document the amount of insulin administered. R1's MAR dated October 1, 2025, through October 15, 2025, lacked documentation of the amount of insulin given for insulin Lispro as follows: -October 2, 2025, at 8:00 a.m., 12:00 p.m., and 6:00 p.m.; -October 3, 2025, at 8:00 a.m., 12:00 p.m., and 6:00 p.m.; -October 4, 2025, at 8:00 a.m., 12:00 p.m., and 6:00 p.m.; -October 5, 2025, at 8:00 a.m., 12:00 p.m., and 6:00 p.m.; -October 9, 2025, at 8:00 a.m., 12:00 p.m., and 6:00 p.m.; and -October 10, 2025, at 8:00 a.m., 12:00 p.m., and 6:00 p.m. R1's MAR dated September 2025, lacked documentation of the amount of insulin given for insulin Lispro at 8:00 a.m., 12:00 p.m., and 6:00 p.m. for the whole month of September. On October 14, 2025, at 12:44 p.m., registered nurse (RN)-E stated they expected staff to	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41132	A. BUILDING: _____ B. WING _____	10/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS HEALTHCARE SERVICES LL	9901 FALLGOLD PARKWAY NORTH BROOKLYN PARK, MN 55443

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01760	Continued From page 19 document the amount of insulin given on the resident's MAR. RN-E stated they were working on making sure the orders were accurate for medications given rather than the need to document the information under a note for the dosage. The licensee's Medication Documentation policy dated July 25, 2025, indicated complete documentation of medication administration would include the medication dosage. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if:	01790		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41132	A. BUILDING: _____ B. WING _____	10/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS HEALTHCARE SERVICES LL	9901 FALLGOLD PARKWAY NORTH BROOKLYN PARK, MN 55443

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01790	Continued From page 20 (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication.	01790		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41132	A. BUILDING: _____ B. WING _____	10/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS HEALTHCARE SERVICES LL	9901 FALLGOLD PARKWAY NORTH BROOKLYN PARK, MN 55443

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01790	Continued From page 21 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) developed written procedures for the unlicensed personnel (ULP) providing medications for residents having unplanned time away when the licensed nurse was not available. This had the potential to affect all residents who would need medications for an unplanned time away. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On October 14, 2025, at 11:02 a.m., the surveyor requested the licensee to provide the written procedure/protocol developed by the nurse for when a resident had an unplanned time away. On October 14, 2025, at 12:44 p.m., registered nurse (RN)-E provided the surveyor two policies and procedure for when the RN has an unplanned time away and ULP has an unplanned time away. Both policies did not include a procedure for when the resident had an unplanned time away. The surveyor explained to RN-E these policies received were not what the surveyor had requested and re-requested the	01790		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41132	A. BUILDING: _____ B. WING _____	10/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS HEALTHCARE SERVICES LL	9901 FALLGOLD PARKWAY NORTH BROOKLYN PARK, MN 55443

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01790	Continued From page 22 written procedure that was developed by a nurse for the staff to follow when a resident had an unplanned time away for handling medications. On October 14, 2025, at 2:43 p.m., clinical nurse supervisor (CNS)-D provided the licensee's policy for when a resident had an unplanned time away. The surveyor pointed out to CNS-D; the policy indicated a RN could delegate to a ULP to provide the medications if the RN had developed written procedure/protocols. CNS-D confirmed an understanding of the policy and stated they had to look further for a written procedure created by the nurse. On October 15, 2025, at 10:30 a.m., the surveyor asked CNS-D what the licensee's process was for when a resident had an unplanned time away. CNS-D did not respond to the surveyor's question but stated they would email the licensee's written procedure developed by the nurse for staff to follow when the resident had an unplanned time away. On October 16, 2025, at 8:52 a.m., the surveyor informed CNS-D the attached documents labeled, Unplanned time was a blank copy of the licensee's Individualized Medication Management Plan form. CNS-D stated they would resend the licensee's written procedure for staff to follow when a resident had an unplanned time away. The surveyor did not receive a written procedure/protocol developed by the nurse for when a resident had an unplanned time away with all the required content. The licensee's Medication Management Plan for Residents Away from Home policy dated July 25, 2025, indicated the RN could delegate to ULP if	01790		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41132	A. BUILDING: _____ B. WING _____	10/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS HEALTHCARE SERVICES LL	9901 FALLGOLD PARKWAY NORTH BROOKLYN PARK, MN 55443

