Electronically Delivered

May 22, 2025

Licensee
Noble Cares LLC
6925 Halifax Avenue North
Brooklyn Center, MN 55429

RE: Project Number(s) SL40383015

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 April 11, 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 SL40383015 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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40383	A. BUILDING: _____ B. WING _____	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOBLE CARES LLC	6925 HALIFAX AVENUE NORTH BROOKLYN CENTER, MN 55429

(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 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: SL40383015-0 On April 7, 2025, through April 11, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were two (2) residents; two 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		

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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, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated April 7, 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	0 480		

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0 480	Continued From page 3 to the FBEIR for any compliance dates.	0 480		
0 650 SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each 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 included all required content (documentation of training and competency for Dexcom monitor (real-time blood glucose monitoring system) and sliding scale insulin) for three of three unlicensed personnel ((ULP)-B, ULP-C, ULP-E). The licensee also lacked	0 650		

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0 650	Continued From page 4 documentation of orientation training for three of three ULPs (ULP-B, ULP-C, 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 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-B, ULP-C, ULP-D, and ULP-E were hired on November 9, 2024, November 15, 2024, November 8, 2024, and April 14, 2023, respectively, to provide assisted living services. TRAINING AND COMPETENCY During interview on April 8, 2025, at 9:22 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A provided a paper-training manual he used for training on medication administration, but the manual did not include training on sliding scale insulin. LALD/CNS-A stated he trained each ULP one-on-one on the sliding scale insulin. During observation and interview on April 8, 2025, at 11:20 a.m., ULP-B checked R2's Dexcom monitor to obtain the blood glucose and used the sliding scale to determine how much insulin to administer. ULP-B, ULP-C, and ULP-E's training records lacked documentation of Dexcom monitor use and changing of Dexcom sensor and transmitter.	0 650		

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0 650	Continued From page 5 On April 8, 2025, at 10:06 a.m., LALD/CNS-A stated he did not have documentation of training and competency for Dexcom monitor use. He further stated ULP-C and ULP-E were trained to change the Dexcom sensor and transmitter. During interview on April 8, 2025, at 1:30 p.m., ULP-B stated LALD/CNS-A trained her on Dexcom monitor use and how to change the sensor and transmitter. During interview on April 9, 2025, at 11:58 a.m., ULP-C stated LALD/CNS-A trained her on insulin administration and Dexcom monitor use twice. During interview on April 9, 2025, at 1:13 p.m., ULP-E stated she was trained by LALD/CNS-A on Dexcom monitor use and insulin administration and sliding scale. ORIENTATION TRAINING ULP-B's employee record included an online training transcript (Educare) that indicated ULP-B received some orientation training in November 2023 and June 2024, which were prior to ULP-B's hire date of November 8, 2024. ULP-B ULP-B's employee record lacked documentation of training on the following required assisted living orientation content: - overview of Assisted Living statutes -review of provider's policies and procedures -reporting maltreatment of vulnerable adults or minors; -assisted living bill of rights; -handing of resident complaints, reporting of complaints, where to report -consumer advocacy services -review of types of Assisted Living services the	0 650		

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0 650	Continued From page 6 employee will provide and provider's scope of license. During interview on April 8, 2025, at 2:23 p.m., ULP-B stated she went over resident care plans, read a brochure, and signed a document at the end of the review. ULP-B did not give specifics on what she was trained on during orientation. ULP-C ULP-C's employee record lacked documentation of training on the following required assisted living orientation content: - overview of Assisted Living statutes; -review of provider's policies and procedures; -handing of resident complaints, reporting of complaints, where to report; -consumer advocacy services; and -review of types of Assisted Living services the employee will provide and provider's scope of license. ULP-D ULP-D's employee record lacked documentation of training on the following required assisted living orientation content: - overview of Assisted Living statutes; -review of provider's policies and procedures; -handling emergencies and using emergency services; -reporting maltreatment of vulnerable adults or minors; -handing of resident complaints, reporting of complaints, where to report; -consumer advocacy services; -review of types of Assisted Living services the employee will provide and provider's scope of license; and -principles of person-centered planning/service delivery.	0 650		

