



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

October 20, 2025

Licensee
Noble Cares LLC
7957 Monroe Street Northeast
Coon Rapids, MN 55448

RE: Project Number(s) SL38831016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on September 19, 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 . . ."

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

DOCUMENTATION OF ACTION TO COMPLY

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>

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,



Kelly Thorson, Supervisor

State Evaluation Team

Email: Kelly.Thorson@state.mn.us

Telephone: 320-223-7336 Fax: 1-866-890-9290

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38831	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/19/2025
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NAME OF PROVIDER OR SUPPLIER NOBLE CARES LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 7957 MONROE STREET NE COON RAPIDS, MN 55448
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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
0 000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)</p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.</p> <p>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.</p> <p>INITIAL COMMENTS:</p> <p>SL38831016-0</p> <p>On September 15, 2025, through September 19, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were four residents; four receiving services under the Assisted Living Facility license.</p>	0 000	<p>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.</p> <p>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.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p> <p>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.</p>	
0 485 SS=C	144G.41 Subdivision 1.a (a) Minimum requirements; required food services	0 485		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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0 485	<p>Continued From page 1</p> <p>(a) All assisted living facilities must offer to provide or make available at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes. The facility must not require a resident to include and pay for meals in the resident's contract.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not require any resident to include and pay for meals as a part of their assisted living contract. This had the potential to affect all residents.</p> <p>This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).</p> <p>The findings include:</p>	0 485		
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0 485	<p>Continued From page 2</p> <p>During the entrance conference on September 15, 2025, at 10:30 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee was familiar with current minimum assisted living requirements. LALD/CNS-A further stated the licensee provided residents three meals per day and the licensee included meal costs in the contracted housing rate.</p> <p>Page two of the licensee's undated Residency Agreement- Assisted Living Contract indicated the cost of a meal plan, if selected, is included in the resident's monthly base fee.</p> <p>On September 16, 2025, at 9:27 a.m., LALD/CNS-A stated all residents had signed the same, undated version of the contract.</p> <p>On September 16, 2025, at 12:07 p.m., LALD/CNS-A stated LALD/CNS-A completed a form with a resident's case manager which determined meal reimbursement rates for residents who received waived services. LALD/CNS-A further stated residents who paid privately would use the same waiver form to determine what would be charged for meals.</p> <p>The licensee's Residency Agreement- Assisted Living Contract lacked an option for residents to opt out of payment for one, two, or three meals a resident would not want.</p> <p>The Minnesota Department of Health Assisted Living Resources and Frequently Asked Questions (FAQs) website, last updated July 1, 2025, indicated the provider cannot have a blanket "one size fits all" meal charge.</p>	0 485		
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0 485	Continued From page 3 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 580 SS=F	<p>144G.42 Subd. 2 Quality management</p> <p>The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to implement and maintain a quality management program appropriate to the size of the facility and relevant to the type of services provided. This had the potential to affect all current residents, staff, and visitors.</p> <p>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</p>	0 580		

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0 580	<p>Continued From page 4</p> <p>a large portion or all of the residents).</p> <p>The findings include:</p> <p>During the entrance conference on September 15, 2025, at 11:17 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee held quality management meetings twice per year.</p> <p>On September 17, 2025, 11:48 a.m., LALD/CNS-A stated QA (quality assurance) meetings were held in February and August each year, however, did not document the meetings. LALD/CNS-A further stated the licensee did not have a specific topic to discuss for quality management at this time.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	0 580		
0 660 SS=F	<p>144G.42 Subd. 9 Tuberculosis prevention and control</p> <p>(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</p>	0 660		