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01790	Continued From page 23 the RN had developed written procedures/protocols that included the following: - special instructions regarding controlled substances; - type of container to be used for the medications appropriate to the facility's medication system; - how the containers should be labeled; - written information about the medications to be provided; - Documentation requirements; - how the RN should be notified that the medications were provided to the resident and whether the RN should be notified before the medications are given; and - medications may be set up for the length of the anticipated absence, not to exceed seven days. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to monitor a medication refrigerator to ensure temperatures were maintained according to the manufacturer's instructions for one of one resident (R1) with medications stored in medication refrigerator.	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41132	A. BUILDING: _____ B. WING _____	10/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS HEALTHCARE SERVICES LL	9901 FALLGOLD PARKWAY NORTH BROOKLYN PARK, MN 55443

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01880	Continued From page 24 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On October 13, 2025, at 11:32 a.m., during the facility tour, the surveyor observed the licensee's refrigerator used to store medications per manufacturer's recommendations. Upon opening the refrigerator, the surveyor observed R1's Lantus and Lispro insulin was being stored in the refrigerator. The surveyor observed the thermometer inside of the refrigerator indicated the temperature was 29 degrees (°) Fahrenheit (F). On October 13, 2025, at 11:32 a.m., during the facility tour, clinical nurse supervisor (CNS)-D stated the refrigerator temperature should be between 36° F and 46° F; and they document the temperatures on a log posted on the fridge. The surveyor observed one temperature log posted on the refrigerator used to store the licensee food. CNS-D then confirmed the temperature log posted was for the refrigerator that stored the food and not medications. The surveyor then observed CNS-D ask staff for the temperature log for the refrigerator that stored medications. The surveyor observed staff telling CNS-D they did not know as it was posted on the refrigerator. On October 14, 2025, at 11:00 a.m., unlicensed	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41132	A. BUILDING: _____ B. WING _____	10/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS HEALTHCARE SERVICES LL	9901 FALLGOLD PARKWAY NORTH BROOKLYN PARK, MN 55443

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01880	Continued From page 25 personnel (ULP)-A was observed opening the refrigerator used to store medications and upon opening, the thermometer inside of the refrigerator indicated the temperature was 70° F. ULP-A stated to the surveyor the refrigerator was not plugged in, and it must have been unplugged when staff were charging laptops. ULP-A asked the surveyor what temperature the refrigerator should be maintained at. The surveyor informed ULP-A it would depend on the medication being stored in the refrigerator and the recommendations of that medication. The surveyor then observed ULP-A reading the medication label that was being stored in the refrigerator and stated it should be between 36° F and 46° F. On October 15, 2025, at 10:31 a.m., CNS-D stated the refrigerator being out of range was a one-time incident as it was a power issue. CNS-D stated they monitor the medication refrigerator once daily. CNS-D stated it is required for the medication refrigerator to be maintained between 36° F and 46° F; and if the refrigerator was out of range, staff know they need to call the nurse. The licensee's Storage/Control of Medications policy dated July 25, 2025, indicated medications requiring refrigeration would be clearly labeled and stored in an enclosed container or area separated from foods. Also, the policy indicated the temperature would be maintained between 35° F and 40° F. The manufacturer's instructions for Lantus Solostar pen revised November 2023, indicated to store unused pens in the refrigerator at 36° F to 46° F and not to use if the pen had been	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41132	A. BUILDING: _____ B. WING _____	10/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS HEALTHCARE SERVICES LL	9901 FALLGOLD PARKWAY NORTH BROOKLYN PARK, MN 55443