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0 650	Continued From page 7 On April 8, 2025, at 10:06 a.m., LALD/CNS-A stated his process was to assign courses on Educare, but he did not check to see if they were completed. LALD/CNS-A then stated he provided one-on-one training with all ULPs on orientation using the paper-training manual. The licensee's undated Orientation of Staff and Supervisors & Content Policy indicated all staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing services to residents. This orientation for each staff member and is not transferrable to other home care providers. The policy also indicated all staff must demonstrate an understanding of the training and evidence of the completion of required orientation topics must be kept in each staff member's record. The licensee's undated Competency Training Evaluations Policy indicated documentation of training and competency evaluations would be kept in each personnel file. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0190, Subpart 6, effective October 2022, the licensee must maintain a record of staff training 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: (1) facility name, location, and license number (2) 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 (3) date of the training and competency	0 650		

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0 650	Continued From page 8 evaluation, and the total amount of time of the training and competency evaluation (4) 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 (5) name and title of the staff person completing the training, and the staff person's signature with 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		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must 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.	0 660		

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0 660	Continued From page 9 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure screenings for active TB (either a two-step tuberculin skin test (TST) or blood test (Quantiferon TB Gold)) were completed upon hire and documented for three of three employees (unlicensed personnel (ULP)-B, ULP-C, ULP-E). 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: During entrance conference on April 7, 2025, at 10:51 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated upon hire, staff received either the blood test or chest x-ray at their clinic prior to working with residents. The Facility TB Risk Assessment completed on January 20, 2025, indicated the facility was at a low risk for TB transmission. ULP-B, ULP-C, and ULP-E were hired November 9, 2024, November 15, 2024, and April 17, 2023, respectively, to provide assisted living services. ULP-B, ULP-C, and ULP-E's records included a Baseline TB Screening Tool for Health Care	0 660		

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0 660	Continued From page 10 Workers file dated November 6, 2024, November 13, 2024, and April 16, 2023, respectively. ULP-B's negative TB Gold test completed on February 26, 2023, was done approximately 20 months prior to employment. ULP-C's negative TB Gold test completed on February 1, 2024, was approximately 9 months prior to employment. ULP-E's negative TB Gold test completed on September 9, 2022, was approximately 8 months prior to employment. During observation on April 7, 2025, at 12:45 p.m., the surveyor observed ULP-C at the medication cart located in the dining area. ULP-C was the only person working the shift and provided supervision. During observations from April 8-9, 2025, at various times, the surveyor observed ULP-B provide medication administration, blood glucose monitoring, meals, supervision, behavior redirection, and housekeeping duties. During interview on April 7, 2025, at 2:00 p.m., LALD/CNS-A explained it was understood a TB Gold test was good forever as long it was negative. If staff had a chest x-ray, it would need to be completed annually. The surveyor provided him with information from the Minnesota Department of Health's Resources and FAQ's page and informed him that a TB test could be accepted within 90 days of hire on the Regulations for TB Control for MN Health care settings. He stated he was never told that. The licensee's undated Tuberculosis (TB) Testing	0 660		

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0 660	Continued From page 11 Protocols policy indicated the condition for protocol was to detect infection with TB in healthcare workers at the time of hire, as part of pre-employment screening, annually (if required), and following exposure (as indicated). No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule.	0 680		

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NOBLE CARES LLC	6925 HALIFAX AVENUE NORTH BROOKLYN CENTER, MN 55429

(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
0 680	Continued From page 12 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. The licensee also failed to post an emergency disaster plan prominently. 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 potential to affect a large portion or all of the residents). The findings include: On April 7, 2025, at 11:25 a.m., the surveyor asked licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A where the EPP could be found. LALD/CNS-A went to an enclosed closet within the kitchen, opened the door and pulled out the EPP binder. The solid closet door did not indicate the EPP could be found in there. The surveyor did not observe any postings near the front entrance indicating where the EPP could be found. The licensee's undated emergency preparedness plan lacked the following required content: - Emergency Preparedness Program Patient Population-identify at risk population needs like maintaining independence, communication, transportation, supervision and medical care;	0 680		

