Electronically Delivered

October 30, 2026

Licensee
Delight Healthcare
4909 Kings Crossing
Brooklyn Center, MN 55443

RE: Project Number(s) SL37150016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on October 14, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

Level 1: no fines or enforcement;
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;
Level 3: a fine of $1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 4: a fine of $3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 5: a fine of $5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

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

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $1,000.00
St - 0 - 0810 - 144g.45 Subd. 2 (b-F) - Fire Protection And Physical Environment - $500.00

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

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

The correction order documentation should include the following:

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

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

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

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

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

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

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

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

If you have any questions, please contact me.

Sincerely,

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

CLN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37150	A. BUILDING: _____ B. WING _____	10/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELIGHT HEALTHCARE	4909 KINGS CROSSING BROOKLYN CENTER, 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: SL37150016-0 On October 12, 2026, through October 14, 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 (3) residents; all of whom were receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 650 SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of	0 650		

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0 650	Continued From page 1 each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records were correctly dated and included instructor signatures as required for two of two employees (unlicensed personnel (ULP)-B, ULP-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic	0 650		

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0 650	Continued From page 2 failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-B On October 13, 2026, at 9:15 a.m., the surveyor observed ULP-B administer oral medication to R2. ULP-B was hired on August 25, 2026, to provide assisted living services to residents. ULP-B's record included skill competencies such as blood glucose testing and oral medication administration. All competencies in ULP-B's record had typed date of February 25, 2026 (6 months before ULP-B's hire date), including a typed name of licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A on every form. All competencies lacked the signature of LALD/CNS-A observing each task. During interview on October 13, 2026, at 10:20 a.m., ULP-B stated LALD/CNS-A trained her in the required skills and observed ULP-B completing the tasks. ULP-B stated she officially began working on September 1, 2026, and had not worked for the licensee before that time. ULP-D On October 12, 2026, at 10:22 a.m., upon entry at the facility, the surveyor observed ULP-D working the shift (7:00 a.m. to 7:00 p.m.) providing supervision to the residents. ULP-D was hired on September 24, 2024, to provide assisted living services to residents. ULP-D's record included skill competencies such	0 650		

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0 650	Continued From page 3 as assistive devices, toileting assistance, skin care assistance, bathing assistance, and dressing assistance. All competencies in ULP-D's record had typed date of February 25, 2025 (5 months after ULP-D's hire date), including a typed name of LALD/CNS-A on every form. All competencies lacked the signature of LALD/CNS-A observing each task. During interview on October 13, 2026, at 11:30 a.m., LALD/CNS-A stated the typed dates on ULP-B and ULP-D's forms were dates from a classroom training and realized she did not change the date. LALD/CNS-A stated she observed ULP-B complete return demonstrations on August 26, 2026. LALD/CNS-A also stated she would start signing the competencies instead of having them typed and because she used the same process for everyone, this would need to be changed on all staff records. The licensee's 5.10 Training Records policy effective August 1, 2021, indicated the licensee would document the following information for each competency evaluation, training, retraining, and orientation topic: 1. Date of the training and competency evaluation, and the total amount of time of the training and competency evaluation; and 2. Name and title of the instructor and the instructor's signature, and the name and title of the competency evaluator, if different from the instructor, and the evaluator's signature with a statement attesting that the employee successfully completed the training and competency evaluation. Minnesota Administrative Rule 4659.0190, subpart 6, A., dated August 11, 2021, indicated the facility must maintain a record of staff training	0 650		

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0 650	Continued From page 4 and competency required under this part and Minnesota Statutes, chapter 144G, that documents the following information for each competency evaluation, training, retraining, and orientation topic: - facility name, location, and license number; - name of the training topic or training program, and the training methodology, such as classroom style, web-based training, video, or one-to-one training; - date of the training and competency evaluation, and the total amount of time of the training and competency evaluation; - name and title of the instructor and the instructor's signature, and the name and title of the competency evaluator, if different from the instructor, and the evaluator's signature with a statement attesting that the employee successfully completed the training and competency evaluation; and - name and title of the staff person completing the training, and the staff person's signature with a statement attesting that the staff person successfully completed the training as described in the training documentation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 680 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	0 680		

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0 680	Continued From page 5 temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	0 680		