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0 660	<p>Continued From page 5</p> <p>the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC). The licensee failed to ensure screening for active TB (either a two-step tuberculin skin test (TST) or blood test) was completed and documented for one of two employees (unlicensed personnel (ULP)-C).</p> <p>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).</p> <p>The findings include:</p> <p>ULP-C was hired on April 2, 2025, to provide direct care services to residents.</p> <p>On September 17, 2025, at 9:03 a.m., the surveyor observed ULP-C administer scheduled medications to R2.</p> <p>ULP-C's employee record contained a radiology report dated February 5, 2025, and lacked evidence of screening for active TB with either a</p>	0 660		
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0 660	<p>Continued From page 6</p> <p>two-step TST or blood test within 90 days of hire.</p> <p>On September 17, 2025, at 11:50 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated all personnel file documents were provided.</p> <p>The licensee's Tuberculosis Screening policy dated January 1, 2025, indicated the licensee conducted TB screening according to Minnesota statute 144A.4798, subdivision 1, and did not address 144G statute.</p> <p>The CDC Tuberculosis Screening, Testing, and Treatment of U.S. Health Care Personnel dated May 17, 2019, indicated all health personnel should have a baseline screening and an individual risk assessment, which is necessary for interpreting any test result.</p> <p>The Minnesota Department of Health Assisted Living Resources and Frequently Asked Questions (FAQs) website, last updated October 13, 2025, indicated a chest x-ray completed within 90 days of hire must be accompanied by documentation of a positive two-step Tuberculin Skin Test (TST) or Interferon-Gamma Release Assay (IGRA) blood test for a new employee.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	0 660		
0 680 SS=F	<p>144G.42 Subd. 10 Disaster planning and emergency preparedness</p> <p>(a) The facility must meet the following requirements:</p>	0 680		

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0 680	<p>Continued From page 7</p> <p>(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;</p> <p>(2) post an emergency disaster plan prominently;</p> <p>(3) provide building emergency exit diagrams to all residents;</p> <p>(4) post emergency exit diagrams on each floor; and</p> <p>(5) have a written policy and procedure regarding missing residents.</p> <p>(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.</p> <p>(c) The facility must meet any additional requirements adopted in rule.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and post a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. In addition, the licensee failed to ensure the missing resident plan was reviewed quarterly. This had the potential to affect all residents, staff, and visitors of the facility.</p> <p>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</p>	0 680		

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0 680	<p>Continued From page 8</p> <p>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).</p> <p>The findings include:</p> <p>During the entrance conference on September 15, 2025, at 10:30 a.m., licensed assisted living director/ clinical nurse supervisor (LALD/CNS)-A stated the licensee was familiar with current minimum assisted living requirements.</p> <p>The licensee's EPP dated February 25, 2025, lacked the following content and/or policies and procedures to address:</p> <ul style="list-style-type: none"> - a missing resident plan that was reviewed quarterly; - identified at risk population needs; - a list of subsistence needs for staff and residents to include food, water, and pharmaceutical supplies; and - must conduct exercises to test the EPP at least twice per year, including unannounced staff drills using the EPP. <p>On September 15, 2025, at 11:47 a.m., LALD/CNS-A stated LALD/CNS-A was aware that the missing resident policy was required to be reviewed quarterly however, that change had not been implemented at [licensee] yet. LALD/CNS-A further stated resident evacuation needs had not yet been included in the EPP.</p> <p>The licensee's undated Emergency Preparedness Plan- Appendix Z Compliance policy indicated the plan would be aligned with the Centers of Medicare and Medicaid Services</p>	0 680		

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0 680	<p>Continued From page 9</p> <p>(CMS) State Operations Manual (SOM) Appendix Z, which provided interpretive guidance for emergency preparedness for all providers.</p> <p>The licensee's undated Missing Resident policy indicated the policy would be reviewed quarterly.</p> <p>Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0110, Subp. 4, effective October 2022, LALD and CNS must review the missing person plan at least quarterly and document any changes to the plan.</p> <p>Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0100, sections A and B, effective October 2022, assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.73, or successor requirements. This part references documents, specifications, methods, and standards in "State Operations Manual Appendix Z - Emergency Preparedness for All Providers and Certified Supplier Types: Interpretive Guidance," which is incorporated by reference.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	0 680		
0 775 SS=D	<p>144G.45 Subd. 2. (a) Fire protection and physical environment</p> <p>Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:</p>	0 775		

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0 775	<p>Continued From page 10</p> <p>This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the requirements of Minnesota State Fire Code Rules, Chapter 7511.</p> <p>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).</p> <p>The findings include:</p> <p>On September 17, 2025, at 1:15 p.m., the surveyor toured the facility with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A. During the facility tour, the surveyor observed the following:</p> <ul style="list-style-type: none"> - An extension cord was plugged into a powerstrip in occupied resident room 5. - There was an accumulation of lint behind the washer and dryer in the basement. <p>During the facility tour interview, LALD/CNS-A verified the above listed observations.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p>	0 775		
0 800 SS=A	144G.45 Subd. 2 (a) (4) Fire protection and physical environment	0 800		