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0 680	Continued From page 13 -Policies and Procedures for Volunteers; and -Emergency Officials Contact Information (lacked state licensing and MN Office of Ombudsman for LTC). Additionally, the EPP included a form titled Individual Emergency Evacuation Plan, which was blank. During interview on April 11, 2025, at 11:40 a.m., LALD/CNS-A was unable to locate the missing content. LALD/CNS-A stated the patient population information should have been on the Individual Emergency Evacuation Plan, but it was not. The licensee's undated Emergency Preparedness Policy indicated to ensure the safety and well-being of residents, staff, and visitors during emergencies by establishing a structured response plan that prepares for, responds to, and recovers from natural and man-made disasters. This policy applied to all employees, volunteers, contractors, residents, and visitors of the facility. The policy also indicated the EPP would include the following components: -communication protocols; -evacuation and shelter-in-place procedures; -resident tracking and accountability; -coordination with local emergency responders; -access to emergency supplies; and -protection of medical records and medications. The policy did not indicate the plan needed to be posted prominently. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		

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0 780	Continued From page 14	0 780		
0 780 SS=E	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 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	0 780		

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0 780	Continued From page 15 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: On April 8, 2025, from 10:30 a.m. to 11:30 a.m., the surveyor toured the facility with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A. The surveyor asked LALD/CNS-A to initiate a test of the smoke alarms throughout the home. Upon testing, it was found that the smoke alarms in the facility were not interconnected. The hardwired smoke alarms (alarms receiving power from the building electrical system) were not interconnected with the wireless smoke alarms. 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. These deficient conditions were visually verified at the time of discovery by LALD/CNS-A accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
0 940 SS=C	144G.50 Subd. 2 (e; 5-7) Contract information (5) a description of the facility's policies related to	0 940		

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0 940	Continued From page 16 medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: (i) whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; (ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); (iii) whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; (iv) whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; (v) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; (vi) a statement that residents may be eligible for assistance with rent through the housing support program; and (vii) a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; (6) the contact information to obtain long-term care consulting services under section 256B.0911; and (7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with	0 940		

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0 940	Continued From page 17 the required content for two of two residents (R1, R2). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 was admitted to licensee for services on February 22, 2025, and had diagnoses of type 2 diabetes, vascular dementia, psychotic and mood disturbance, anxiety, and history of stroke. R2 was admitted to licensee for services on October 16, 2024, and had diagnoses of type 1 diabetes, history of stroke, schizophrenia (hallucinations and delusions), seizure disorder, and traumatic brain injury. R1 and R2's Residency Agreement/Assisted Living Contract signed March 1, 2025, and October 17, 2024, respectively, lacked a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: - whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; and - whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b). -whether there is a limit on the number of people	0 940		

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0 940	Continued From page 18 residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; -whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; -a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; -a statement that residents may be eligible for assistance with rent through the housing support program; and -a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program. On April 11, 2025, at 11:40 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A was unaware of the content requirement and after reviewing the content requirement on the Minnesota Revisor website, he stated the contract did not include the required content. The licensee's undated Contract Signing policy indicated when a prospective resident decides to move into the facility, the licensee must ensure that all sections of the contract are properly filled out and provide the resident and/or their responsible person with a copy of the contract. The licensee must go over the contents of the assisted living contract with the resident and/or their responsible person, addressing any questions or concerns they may have. No further information was provided.	0 940		

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0 940	Continued From page 19 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 940		
01370 SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries	01370		

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01370	Continued From page 20 between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency evaluations were completed for all required skill areas, prior to providing services, for one of two unlicensed personnel ((ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 entrance conference on April 7, 2025, at 10:51 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated newly employed staff were trained on their online training program (Educare), one-on-one training with LALD/CNS-A on skills, medication administration, and treatments, then have staff do return demonstrations. Staff would sign the training/competency forms once completed. ULP-C was hired by the licensee on November 15, 2024, to provide assisted living services.	01370		

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01370	Continued From page 21 ULP-C's training record lacked evidence of training and demonstrated competency on the following required topics: -documentation requirements for all services provided; -maintenance of a clean and safe environment; -training on the prevention of falls; -understanding appropriate boundaries between staff and residents and the resident's family; and -awareness of commonly used health technology equipment and assistive devices. During observation on April 7, 2025, at 12:45 p.m., the surveyor observed ULP-C at the medication cart located in the dining area. ULP-C was the only person working the shift and provided supervision. On April 11, 2025, at 11:40 a.m., LALD/CNS-A stated their process was to assign courses on Educare for the missing topics, which ULP-C did not complete those training. The licensee's undated Competency Training Evaluations Policy indicated before delegating tasks to ULPs, a registered nurse or licensed health professional must ensure that the ULPs are trained and competent in performing these tasks for each client. The policy also indicated the above missing content were required to be trained and found competent on. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01380 SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn	01380		