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0 680	Continued From page 6 On October 12, 2026, at 12:55 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A provided a white binder with floral designs stating it was their EPP and she was responsible for maintaining the plan. The licensee's EPP dated November 1, 2023, lacked emergency prep testing requirements. During interview on October 12, 2026, at 12:55 p.m., when the surveyor requested to view the licensee's EPP testing exercises, LALD/CNS-A provided the surveyor with completed fire drills. The surveyor showed LALD/CNS-A their blank testing exercise form within their EPP, LALD/CNS-A stated they had not completed any exercises but was told about it during a survey at a sister facility. The licensee's 4.01 Training, Exercises, and Testing policy effective November 1, 2023, indicated the licensee would participate in a full-scale exercise that is community-based, or when community-based exercise is not accessible, an individual, facility-based tabletop exercise. The facility would also conduct an additional annual exercise that may include either a second full-scale exercise (community-based or facility-based), tabletop exercise, or a mock disaster drill. Following exercise events, the licensee would document the exercises and document an after-action plan providing feedback on the accuracy and effectiveness of established policies, the emergency plan and implementing procedures. Minnesota Administrative Rule 4659.0100 dated August 11, 2021, indicated assisted living facilities shall comply with the federal emergency	0 680		

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0 680	Continued From page 7 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		
0 775 SS=I	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, 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, 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:	0 775		

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0 775	Continued From page 8 Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated October 13, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Two (2) days	0 775		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic	0 800		

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0 800	Continued From page 9 failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated October 13, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or 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	0 810		

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0 810	Continued From page 10 include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated October 13, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 810		

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01620 SS=D	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 (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	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37150	A. BUILDING: _____ B. WING _____	10/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELIGHT HEALTHCARE	4909 KINGS CROSSING BROOKLYN CENTER, 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
01620	Continued From page 12 services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) updated the smoking assessment for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: During the entrance conference on October 12, 2026, at 10:37 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she was responsible for completing nursing assessments and one of three residents smoked. R2's diagnoses included schizophrenia, anxiety, major depression, and attention deficit	01620		

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	37150	A. BUILDING: _____ B. WING _____	10/14/2026

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01620	Continued From page 13 hyperactive disorder (ADHD). R2's Service Plan (Waiver) - Addendum to Contract signed August 4, 2024, indicated R2 received assistance with behavior management, activities, bathing reminders, housekeeping, laundry, medication administration, and mental health monitoring. R2's individual abuse prevention plan dated July 22, 2026, indicated R2 was as risk to abuse themselves by smoking in her room, burning incense in her room, "grill incense in the oven, and cook it in the pot and it will dry and cause smoke then triggering the alarms." Interventions included staff redirecting R2 and the nurse would intervene. R2's nursing assessments completed by LALD/CNS-A on January 25, 2026, April 23, 2026, and July 22, 2026, respectively, indicated the following exact information about R2's smoking habits: -smoked more than half a pack a day; -stored smoking material in R2's room; -disposed of ashes and cigarette butts in ash tray and in room trash; -used disposable lighters; -R2 was unable to handle lit cigarettes responsibly and smoked in her room; -R2 was able to extinguish cigarettes completely; -there were signs of mishandled cigarettes within R2's room and her clothing; -ashtrays were emptied in the waste basket; and -R2 could not smoke safely and independently without interventions. R2's Behavior Plan - Assessed Needs and Services with as of date October 13, 2026, indicated under managing "property destruction,"	01620		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELIGHT HEALTHCARE	4909 KINGS CROSSING BROOKLYN CENTER, MN 55443

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01620	Continued From page 14 it instructed staff to remove R2's incense from her room while R2 was out of her room. During facility tour on October 12, 2026, at 11:30 a.m., the facility was a split-level home with three occupied bedrooms upstairs and two unoccupied bedrooms downstairs. The surveyor observed two designated smoking areas with cigarette disposal containers next to the front door and on the deck. The surveyor was able to enter R2's room because R2 had just left the facility. Unlicensed personnel (ULP)-D stated R2 did not like anyone in her room and touching her things so they would always have to wait until she left to enter and clean up. The surveyor observed a trash can with a broken plate, used incense stick, and a cigarette butt. The trash can also had unidentified black substances (large chunks). R2's dresser next to the window (only window in the bedroom) had a box of cigarette tubes and a cigarette rolling machine to make own cigarettes out of tobacco. The desk also had a disposable lighter, two unlit cigarettes, vape, and incense holder. R2's bed had 3 or 4 burned incense sticks. R2's nursing assessment lacked an updated smoking assessment of current smoking behavior and lacked assessment of ongoing behavior of inappropriate incense burning. During interview on October 13, 2026, at 3:15 p.m., LALD/CNS-A stated R2 did not smoke in her room anymore but acknowledged the smoking assessment was not updated when the information from the previous assessment was automatically brought forward. LALD/CNS-A stated her concern now was R2 burning incense in her room and stated interventions placed under "property destruction" were not sufficient and	01620		