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01880	Continued From page 26 frozen. The manufacturer's instructions for Insulin Lispro Kwikpen revised July 2023, indicated to store unused pens in the refrigerator at 36° F to 46° F and not to use if the pen had been frozen. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01940 SS=E	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41132	A. BUILDING: _____ B. WING _____	10/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS HEALTHCARE SERVICES LL	9901 FALLGOLD PARKWAY NORTH BROOKLYN PARK, MN 55443

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01940	Continued From page 27 therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to include a statement of general treatment services to be provided on the service plan for one of one resident (R1) with a treatment. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 was admitted on June 30, 2025, with diagnoses of type 1 diabetes and bilateral below knee amputation. On October 14, 2025, at 12:24 p.m., the surveyor observed unlicensed personnel (ULP)-A assist R1 with blood glucose monitoring. R1's Service Agreement/Service Plan dated June 30, 2025, lacked a statement of treatment services for monitoring blood glucose.	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41132	A. BUILDING: _____ B. WING _____	10/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS HEALTHCARE SERVICES LL	9901 FALLGOLD PARKWAY NORTH BROOKLYN PARK, MN 55443

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01940	Continued From page 28 R1's Physician's Order dated June 30, 2025, was signed by R1's provider on July 3, 2025, indicated R1 was to have blood glucose check two times per day and two times per day as needed. R1's Provider Orders dated September 16, 2025, indicated R1 was to have blood glucose check three times per day. On October 14, 2025, at 12:43 p.m., registered nurse (RN)-E confirmed R1's only signed service plan was from June 30, 2025. RN-E stated they signed a new service plan today to reflect current services R1 was receiving. On October 15, 2025, at 9:46 a.m., clinical nurse supervisor (CNS)-D stated it was an oversight with changing from paper to electronic records for the service plan not being updated with treatment of blood glucose. CNS-D confirmed R1 had always needed blood sugar monitoring but initially the licensee did not have all the treatments clarified from the provider and it was another oversight not to update the service plan once the orders were clarified. The licensee's Treatment and Therapy Management policy dated July 25, 2025, indicated the registered nurse was responsible for assessing and developing the treatment and/or therapy service plan for residents. The licensee's Service Plan policy dated May 1, 2025, indicated the service plan would include health services related to medication management, nursing services, and other clinical needs.	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41132	A. BUILDING: _____ B. WING _____	10/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS HEALTHCARE SERVICES LL	9901 FALLGOLD PARKWAY NORTH BROOKLYN PARK, MN 55443

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01940	Continued From page 29 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01950 SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) had communication with unlicensed personnel (ULP) about the individual needs of the resident for one of one resident (R1) who had an ordered treatment. This practice resulted in a level two violation (a	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41132	A. BUILDING: _____ B. WING _____	10/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS HEALTHCARE SERVICES LL	9901 FALLGOLD PARKWAY NORTH BROOKLYN PARK, MN 55443

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01950	Continued From page 30 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 June 30, 2025, with diagnoses of type 1 diabetes and bilateral below knee amputation. On October 14, 2025, at 12:24 p.m., the surveyor observed unlicensed personnel (ULP)-A check R1's blood glucose. R1's blood glucose was observed to be 384. The surveyor did not observe ULP-A notify a nurse immediately after checking a blood glucose with a result that indicated hyperglycemia. R1's Service Agreement/Service Plan dated June 30, 2025, lacked a statement of treatment services for monitoring blood glucose. R1's Physician's Order dated June 30, 2025, was signed by R1's provider on July 3, 2025, indicated R1 was to have blood glucose check two times per day and two times per day as needed. R1's Provider Orders dated September 16, 2025, indicated R1 was to have blood glucose check three times per day. R1's Individualized Treatment and Therapy Plan dated October 13, 2025, last updated on October	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41132	A. BUILDING: _____ B. WING _____	10/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS HEALTHCARE SERVICES LL	9901 FALLGOLD PARKWAY NORTH BROOKLYN PARK, MN 55443