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01380	Continued From page 22 (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency evaluations were completed for all required skill areas, prior to providing services, for one of two unlicensed personnel ((ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 entrance conference on April 7, 2025, at	01380		

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01380	Continued From page 23 10:51 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated newly employed staff were trained on their online training program (Educare), one-on-one training with LALD/CNS-A on skills, medication administration, and treatments, then have staff do return demonstrations. Staff would sign the training/competency forms once completed. ULP-C was hired by the licensee on November 15, 2024, to provide assisted living services. ULP-C's training record lacked evidence of training and demonstrated competency on the following required topics: -observation, reporting, and documenting of resident status; -basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; and -recognizing physical, emotional, cognitive, and developmental needs of the resident. During observation on April 7, 2025, at 12:45 p.m., the surveyor observed ULP-C at the medication cart located in the dining area. ULP-C was the only person working the shift and provided supervision. On April 11, 2025, at 11:40 a.m., LALD/CNS-A stated their process was to assign courses on Educare for the missing topics, which ULP-C did not complete those training. He failed to check if ULP-C completed the assigned courses. The licensee's undated Competency Training Evaluations Policy indicated before delegating tasks to ULPs, a registered nurse or licensed health professional must ensure that the ULPs	01380		

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01380	Continued From page 24 are trained and competent in performing these tasks for each client. The policy also indicated the above missing content were required to be trained and found competent on. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
01750 SS=F	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) instructed the unlicensed personnel (ULP) in the proper methods to administer the medications, and the ULPs have demonstrated the ability to competently follow the procedure and the licensee also failed to ensure the RN specified in writing, specific instructions for medication administration for one of two residents (R2).	01750		

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01750	Continued From page 25 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: R2 was admitted to licensee for services on October 16, 2024, and had diagnoses of type 1 diabetes, history of stroke, schizophrenia (hallucinations and delusions), seizure disorder, and traumatic brain injury. R2's Service Agreement/Service Plan signed October 17, 2024, indicated R2 received assistance with medication administration. R2's provider orders signed October 8, 2024, included the following medications for diabetes: -Fiasp FlexTouch injection 100 unit/milliliter (u/ml) (insulin aspart-short acting)-inject three times a day per sliding scale: 2u for blood glucose (BG) 150-200, 4u for BG 201-250, 6u for BG 251-300, 8u for BG 301-350, 10u for BG greater than 351, and inject 2 units for every 15 grams of carbohydrates. R2's Med Admin Summary (electronic medication administration record (eMAR)) dated April 2025, indicated R2 received: -Fiasp FlexTouch injection 100 u/ml-inject three times a day per sliding scale: 2u for BG 150-200, 4u for BG 201-250, 6u for BG 251-300, 8u for BG 301-350, 10u for BG greater than 351, and inject 2 units for every 15 grams of carbohydrates.	01750		

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01750	Continued From page 26 R2's record lacked instructions for staff to complete carbohydrate counting for every meal. During observation and interview on April 8, 2025, at 11:20 a.m., ULP-B entered R2's bedroom where resident had completed his lunch which was two corndogs and a fruit cup. ULP-B explained to the surveyor that R2 received his insulin after lunch because he had a history of not eating a meal after insulin was administered. ULP-B looked at R2's Dexcom monitor (real time glucose receiver for diabetes) and observed R2's blood glucose to be 181. ULP-B went to the medication cart within the dining room and set up R2's Fiasp insulin and observed on R2's sliding scale insulin required two (2) units if BG was between 150-200. Below the sliding scale, the surveyor observed the following instruction on the eMAR, "give 2 units for every 15 grams of carbs." The surveyor asked ULP-B how many units she was going to give based on the blood glucose result and carbohydrate consumption, ULP-B was unsure and went directly to licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A for instruction. LALD/CNS-A instructed ULP-B to administer 4 units of insulin. ULP-B and LALD/CNS-A stated there were no instructions for carbohydrate counting. At 3:23 p.m., LALD/CNS-A stated he added a list of popular food items R2 ate onto the eMAR and that was his "correction" for lack of instruction. During interview on April 9, 2025, at 11:58 a.m., ULP-C stated her process for administering insulin to R2 was check the Dexcom for BG result, then check the sliding scale to determine the range and give the insulin based on the range. ULP-C stated insulin was given after R2	01750		