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01620	Continued From page 15 would include additional information. The licensee's 6.01 Assessments, Reviews & Monitoring Policy effective August 1, 2021, indicated the registered nurse would complete the resident reassessment as needed based on changes in the needs of the resident. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01640 SS=E	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan.	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37150	A. BUILDING: _____ B. WING _____	10/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELIGHT HEALTHCARE	4909 KINGS CROSSING BROOKLYN CENTER, MN 55443

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01640	Continued From page 16 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to obtain a signature or other authentication by the licensee to document agreement of services to be provided for two of three residents (R2, R3) that were receiving services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: During entrance conference on October 12, 2026, at 10:37 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated upon admission of services, residents would sign the service plan, and the licensee would complete the same process for changes in the service plan. R2 On October 13, 2026, at 9:15 a.m., the surveyor observed unlicensed personnel (ULP)-B administer oral medication to R2. R2 was able to independently ambulate. R2 was admitted for services on May 15, 2022, and had a diagnosis of schizophrenia. R2's service plan authenticated by R2 on August	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01640	Continued From page 17 4, 2024, indicated R2 received daily assistance with bathing reminders, dressing, escort and mobility, and grooming. R2's Service Recap Summary dated October 2026, indicated staff provided assistance with activities, housekeeping, managing behaviors (agitation, anxiety, physical and verbal aggression, and property destruction), managing symptoms (auditory hallucination, delusions, depression, and paranoia), meal tray, medication assistance, medication setup, mental health monitoring, safety checks, shopping assistance, and linen change. The documentation indicated R2 did not receive assistance with bathing reminders, dressing, escort and mobility, and grooming. R3 On October 13, 2026, at 8:36 a.m., the surveyor observed ULP-C administer medication to R3 while sitting at the dining room table eating breakfast. R3 was admitted on November 2, 2020, and began assisted living services on August 1, 2021. R3 had a diagnosis of diabetes. On October 12, 2026, at 2:28 p.m., LALD/CNS-A provided R3's service plan, which was printed on February 15, 2022, and was authenticated by R3 with the date of August 1, 2021 (dated approximately 6 months prior to the print date). On October 12, 2026, at 2:38 p.m., LALD/CNS-A provided the surveyor with another service plan for R3, with a print date of August 2, 2021, and authenticated by R3 on July 29, 2021. The surveyor asked which service plan was the current service plan and LALD/CNS-A stated the	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37150	A. BUILDING: _____ B. WING _____	10/14/2026

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01640	Continued From page 18 service plan signed July 29, 2021, was the "current service plan." The surveyor asked why the other service plans' signature pre-dated the print date. LALD/CNS-A stated she was unable to locate the original service plan, so she had R3 sign another service plan but located the original service plan later. R3's current service plan in use (signed July 29, 2021) lacked blood glucose monitoring twice daily but all other services were the same between the two service plans. On October 14, 2026, at 12:53 p.m., LALD/CNS-A stated she had removed the services R2 no longer needed but did not print R2's service plan and have R2 sign it after changes were made to it. The licensee's Service Plan policy effective August 1, 2021, indicated authenticated service plans and any revisions would be maintained in each resident's record to document agreement of services to be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		

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

DELIGHT HOME HEALTHCARE LLC (HFID 37150)
4909 KINGS CROSSING
Brook Park, MN 55443
Hennepin County
Parcel:

Phone:
nkluvken@yahoo.com

License Info

License: HFID 37150

Risk:
License:
Expires on:
CFPM: NKEIRUKA OKWUOMA OKONKWO
CFPM #: 14701; Exp: 10/17/2028

Inspection Info

Report Number: F1029261361
Inspection Type: Full - Single
Date: 10/12/2026 Time: 1:45:39 PM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery:

No orders were issued for this inspection report.

Food & Beverage General Comment

FOOD AND BEVERAGE INSPECTION OF ALF PERFORMED AS PART OF HRD SURVEY.