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0 800	<p>Continued From page 11</p> <p>(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.</p> <p>This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents.</p> <p>This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at 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).</p> <p>On September 17, 2025, at 1:15 p.m., the surveyor toured the facility with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A. During the facility tour, the surveyor observed discharge piping was not installed on the pressure relief valve for the water heater in the mechanical room. Discharge piping serving a pressure relief valve must terminate to a safe place of disposal within 18 inches of the floor and in a manner that would not cause personal injury.</p>	0 800		

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NAME OF PROVIDER OR SUPPLIER NOBLE CARES LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 7957 MONROE STREET NE COON RAPIDS, MN 55448
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0 800	Continued From page 12 During the facility tour interview, LALD/CNS-A verified the above listed observation and stated this would be corrected. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=E	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to 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	0 810		

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0 810	<p>Continued From page 13</p> <p>residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.</p> <p>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 required content and provide required training.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).</p> <p>The findings include:</p> <p>On September 17, 2025, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility.</p> <p>FIRE SAFETY AND EVACUATION PLAN</p> <p>The licensee failed to develop the FSEP floor plan evident by the following:</p>	0 810		
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0 810	<p>Continued From page 14</p> <p>On September 17, 2025, at 1:15 p.m., the surveyor toured the facility with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A. During the facility tour, the surveyor observed the following:</p> <ul style="list-style-type: none"> - LALD/CNS-A verbally identified a room in the basement as an office. The surveyor observed the posted floor plan, dated October 14, 2022, labeled this room as bedroom 6. FSEP floor plans must be maintained as accurate to provide efficient communication for exiting in the event of a fire or similar emergency. <p>Record review of the available documentation indicated the licensee failed to develop and maintain the FSEP with site specific procedures for the facility and building occupants. The FSEP had been created using templates from a third party provider.</p> <ul style="list-style-type: none"> - The FSEP included standard employee procedures, but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. - The FSEP failed to include fire safety and evacuation instructions for residents evident by a lack of these procedures in the plan. <p>During an interview on September 17, 2025, at 2:20 p.m., LALD/CNS-A verified the FSEP required revision and stated they were working on creating site specific procedures based on the feedback received two weeks ago at another location.</p> <p>TRAINING</p>	0 810		
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0 810	<p>Continued From page 15</p> <p>Record review indicated the licensee failed to provide fire safety and evacuation training to residents at least once per year evident by training documentation lacking the required frequency. A fire safety and evacuation training resident record dated 2023 was provided. During an interview on September 17, 2025, at 2:20 p.m., LALD/CNS-A stated residents were trained at the time of admission and the licensee already had plans to correct the training frequency based on survey feedback received two weeks ago at another location</p> <p>Record review indicated the licensee failed to provide training to employees on the FSEP at least twice per year evident by training documentation lacking the required frequency. A fire emergency training log was provided, with a date range of March 2024 to August 2025. During an interview on September 17, 2025, at 2:20 p.m., LALD/CNS-A stated this employee training log was used to document training at the time of hire and then annually. LALD/CNS-A stated the licensee already had plans to correct the training frequency based on survey feedback received two weeks ago at another location.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	0 810		
0 910 SS=C	<p>144G.50 Subd. 2 (a-b) Contract information</p> <p>(a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility.</p> <p>(b) The contract must include the name, telephone number, and physical mailing address,</p>	0 910		

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0 910	<p>Continued From page 16</p> <p>which may not be a public or private post office box, of:</p> <p>(1) the facility and contracted service provider when applicable;</p> <p>(2) the licensee of the facility;</p> <p>(3) the managing agent of the facility, if applicable; and</p> <p>(4) the authorized agent for the facility.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for one of one resident (R2).</p> <p>This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>During the entrance conference on September 15, 2025, at 10:30 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee was familiar with current minimum assisted living requirements.</p> <p>R2's Residency Agreement- Assisted Living Contract was signed on February 6, 2024.</p> <p>R2's assisted living contract lacked:</p> <ul style="list-style-type: none"> - the licensee's legal name healthcare facility identification number (HFID); - phone number; and - authorized agent for the facility. 	0 910		