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01750	Continued From page 27 ate. ULP-C was not familiar with carbohydrate counting. During phone interview at 1:13 p.m., ULP-E explained she provided medication administration and was trained by LALD/CNS-A. ULP-E was unable to explain how carbohydrate counting worked and only followed the sliding scale. The licensee's undated Competency Training Evaluations Policy indicated ULPs would be properly trained and evaluated for competency in the tasks they were delegated, and instructions for delegated tasks must be documented in the resident's record, and evidence of all education, training, and competency testing should be kept in each employee's personnel file. The licensee's undated Medication Management Individualized Plan policy indicated the licensee would develop and maintain a current, individualized medication management record for each resident. The record would include documentation of specific resident instructions relating to medication administration No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01750		
01760 SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation	01760		

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01760	Continued From page 28 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 observation, interview, and record review, the licensee failed to ensure insulin administration was documented accurately for two of two residents (R1, R2). The licensee also failed to document insulin administration based on carbohydrate count 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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted to licensee for services on February 22, 2025, and had diagnoses of type 2 diabetes, heart disease, history of stroke, and hyperglycemia (high blood glucose). R1's Service Agreement/Service Plan signed March 1, 2025, indicated R1 received assistance	01760		

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01760	Continued From page 29 with medication administration. R1's provider orders signed March 4, 2025, included the following medication for diabetes: -Novolog injection 100 units (u)/milliliters (ml) (insulin aspart-short acting)-inject three times a day per sliding scale: 2u for blood glucose (BG) 120-149, 3u for BG 150-199, 6u for BG 200-249, 9u for BG 250-299, 12u for BG 300-349, and 15u for BG 350 or greater. During observation on April 8, 2025, at 11:09 a.m., unlicensed personnel (ULP)-B checked R1's BG which was 325, then looked at the sliding scale on the electronic medication administration record (eMAR) and administered 12u of Novolog insulin. R1's Med Admin Summary (eMAR) dated April 2025, lacked documentation of how many units were given for 12 out of 29 Novolog insulin administrations. R2 R2 was admitted to licensee for services on October 16, 2024, and had diagnoses of type 1 diabetes, history of stroke, schizophrenia (hallucinations and delusions), seizure disorder, and traumatic brain injury. R2's Service Agreement/Service Plan signed October 17, 2024, indicated R2 received assistance with medication administration. R2's provider orders signed October 8, 2024, included the following medication for diabetes: -Fiasp FlexTouch injection 100 u/ml (insulin aspart-short acting)-inject three times a day per sliding scale: 2u for BG 150-200, 4u for BG 201-250, 6u for BG 251-300, 8u for BG 301-350,	01760		

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01760	Continued From page 30 10u for BG greater than 351, and inject 2 units for every 15 grams of carbohydrates. R2's Med Admin Summary (eMAR) dated April 2025, lacked documentation of how many units were given for 12 out of 23 Fiasp insulin administrations. During observation and interview on April 8, 2025, at 11:20 a.m., ULP-B entered R2's bedroom where resident had completed his lunch which was two corndogs and a fruit cup. ULP-B explained to the surveyor that R2 received his insulin after lunch because he had a history of not eating a meal after insulin was administered. ULP-B looked at R2's Dexcom monitor (real time glucose receiver for diabetes) and observed R2's BG to be 181. ULP-B went to the medication cart within the dining room to set up R2's Fiasp insulin and observed on R2's sliding scale insulin required two (2) units (u) if BG was between 150-200. Below the sliding scale, the surveyor observed the following instruction on the eMAR, "give 2 units for every 15 grams of carbs." The surveyor asked ULP-B how many units she was going to give based on the blood glucose result and carbohydrate consumption, ULP-B was unsure and went directly to licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A for instruction. LALD/CNS-A instructed ULP-B to administer 4 units of insulin. ULP-B and LALD/CNS-A stated there were no instructions for carbohydrate counting. R2's record lacked documentation of amount of Fiasp insulin given based on carbohydrate counting. The licensee's undated Medication & Treatment-Documentation & Refusal policy	01760		

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01760	Continued From page 31 indicated documentation requirements included documenting the date, time, quantity of dosage, and method of administration for all prescribed legend and over-the-counter medications, treatments, or therapies. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
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 interview and record review, the licensee failed to ensure refrigerated medication were maintained at manufacturer recommended temperatures by failing to monitor and document medication refrigerator temperatures for one of one medication refrigerators. Additionally, the licensee failed to allow authorized personnel access to medication storage. 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).	01880		