HRD NURSING SURVEYOR EVALUATOR: ANNA BOHNEN, RN

FACILITY IS RESIDENTIAL IN NATURE WITH LAMINATE FLOOR, COMPOSITE STONE COUNTERTOPS, SMOOTH PAINTED WALLS AND CEILING, WOOD/COMPOSITE WOOD MILLWORK. FACILITY USES HIGH HEAT DISHWASHER TO SANITIZE EQUIPMENT AND UTENSILS.

FOOD SAFETY AND FOODBORNE ILLNESS RISK FACTORS REVIEWED WITH PIC.

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 F1029261361 from 10/12/2026

NKEIRUKA OKONKWO
LALD - PERSON IN CHARGE (PIC)

Trevor McCliment

Trevor McCliment,
Public Health Sanitarian 3
651-201-3957
trevor.mccliment@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

DELIGHT HOME HEALTHCARE LLC (HFID 37150)
Brook Park
County/Group: Hennepin County

Inspection Info

Report Number: F1029261361
Inspection Type: Full
Date: 10/12/2026
Time: 1:45:39 PM

New Record: **Product/Item/Unit:** deli meat**; Temperature Process:** Cold-Holding
Location: fridge at 42 Degrees F.
Comment:
Violation Issued?: No

New Record: **Product/Item/Unit:** milk**; Temperature Process:** Cold-Holding
Location: fridge at 41 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

DELIGHT HOME HEALTHCARE LLC (HFID 37150)
Brook Park
County/Group: Hennepin County

Inspection Info

Report Number: F1029261361
Inspection Type: Full
Date: 10/12/2026
Time: 1:45:39 PM

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Greater Than 160 Degrees F.
Comment:
Violation Issued?: No

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL37150016	**Date:** 10/13/2026
Facility Name: Delight Home Healthcare	
Facility Address: 4909 Kings Crossing Brooklyn Park, Mn 55443	

☒ **TAG IDENTIFICATION: 0775**

SCOPE/ SEVERITY: Level 3; Widespread **TIME PERIOD OF CORRECTION:** Two (2) days

1. Each assisted living facility must comply with the provisions of the Minnesota State Fire Code (MSFC) in Minnesota Rules chapter 7511. [Minn. Stat. 144G.45 subd. 2]

2. Lighted matches, cigarettes, cigars or other burning object shall not be discarded in such a manner that could cause ignition of other combustible material. [Minn. Stat. 144G.45 subd. 2; MSFC 310.7]

   Comments: The residents had two designated smoking areas, one was on the deck off the dining room, and one was on the front step by the front door. There was a cigarette disposal receptacle provided at each location. Cigarette butts were found on the deck and all over the ground below the deck by the house. There was evidence of burn marks on the wooden deck boards. There was also cigarette butts found on the ground by the front doorstep.

3. Electrical wiring, devices, appliances and other equipment that is modified or damaged and constitutes an electrical shock or fire hazard shall not be used. [Minn. Stat. 144G.45 subd. 2; MSFC 604.1]

   Comments: There was evidence of burn marks on two of the electrical outlets in resident #2 bedroom. Licensed assisted living director/ clinical nurse supervisor (LALD/CNS)-A stated that the resident was overloading the electrical outlets by plugging in heaters. It was advised to consult with an electrician on these outlets in hopes to prevent a fire from starting.

☒ **TAG IDENTIFICATION: 0800**

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

1. The physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment are in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. [Minn. Stat. 144G.45 subd.2]

   Comments: Maintenance findings include:
   There was a hole in the storage closet door in the basement.
   There were heavily soiled carpet stains on the staircase going to the basement and up to the main floor.
   Resident bedroom #2 had a heavily soiled floor and several holes in the wall throughout the bedroom.
   There were dark marks on the windowsill and on the floor below the windowsill. LALD/CNS-A stated that the resident likes to burn incense. The window was broken but fixed during the survey. LALD/CNS-A stated that the resident broke her window a few days ago.

☒ **TAG IDENTIFICATION: 0810**

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

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

   Comments: The fire safety and evacuation plan did not include site-specific staff actions during an emergency and relied on a basic acronym R.A.C.E. (Rescue, Alert, Confine, Extinguish or Evacuate) that lacked detailed procedural guidance.

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

   Comments: The licensee failed to provide an FSEP that included any unique resident needs for evacuation. No procedures were provided to the surveyor that included procedures for resident evacuation that identified unique resident needs. No documentation was provided at the time of the survey.