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0 910	Continued From page 17 On September 16, 2025, at 9:27 a.m., LALD/CNS-A stated the same assisted living contract was used for all residents. LALD/CNS-A further stated a newer contract version was created but has not been signed by any of the current residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 910		
0 920 SS=C	144G.50 Subd. 2 (c) Contract information (c) The contract must include: (1) a disclosure of the category of assisted living facility license held by the facility and, if the facility is not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license; (2) a description of all the terms and conditions of the contract, including a description of and any limitations to the housing or assisted living services to be provided for the contracted amount; (3) a delineation of the cost and nature of any other services to be provided for an additional fee; (4) a delineation and description of any additional fees the resident may be required to pay if the resident's condition changes during the term of the contract; (5) a delineation of the grounds under which the resident may be transferred or have housing or services terminated or be subject to an emergency relocation; (6) billing and payment procedures and	0 920		

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0 920	<p>Continued From page 18</p> <p>requirements; and (7) disclosure of the facility's ability to provide specialized diets.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for one of one resident (R2).</p> <p>This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>During the entrance conference on September 15, 2025, at 10:30 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee was familiar with current minimum assisted living requirements.</p> <p>R2's Residency Agreement- Assisted Living Contract was signed on February 6, 2024.</p> <p>R2's assisted living contract lacked a disclosure of the category of assisted living facility (ALF) license and disclosure if not licensed as an ALF with dementia care.</p> <p>On September 16, 2025, at 9:27 a.m., LALD/CNS-A stated the same assisted living contract was used for all residents. LALD/CNS-A further stated a newer contract version was created but has not been signed by any of the</p>	0 920		
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0 920	Continued From page 19 current residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 920		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and	01060		

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01060	<p>Continued From page 20</p> <p>designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide written notice with required content to the resident, legal representative, and designated representative for one of one resident (R3).</p> <p>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).</p> <p>The findings include:</p> <p>During the entrance conference on September 15, 2025, at 10:30 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee was familiar with current minimum assisted living requirements.</p>	01060		

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01060	<p>Continued From page 21</p> <p>R3's diagnoses included schizophrenia (mental disorder characterized by hallucinations, delusions, disorganized behavior and flat affect), chronic kidney disease, atrial fibrillation (rapid and irregular heart rhythm), benign prostatic hyperplasia (BPH- enlarged prostate gland), depression, hypertension (high blood pressure), cognitive impairment, and obstructive sleep apnea (recurrent obstruction of the upper airway when sleeping).</p> <p>R3's Service Plan dated December 1, 2022, indicated R3's services included medication administration, bathing, grooming, dressing, toileting, standby assistance, meals, laundry and housekeeping.</p> <p>R3's Fall- Incident report dated April 4, 2025, indicated R3 was sent to the emergency room on April 4, 2025. R3's record lacked a return date as of the time survey was completed.</p> <p>R3's record lacked a written notice that contained, at a minimum:</p> <ul style="list-style-type: none"> - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the OOLTC; - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. 	01060		
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01060	Continued From page 22 On September 17, 2025, at 11:40 a.m., LALD/CNS-A stated the licensee lacked an emergency relocation notice that would be offered to residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
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 monitor for expired medications for one of four residents (R2) and house supply of Narcan (reverses effect of opioids). 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).	01890		