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01880	Continued From page 32 The findings include: During the entrance conference on April 7, 2025, at 10:51 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee provided medication management services to all residents at the facility. On April 9, 2025, at 11:11 a.m., the surveyor received an electronic email from LALD/CNS-A stating there was a thermometer in the downstairs refrigerator which random temperature checks were done but not documented. During observation of that refrigerator, there were two locked metal boxes with a passcode dial and noted plastic bags showing through the seams of the boxes. The temperature was 38 degrees Fahrenheit. On April 9, 2025, at 1:59 p.m., the surveyor requested unlicensed personnel (ULP)-B to open the two metal black boxes in the downstairs refrigerator. ULP-B attempted to open both boxes using a code but was unsuccessful. ULP-B contacted LALD/CNS-A over the telephone and opened R2's box which contained two plastic bags. One bag contained one Lantus Solostar FlexPen (100 units/milliliter (ml)) and the other bag contained one Fiasp Flex injector pen (100 units/ml). ULP-B was unable to open the other metal box which was R1's. The manufacturer's instructions for Lantus Solostar insulin pen revised June 2023, indicated to keep new Lantus insulin pens in the refrigerator between 36 to 46 degrees Fahrenheit (F). Do not freeze.	01880		

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01880	Continued From page 33 The manufacturer's instructions for Fiasp insulin pen revised June 2023, indicated to keep new Fiasp insulin pens in the refrigerator between 36 to 46 degrees F. Do not freeze. The licensee's undated Prescription Drugs & Prohibition policy indicated when the licensee receives a prescription drug for a resident, it must be kept in the original container in which it was dispensed by the pharmacy. This container should bear the original prescription label with legible information, including the expiration or beyond-use date of a time-dated drug. The policy did not indicate that medications should be stored per manufacturer's instructions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=F	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 included required patient identifying labels and medication administration instructions for two of two residents (R1, R2).	01890		

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01890	Continued From page 34 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: During the entrance conference on April 7, 2025, at 10:51 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee provided medication management services to all residents. R1 R1 was admitted to licensee for services on March 1, 2025, and had diagnoses of type 2 diabetes, vascular dementia, psychotic and mood disturbance, anxiety, and history of stroke. R1's Service Agreement/Service Plan signed March 1, 2025, indicated R1 received assistance with medication administration. R1's prescriber orders signed March 4, 2025, included the following medications for diabetes: -insulin glargine 100 units (u)/ml (milliliters) (long-acting insulin)-inject 25 units subcutaneously every morning; and -NovoLog 100 u/ml (insulin aspart-short acting insulin)-inject three times per day per sliding scale: 3u for blood glucose (BG) 150-199, 6u for BG 200-249, 9u for BG 250-299, 12u for BG 300-349, and 15u for BG 350 or greater. R2	01890		

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01890	Continued From page 35 R2 was admitted to licensee for services on October 16, 2024, and had diagnoses of type 1 diabetes, history of stroke, schizophrenia (hallucinations and delusions), seizure disorder, and traumatic brain injury. R2's Service Agreement/Service Plan signed October 17, 2024, indicated R2 received assistance with medication administration. R2's provider orders signed October 8, 2024, included the following medications for diabetes: -Fiasp FlexTouch injection 100 u/ml (insulin aspart-short acting)-inject three times a day per sliding scale: 2u for blood glucose (BG) 150-200, 4u for BG 201-250, 6u for BG 251-300, 8u for BG 301-350, and 10u for BG greater than 351. -Basaglar KwikPen 100 u/ml (insulin glargine-short acting)-inject 23u subcutaneously once daily. During observation and interview on April 7, 2025, at 12:45 p.m., the surveyor observed unlicensed personnel (ULP)-C at the medication cart within the dining room area. During cart review, the first/top drawer of the medication cart held R1 and R2's insulin pens which in separate compartments. The pens were labeled with the open date but did not bear a label or written identifying information. LALD/CNS-A observed the pens and stated staff would not be able to match the resident name from the pen to the medication administration record, so they immediately wrote the name on each pen. LALD/CNS-A stated the pharmacy did not label each pen individually, just the box that they come in. The licensee's undated Prescription Drugs & Prohibition policy indicated when the licensee	01890		

