Electronically Delivered

July 10, 2025

Licensee
Caring Nurses LLC
7700 Shingle Creek Drive
Brooklyn Center, MN 55443

RE: Project Number(s) SL31336016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on May 14, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, 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 - 0780 - 144g.45 Subd. 2 (a) (1) - Fire Protection And Physical Environment - $500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $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. 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,

Renee L. Anderson

Renee L. Anderson, Supervisor
State Evaluation Team
Email: Renee.L.Anderson@state.mn.us
Telephone: 651-201-5871 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31336	A. BUILDING: _____ B. WING _____	05/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING NURSES LLC	7700 SHINGLE CREEK DRIVE 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 In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been 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: SL31336016-0 On May 12, 2025, through May 14, 2025, the Minnesota Department of Health conducted an initial survey at the above provider, and the following correction orders are issued. At the time of the survey, there were four (4) residents receiving services under the provider's Assisted Living license. The survey was completed in conjunction with follow-up investigation #HL313361801C.	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 License 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 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 surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated May 13, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		

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0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate 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 functioned and were interconnected so that the actuation of one alarm caused all alarms in the dwelling unit to actuate. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 780		

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0 780	Continued From page 4 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On May 13, 2025, from 10:00 a.m. to 11:00 a.m., the surveyor toured the facility with maintenance staff (M)-E. The surveyor asked M-E to initiate a test of the smoke alarms throughout the home. The following was observed: The smoke alarm in the upstairs hallway was not interconnected to the rest of the smoke alarms in the facility. The hardwired (receiving power from the building electrical system) smoke alarm in the basement living room was disconnected from the building electrical system. M-E connected the smoke alarm and the other hardwired smoke alarms in the facility began to sound. The hardwired smoke alarms in the basement storage area and basement living room were chirping to indicate maintenance was required. The wireless smoke alarms in the rest of the facility did not sound when the basement living room smoke alarm was reconnected. The hardwired smoke alarms in the basement storage area and basement living room were not interconnected with the rest of the smoke alarms in the facility. Existing hardwired smoke alarms are required to be maintained as installed at the time of construction and interconnected to additional battery-operated alarms so activation of one alarm activates all alarms throughout the facility.	0 780		

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0 780	Continued From page 5 These deficient conditions were visually verified by M-E accompanying on the tour. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 800 SS=D	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, in a continuous state of good repair and operation. This deficient condition had the potential to affect all staff, residents, 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 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)	0 800		

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0 800	Continued From page 6 The findings include: On May 13, 2025, from 10:00 a.m. to 11:00 a.m., the surveyor toured the facility with maintenance staff (M)-E. The surveyor observed the following: The carpet on the basement stairs was frayed and pulling away from the steps causing a potential tripping hazard. The bathroom on the main level had loose tiles and damage to the laminate flooring in the hallway where the two materials met causing a potential tripping hazard and a location where water from the bathroom could penetrate the floor surface and cause damage to the structure below. These deficient conditions were visually verified by M-E accompanying on the tour. No further information was provided. 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	0 810		

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0 810	Continued From page 7 (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and to provide the required training. This had the potential to directly 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) 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	0 810		

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0 810	Continued From page 8 the residents). The findings include: On May 13, 2025, unlicensed personnel/ housing manager (ULP)-C 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's FSEP, Fire Emergency Response Plan and Fire safety & Evacuation Plan, undated, failed to include the following: The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include the identification of any residents that needed assistance, any resident-specific procedures to staff for assisting residents during evacuation, nor did it include instructions for staff to follow in case of relocation. TRAINING: The licensee failed to provide evacuation training to residents at least once per year. ULP-C lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan in the last twelve months. The licensee's training records, Fire Training Log-Clients, dated October 31, 2013, indicated residents were offered training on July 20, 2023 and January 20, 2024. The licensee failed to provide training to	0 810		

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0 810	Continued From page 9 employees on the FSEP upon hire and at least twice per year. The licensee's training records, Fire Training-Staff, dated October 31, 2013, indicated two staff members completed training on July 20, 2023 and January 30, 2024. No other training documentation was provided. On May 13, 2025, at 1:30 p.m., ULP-C stated director of maintenance (DM)-F was responsible for the development of the FSEP, training residents and staff, and conducting evacuation drills. ULP-C stated they did not know the requirements for the FSEP, training, or evacuation drills. On May 14, 2025, at 9:13 a.m., survey called DM-F and left a voicemail requesting a return call to review the FSEP. No return call was received. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing	01500		