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01950	Continued From page 31 8, 2025, indicated staff were to check blood glucose three times per day following agency procedure and notify the nurse if blood glucose was greater than 300. On October 15, 2025, at 3:20 p.m., ULP-A stated they would notify a nurse if the blood glucose was over 400 as they were instructed by the nurse. On October 15, 2025, at 9:46 a.m., clinical nurse supervisor (CNS)-D stated staff knew to notify the nurse for any blood sugar over 300. The licensee's Care of the Diabetic Client dated 2023, under procedure for blood glucose monitoring, indicated to notify the nurse for hyperglycemia (high blood glucose) over 200. The licensee's undated Management of Hyperglycemia policy indicated to notify an RN immediately if a blood glucose reading exceeded 250. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		

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

CARE PARTNERS HEALTHCARE SERV
9901 FALLGOLD PARKWAY NORTH
Brooklyn Park, MN 55443
Hennepin County
Parcel:

Phone:

License Info

License: HFID 41132

Risk:
License:
Expires on:
CFPM: Olufemi Akinwande
CFPM #: CFPM-60949; Exp: 08/22/2028

Inspection Info

Report Number: F1005251164
Inspection Type: Full - Single
Date: 10/13/2025 Time: 12:00 PM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 1
Total Priority 3 Orders: 0
Delivery: Emailed

New Order: 4-300 Equipment Numbers and Capacities
4-302.12B *Priority Level: Priority 2 CFP#: 36*
MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.
COMMENT: THE FOOD THERMOMETER ON SITE HAD A MINIMUM RANGE OF 50 DEGREES F AND DID NOT HAVE A SMALL DIAMETER PROBE. PROVIDE A THERMOMETER THAN CAN TAKE BOTH HOT AND COLD TEMPERATURES AND THAT HAS A SMALL DIAMETER PROBE.
Comply By: 10/20/2025 Originally Issued On: 10/13/2025

Food & Beverage General Comment

INSPECTION COMPLETED WITH STAFF AND REVIEWED WITH HRD NURSING EVALUATOR RHAWNIE QUINEHAN.

DISCUSSED DATE MARKING, GLOVE USE, COOKING TEMPERATURES, CROSS-CONTAMINATION, AND EMPLOYEE ILLNESS.

KITCHEN IS RESIDENTIAL AND FOOD IS PREPARED FOR SAME DAY SERVICE.

FACILITY HAS THERMOLABELS FOR THE DISHWASHER AND JUST RAN ONE THROUGH YESTERDAY, WHICH INDICATED A TEMPERATURE OF AT LEAST 160 DEGREES F.

FLOORING IS WOOD, CABINETS ARE WOOD WITH HOLLOW BASE, AND COUNTERS ARE LAMINATE. ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT SUCH A TIME THEY ARE FOUND TO BE A CONCERN OR RISK OF CONTAMINATION, THEY WILL BE ORDERED TO BE REPLACED AND BROUGHT UP TO CODE.

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 F1005251164 from 10/13/2025

ESTHER DAVIS

Jessica Davis, REHS
Public Health Sanitarian 3
651-201-3961
jessica.davis@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

CARE PARTNERS HEALTHCARE SERVI
Brooklyn Park
County/Group: Hennepin County

Inspection Info

Report Number: F1005251164
Inspection Type: Full
Date: 10/13/2025
Time: 12:00 PM

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

Food Temperature: Product/Item/Unit: COTTAGE CHEESE**; Temperature Process:** Cold-Holding
Location: Refrigerator at 39 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

CARE PARTNERS HEALTHCARE SERVI
Brooklyn Park
County/Group: Hennepin County

Inspection Info

Report Number: F1005251164
Inspection Type: Full
Date: 10/13/2025
Time: 12:00 PM

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** DISHWASHER
Location: Equal To 160 Degrees F.
Comment:
Violation Issued?: No