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01890	<p>Continued From page 23</p> <p>The findings include:</p> <p>During the entrance conference on September 15, 2025, at 10:49 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee provided medication management services to residents at the facility.</p> <p>On September 15, 2025, at 2:15 p.m., the surveyor observed the licensee's medication cart with unlicensed personnel (ULP)-B and noted the following:</p> <ul style="list-style-type: none"> - R2's olanzapine (antipsychotic treatment) five milligrams (mg), quantity 15 tablets, expired on May 13, 2025; and - house supply of Narcan four mg nasal spray, quantity one spray, expired June 2025. <p>On September 15, 2025, at 2:19 p.m., ULP-B stated medication cart audits were completed by the nurse each month. ULP-B further stated licensee staff also checked the medications for expiration date before they were administered.</p> <p>On September 15, 2025, at 2:29 p.m., LALD/CNS-A stated LALD/CNS-A and licensed practical nurse (LPN)-D completed monthly medication cart audits and missed the olanzapine and Narcan.</p> <p>The licensee's undated Medication Disposal policy indicated expired medications were disposed of according to the practices of the Minnesota Board of Pharmacy and medication labels destroyed.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7)</p>	01890		
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01890	Continued From page 24 days	01890		
01940 SS=D	<p>144G.72 Subd. 3 Individualized treatment or therapy managemen</p> <p>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:</p> <ul style="list-style-type: none"> (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 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. <p>This MN Requirement is not met as evidenced by: Based on observation, interview and record</p>	01940		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38831	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/19/2025
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NAME OF PROVIDER OR SUPPLIER NOBLE CARES LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 7957 MONROE STREET NE COON RAPIDS, MN 55448
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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
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01940	<p>Continued From page 25</p> <p>review, the licensee failed to include in the service plan a written statement of the treatment or therapy services that would be provided for one of one resident (R2).</p> <p>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 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).</p> <p>The findings include:</p> <p>During the entrance conference on September 15, 2025, at 11:00 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee provided treatment management services to residents at the facility.</p> <p>R2's diagnoses included diabetes mellitus type 2, functional incontinence, heart failure and major depressive disorder.</p> <p>On September 16, 2025, at 8:48 a.m., the surveyor observed unlicensed personnel (ULP)-B complete blood glucose testing for R2.</p> <p>On September 17, 2025, at 9:03 a.m., the surveyor observed ULP-C empty R2's foley catheter bag and administer scheduled medications.</p> <p>R2's Service Plan dated February 6, 2023, indicated R2 received services including assistance with bathing, dressing, medication</p>	01940		
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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38831	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/19/2025
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NAME OF PROVIDER OR SUPPLIER NOBLE CARES LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 7957 MONROE STREET NE COON RAPIDS, MN 55448
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01940	<p>Continued From page 26</p> <p>administration, laundry, and housekeeping. However, it did not include blood glucose monitoring or foley catheter care and exchange.</p> <p>R2's prescriber order dated September 6, 2024, indicated the licensee nurse was to perform monthly foley catheter exchange.</p> <p>R2's record lacked an order for blood glucose monitoring.</p> <p>R2's Planned Services as of September 15, 2025, instructed nursing to exchange R2's catheter monthly and licensee staff to record R2's blood glucose on Tuesday and Friday mornings before breakfast.</p> <p>On September 17, 2025, at 11:38 a.m., LALD/CNS-A stated R2's catheter care and exchange and blood glucose monitoring was not included on the service plan and must have been missed.</p> <p>The licensee's undated Treatment & Therapy Management Plan policy indicated a written statement detailing the specific services to be provided is included in the resident's service plan.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p>	01940		
01970 SS=D	<p>144G.72 Subd. 6 Treatment and therapy orders</p> <p>There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The</p>	01970		

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER NOBLE CARES LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 7957 MONROE STREET NE COON RAPIDS, MN 55448
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01970	<p>Continued From page 27</p> <p>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.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure up-to-date written or electronically recorded orders were maintained for one of one resident (R2) who received treatments managed by the provider.</p> <p>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 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).</p> <p>The findings include:</p> <p>During the entrance conference on September 15, 2025, at 11:00 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee provided treatment management services to residents at the facility.</p> <p>R2's diagnoses included diabetes mellitus type 2, functional incontinence, heart failure and major depressive disorder.</p> <p>R2's Planned Services as of September 15, 2025, instructed nursing to exchange R2's</p>	01970		
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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38831	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/19/2025
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NAME OF PROVIDER OR SUPPLIER NOBLE CARES LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 7957 MONROE STREET NE COON RAPIDS, MN 55448
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01970	<p>Continued From page 28</p> <p>catheter monthly and licensee staff to record R2's blood glucose on Tuesday and Friday mornings before breakfast.</p> <p>On September 16, 2025, at 8:48 a.m., the surveyor observed unlicensed personnel (ULP)-B complete blood glucose testing for R2.</p> <p>On September 17, 2025, at 9:03 a.m., the surveyor observed ULP-C empty R2's foley catheter bag and administered scheduled medications.</p> <p>R2's prescriber order dated September 6, 2024, indicated the licensee nurse was to perform monthly foley catheter exchange. R2's record lacked an order for catheter exchange renewed at least every 12 months.</p> <p>R2's record lacked an order for blood glucose monitoring.</p> <p>On September 16, 2025, at 12:17 p.m., LALD/CNS-A stated resident treatment orders were required to be renewed annually. LALD/CNS-A further stated R2's catheter order was expired due to extended wait time when the appointment was scheduled.</p> <p>On September 17, 2025, at 11:37 a.m., LALD/CNS-A stated R2's record lacked an order for blood glucose monitoring, and one had been requested upon realization of this.</p> <p>The licensee's undated Medication & Treatment Orders policy indicated a current prescriber's orders was required for any treatment provided to a resident. The policy further indicated the treatment orders were renewed at least every 12</p>	01970		