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01500	Continued From page 10 techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication	01500		

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01500	Continued From page 11 access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employees received at least eight (8) hours of annual training for each 12 months of employment for two of two employees (unlicensed personnel (ULP)-C, ULP-G). This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-C ULP-C had a hire date of November 16, 2023, and provided direct cares and services to residents of the assisted living facility. On May 13, 2025, at 9:40 a.m., through 11:50 a.m., ULP-C was observed to provide assisted living services including assisting R2 and R3 with medication administration. ULP-G ULP-G had a hire date of January 1, 2023, and provided direct cares and services to residents of the assisted living facility. ULP-C and ULP-G's employee records lacked evidence of eight (8) hours of annual training.	01500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31336	A. BUILDING: _____ B. WING _____	05/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING NURSES LLC	7700 SHINGLE CREEK DRIVE BROOKLYN CENTER, MN 55443

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01500	Continued From page 12 On May 13, 2025, at 3:00 p.m., licensed assisted living director (LALD)-A stated ULP-C and ULP-G lacked annual training. LALD-A further stated she spoke with ULP-C about annual training that had been assigned to her, however, ULP-C did not give a reason for not completing annual training. Moreover, LALD-A stated the licensee changed training providers towards the end of last year, and they thought it would be better for their staff because they would have an option to push training out periodically instead of all at once. The licensee's undated Annual Training Requirements policy indicated all staff that provided direct care services in assisted living would complete at least eight (8) hours of annual training for each 12 months of employment. Furthermore, annual training topics would include the following: - training on reporting of maltreatment of vulnerable adults under section 626.557; - review of the Assisted Living Bill of Rights and staff responsibilities related to ensuring the exercise and protection of those rights; - review of infection control techniques used in the home and implementation of infection control standards including: a. a review of hand-washing techniques b. need for and use of protective gloves, gowns, and masks c. appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes and razor blades d. disinfecting reusable equipment e. disinfecting environmental surfaces f. reporting of communicable diseases - effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with	01500		

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	31336	A. BUILDING: _____ B. WING _____	05/14/2025

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01500	Continued From page 13 residents who have dementia, Alzheimer's disease or related disorders; - review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; and - training on providing services to residents with hearing loss. Moreover, evidence that each employee had completed the orientation and training would be in the employee file. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
01540 SS=F	144G.64 (a) (3) Training in Dementia, Mental Illness, and De- (3) for assisted living facilities with dementia care, direct-care staff must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, the staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is	01540		

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01540	Continued From page 14 complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure all staff received two (2) hours of dementia training annually for direct care employees as required for two of two employees (unlicensed personnel (ULP)-C, ULP-G). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-C ULP-C had a hire date of November 16, 2023, and provided direct cares and services to residents of the assisted living facility. On May 13, 2025, at 9:40 a.m., through 11:50 a.m., ULP-C was observed to provide assisted living services including assisting R2 and R3 with medication administration. ULP-G	01540		

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	31336	A. BUILDING: _____ B. WING _____	05/14/2025

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01540	Continued From page 15 ULP-G had a hire date of January 1, 2023, and provided direct cares and services to residents of the assisted living facility. ULP-C and ULP-G's employee records lacked evidence of two (2) hours of annual dementia training. On May 13, 2025, at 3:00 p.m., licensed assisted living director (LALD)-A stated ULP-C and ULP-G lacked annual dementia training. LALD-A further stated she spoke with ULP-C about annual training that had been assigned to her; ULP-C did not give a reason for not completing annual training. Moreover, LALD-A stated the licensee changed training providers towards the end of last year, and they thought it would be better for their staff because they would have an option to push training out periodically instead of all at once. The licensee's undated Annual Training Requirements policy indicated all staff that provided direct care services in assisted living would complete at least eight (8) hours of annual training for each 12 months of employment. Furthermore, annual training topics would include the following: - effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease or related disorders. Moreover, evidence that each employee had completed the orientation and training would be in the employee file. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	01540		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01540	Continued From page 16 (21) days	01540		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were labeled correctly for one of two residents (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: R2's diagnoses included but were not limited to, spina bifida, paraplegia, osteomyelitis, and seizures. R2's master care plan dated May 12, 2025, indicated R2 received services to include assistance with bathing, dressing, grooming, turning and repositioning, transferring, toileting,	01890		