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01890	Continued From page 36 receives a prescription drug for a resident, it must be kept in the original container in which it was dispensed by the pharmacy. This container should bear the original prescription label with legible information, including the expiration or beyond-use date of a time-dated drug. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written 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		

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01940	Continued From page 37 therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop a treatment management plan (TMP) to include all required content for one of one resident (R2) who received assistance with treatments. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 had diagnoses of type 1 diabetes, history of stroke, schizophrenia (hallucinations and delusions), seizure disorder, and traumatic brain injury. R2's Master Care Plan last updated on February 19, 2025, indicated R2 required assistance with applying a compression sock to the right lower extremity daily. On April 9, 2025, at 2:05 p.m., unlicensed personnel (ULP)-B stated R2 did not have his compression sock on but when she attempted to	01940		

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01940	Continued From page 38 apply it that morning, R2 became aggressive. ULP-B stated the compression sock was used for swelling. The surveyor observed R2 within his room standing and had normal sock on his right foot (no shoe) which was swollen at the ankle and a shoe on his left foot. On April 10, 2025, at 3:17 p.m., by electronic email, the surveyor requested R2's compression sock order. An order for wound care was received but not for the compression sock. R2's record lacked an individual treatment or therapy management plan to include all required content as follows: -identification of treatment or therapy tasks that will be delegated to unlicensed personnel; -procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and -any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. During exit conference on April 11, 2025, at 12:15 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the swelling was resolved November 2024, but due to R2 dangling his right leg to the side of the bed while sleeping, the right leg became swollen, so they started implementing the compression sock. LALD/CNS-A stated because the task was not added back when they resumed the compression sock, it was missing the above required content. The licensee's undated Treatment & Therapy	01940		

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01940	Continued From page 39 Management Plan policy indicated the licensee will develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: - a statement of the type of services that will be provided; - documentation of specific resident instructions relating to the treatments or therapy administration; - identification of treatment or therapy tasks that will be delegated to unlicensed personnel; - procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; - any resident-specific requirements relating to documentation of treatment and therapy received; - verification that all treatment and therapy was administered as prescribed; and - monitoring of treatment or therapy to prevent possible complications or adverse reactions. The policy also indicated the treatment and therapy management record are kept current and updated as needed to reflect any changes. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01940		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must	01960		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01960	Continued From page 40 include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure documentation of administration or the reason why a treatment was not administered for one of two residents (R2) who had a treatment. 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 client'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 clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 was admitted to licensee for services on October 16, 2024, and had diagnoses of type 1 diabetes, history of stroke, schizophrenia (hallucinations and delusions), seizure disorder, and traumatic brain injury. R2's Master Care Plan last updated on February 19, 2025, indicated R2 required assistance with applying compression sock to right lower extremity daily. On April 9, 2025, at 2:05 p.m., unlicensed personnel (ULP)-B stated R2 did not have his	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40383	A. BUILDING: _____ B. WING _____	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOBLE CARES LLC	6925 HALIFAX AVENUE NORTH BROOKLYN CENTER, MN 55429

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01960	Continued From page 41 compression sock on but when she attempted to apply it that morning, R2 became aggressive. ULP-B stated the compression sock was used for swelling. The surveyor observed R2 within his room standing and had normal sock on his right foot (no shoe) which was swollen at the ankle and a shoe on his left foot. R2's medical record lacked a prescriber order for use of compression sock to reduce swelling to R2's right lower extremity. R2's record lacked documentation of compression sock application or the reason why the compression sock was not applied. During exit conference on April 11, 2025, at 12:15 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the swelling was resolved November 2024, but due to R2 dangling his right leg to the side of the bed while sleeping, the right leg became swollen, so they started implementing the compression sock. LALD/CNS-A stated because the task was not added back when they resumed the compression sock, there would be no documentation available. He stated the compression sock task was added back now. The licensee's undated Medications & Treatment Record-Documentation & Refusal policy indicated documentation of administration and the reason for not administering the treatment would be included in the resident's record. The policy also indicated the licensee would discuss with the resident the potential consequences of refusal and document the discussion in the resident's record. No further information provided.	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40383	A. BUILDING: _____ B. WING _____	04/11/2025