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER NOBLE CARES LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 7957 MONROE STREET NE COON RAPIDS, MN 55448
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01970	Continued From page 29 months. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		



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

Page: 1

Establishment Info

NOBLE CARES LLC
7957 MONROE STREET NE
Spring Lake Park, MN 55432
Anoka County
Parcel:

Phone:

License Info

License: HFID 38831

Risk:
License:
Expires on:
CFPM: FAITH AKINBAMIJO
CFPM #: FM108380; Exp: 11/04/2027

Inspection Info

Report Number: F8087251117
Inspection Type: Full - Single
Date: 9/16/2025 Time: 2:00:00 PM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

No orders were issued for this inspection report.

Food & Beverage General Comment

THIS WAS AN ANNOUNCED AND SCHEDULED FULL INSPECTION.

INSPECTION CONDUCTED IN THE PRESENCE OF HRD NURSE EVALUATOR.

THE FOLLOWING OBSERVATIONS WERE MADE:

CEILING: PAINTED, SMOOTH, APPEARS TO BE DURABLE - COMPLIANT

FLOORS: TILE - COMPLIANT

COUNTERTOPS: LAMINATE - NON COMPLIANT

CABINETS: WOOD - NON COMPLIANT

REFRIGERATOR/FREEZER: FRIGIDARE

DISHWASHER: LG

STOVE/RANGE: WHIRLPOOL

HAND WASHING SINK: YES - RIGHT SIDE OF 2-BIN STAINLESS STEEL KITCHEN SINK

NON COMPLIANT COUNTERTOP AND CABINETS 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.

DISHWASHER IS RESIDENTIAL BUT HAS SANITIZING RINSE CYCLE OPTION. TEMPERATURE PROBE USED TO ENSURE UTENSIL SURFACE TEMPERATURES REACH 165.

HOT WATER TEMPERATURE AT THE KITCHEN SINK REACHED 120 DEGREES.

INSPECTION REPORT EMAILED TO FACILITY AND HRD NURSE SURVEYOR.

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 F8087251117 from 9/16/2025

John Boettcher

FAITH AKINBAMIJO
DIRECTOR

John Boettcher,
Public Health Sanitarian 3
651-201-5076
john.boettcher@state.mn.us



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

Temperature Observations/Recordings

Page: 1

Establishment Info

NOBLE CARES LLC
Spring Lake Park
County/Group: Anoka County

Inspection Info

Report Number: F8087251117
Inspection Type: Full
Date: 9/16/2025
Time: 2:00:00 PM

Equipment Temperature: Product/Item/Unit: AMBIENT AIR; Temperature Process: Ambient Air

Location: Upright Cooler at 40 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: Product/Item/Unit: MILK; Temperature Process: Cold-Holding

Location: Upright Cooler at 40 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: Product/Item/Unit: CHEESE; Temperature Process: Cold-Holding

Location: Upright Cooler at 40 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: Product/Item/Unit: DELI MEAT; Temperature Process: Cold-Holding

Location: Upright Cooler at 40 Degrees F.

Comment:

Violation Issued?: No

Equipment Temperature: Product/Item/Unit: AMBIENT AIR; Temperature Process: Ambient Air

Location: Upright Freezer at -9 Degrees F.

Comment:

Violation Issued?: No