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01890	Continued From page 17 housekeeping, laundry, full medication management, and medication administration. R2's provider orders signed April 3, 2025, included Oxycodone 5mg (milligram) tablet, take one (1) tablet by mouth every six (6) hours as needed for severe pain. Incorrectly labeled medications: On May 13, 2025, at 9:57 a.m., during a review of narcotic medication storage with unlicensed personnel (ULP)-C, the surveyor observed a medication punch card with twenty Oxycodone 5mg tablets remaining. The prescription label indicated the medication was prescribed to R2, and included the required information. There was another medication punch card with seven (7) Oxycodone 5mg tablets remaining. The card included R2's name hand-written, but did not include the original prescription label with legible information. On May 13, 2025, at 10:00 a.m., ULP-C stated this was the first time she had seen medication without a label on it. ULP-C further stated she had not noticed anything was wrong because she had not administered Oxycodone to R2 for quite a while. On May 13, 2025, at 11:37 a.m., during a telephone conversation, licensed assisted living director (LALD)-A stated all medications usually come from the pharmacy with a prescription label on them, and it was the nurse's responsibility to ensure all medications delivered had a label on them. LALD-A further stated she was unaware R2's Oxycodone was not labeled. The licensee's undated Medication Storage policy indicated until the medication was set up for	01890		

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01890	Continued From page 18 immediate or later administration by a nurse, a legend drug must be kept in its original container, bearing the original prescription label, with legible information stating the prescription number, name of drug, strength and quantity of drug, expiration date of time-dated drug, directions for use, resident's name, prescriber's name, date of issue, and the name and address of the licensed pharmacy that issued the medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

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

Caring Nurses LLC
7700 Shingle Creek Drive
Brooklyn Park, MN 55443
Hennepin County
Parcel:

Phone:

License Info

License: HFID 31336

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

Inspection Info

Report Number: F1005251025
Inspection Type: Full - Single
Date: 5/13/2025 Time: 11:00:33 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 1
Total Priority 2 Orders: 0
Total Priority 3 Orders: 1
Delivery: Emailed

New Order: 2-100 Supervision
2-102.12AMN *Priority Level: Priority 3 CFP#: 2*
MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.
COMMENT: EMPLOYEE ON SITE HAS A FOOD SAFETY CERTIFICATE FROM 10/1/2024, BUT DOES NOT HAVE THE MN CFPM.
Comply By: 6/13/2025 Originally Issued On: 5/13/2025

! **New Order: 4-700 Sanitizing Equipment and Utensils**
4-703.11B *Priority Level: Priority 1 CFP#: 16*
MN Rule 4626.0905B Sanitize food contact surfaces of equipment and utensils after cleaning by using mechanical hot water operations that achieve a utensil surface temperature of 160 degrees F (71 degrees C) and are set up and maintained in accordance with the specifications of NSF International and the manufacturer's data plate.
COMMENT: FACILITY FAILED TO PROVIDE VERIFICATION THAT THE DISHWASHER IS REACHING THE PROPER TEMPERATURE TO SANITIZE. SEND INSPECTOR PICTURE OF THERMOLABEL THAT HAS BEEN RUN THROUGH THE DISHWASHER TO VERIFY IT IS REACHING 160 DEGREES F.
Comply By: 5/13/2025 Originally Issued On: 5/13/2025

Food & Beverage General Comment

INSPECTION COMPLETED WITH STAFF AND EMAILED TO HRD NURSING EVALUATOR RHONDA MAKELA.

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

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

FLOORING IS LAMINATE, 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 F1005251025 from 5/13/2025

JOSEPHINE GURLEY
CLINICAL NURSE SUPERVISOR

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

Caring Nurses LLC
Brooklyn Park
County/Group: Hennepin County

Inspection Info

Report Number: F1005251025
Inspection Type: Full
Date: 5/13/2025
Time: 11:00:33 AM

Food Temperature: Product/Item/Unit: MILK**; Temperature Process:** Cold-Holding
Location: KITCHEN REFRIGERATOR at 40 Degrees F.
Comment:
Violation Issued?: No

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

Equipment Temperature: Product/Item/Unit: AMBIENT**; Temperature Process:** Cold-Holding
Location: BASEMENT REFRIGERATOR at 39 Degrees F.
Comment:
Violation Issued?: No