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01960	Continued From page 42 TIME PERIOD FOR CORRECTION: Seven (7) days	01960		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain written or electronically signed treatment or therapy orders from an authorized prescriber for one of one resident (R2) receiving treatments. 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 client'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 clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 was admitted to licensee for services on October 16, 2024, and had diagnoses of type 1 diabetes, history of stroke, schizophrenia	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40383	A. BUILDING: _____ B. WING _____	04/11/2025

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NOBLE CARES LLC	6925 HALIFAX AVENUE NORTH BROOKLYN CENTER, MN 55429

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01970	Continued From page 43 (hallucinations and delusions), seizure disorder, and traumatic brain injury. R2's Admission Assessment dated October 17, 2024, indicated R2 required a compression sock to right lower extremity daily. R2's Master Care Plan last updated on February 19, 2025, indicated R2 required assistance with applying compression sock to right lower extremity daily. On April 9, 2025, at 2:05 p.m., unlicensed personnel (ULP)-B stated R2 did not have his compression sock on but when she attempted to apply it that morning, R2 became aggressive. ULP-B stated the compression sock was used for swelling. The surveyor observed R2 within his room standing and had normal sock on his right foot (no shoe) which was swollen at the ankle and a shoe on his left foot. On April 10, 2025, at 3:17 p.m., by electronic email, the surveyor requested R2's compression sock order. On April 11, 2025, at 12:32 p.m., after survey completion, the surveyor received an email with attached document stating it was R2's compression sock order. The prescriber order dated October 16, 2024, was for Unna Boot Coflex (two-step compression bandage with zinc to absorb drainage) and silver veil (wound dressing) and attached were measurements of R2's right and left ankle, calf, and thigh. The document lacked an order for the compression sock. The licensee's undated Medication & Treatment Orders-Implementing policy indicated current	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01970	Continued From page 44 authenticated provider orders would be maintained for all treatments licensee provided to a resident. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		

Minnesota Department of Health

625 Robert Street North
St Paul
651-201-4500

Type: Full
Date: *04/07/25*
Time: 11:17:27
Report: 7994251096

Food and Beverage Establishment Inspection Report

Location:

Noble Cares Llc
6925 HALIFAX AVENUE NORTH
Brooklyn Center, MN55429
Hennepin County, 27

Establishment Info:

ID #: 0044103
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/25

Operator:

Phone #:
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

The following orders were issued during this inspection.

3-500B Microbial Control: hot and cold holding

3-501.16A2 ***** Priority 1 *****

MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

ITEMS IN DOOR OF FRIDGE FOUND ABOVE 41 F. INSTRUCTED STAFF TO MONITOR FOODS AND KEEP AS MANY AS POSSIBLE IN THE MAIN PART OF THE FRIDGE.

Comply By: 04/07/25

4-500 Equipment Maintenance and Operation

4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

DISHWASHER FOUND WITH THERMOMETER INDICATING 140 F AS THE HIGHEST TEMP. ENSURE DISHWASHER IS RUN ON THE SANITIZING CYCLE AT ALL TIMES. STAFF WILL PROVIDE A PICTURE OF THE THERMOMETER ONCE A CYCLE IS COMPLETE.

Comply By: 04/07/25

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	1	0	1

INSPECTION CONDUCTED IN THE PRESENCE OF HRD STAFF AND FINDINGS SHARED AT THE END OF INSPECTION.

WILL EMAIL SUPPORTING DOCUMENTS AND LINKS TO HRD STAFF AT THE END OF THE DAY.

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

Food and Beverage Establishment Inspection Report

FLOOR IS CERAMIC TILE, CABINETS ARE WOOD WITH HALLOWED ENCLOSED BASES, LAMINATE COUNTER TOPS AND SMOOTH PAINTED CEILING. ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT ANY TIME THERE IS FOUND TO BE A RISK OF CONTAMINATION OR CONCERN THE PHYSICAL FACILITIES WILL BE REQUIRED TO BE BROUGHT UP TO CODE.

TEMPERATURES:
MILK 38
HAM 45

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 7994251096 of 04/07/25.

Certified Food Protection Manager: Bukola Fatile

Certification Number: 121072 Expires: 11/23/26

Inspection report reviewed with person in charge and emailed.

Signed: _____
Ebenezer Akinbamijo

Signed: Crystal Elva

Crystal Elva
Public Health Sanitarian 3
St Paul
651-201-3981
Crystal.Elva@state.mn.us