Protecting, Maintaining and Improving the Health of All Minnesotans

AMENDED

Electronically Delivered

August 7, 2025

Licensee
Liberty Care LLC
10820 Direct River Drive Northwest
Coon Rapids, MN 55433

RE: Project Number(s) SL40941015

Dear Licensee:

Please Note: This letter amends the previous letter dated August 7, 2025. Specifically, the first paragraph has been corrected to accurately reflect that you have been granted an assisted living facility license. No other changes have been made.

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 June 10, 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 . . ."

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

Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;

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

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00

The total amount you are assessed is $500.00. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
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

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a

hearing must be in writing and received by MDH within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

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

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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

Kelly Thorson

Kelly Thorson, Supervisor
State Evaluation Team
Email: Kelly.Thorson@state.mn.us
Telephone: 320-223-7336 Fax: 1-866-890-9290

HHH

Electronically Delivered

August 7, 2025

Licensee
Liberty Care LLC
10820 Direct River Drive Northwest
Coon Rapids, MN 55433

RE: Project Number(s) SL40941015

Dear Licensee:

This is your **official notice** that you have been **granted your assisted living facility license with dementia care.** 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.

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- Identify how the area(s) of noncompliance was corrected for all of the provider's residents/employees that may be affected by the noncompliance.
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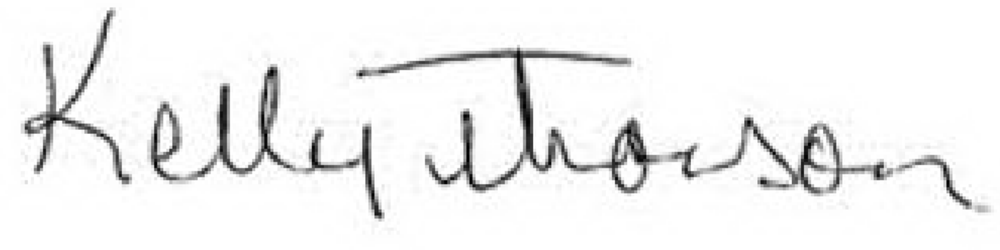
You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and state form with your organization's Governing Body.

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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40941	A. BUILDING: _____ B. WING _____	06/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY CARE LLC	10820 DIRECT RIVER DR NW COON RAPIDS, MN 55433

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ***ATTENTION*** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL40941015-0 On June 9, 2025, through June 10, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there was one resident; one receiving services under the Provisional Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management	0 580		

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0 580	Continued From page 1 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. 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 the licensee's one resident, 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 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: On June 10, 2025, at 11:35 a.m., licensed assisted living director in residency (LALDR)-A stated she did not document the quality management meetings anywhere.	0 580		

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0 580	Continued From page 2 The licensee's Quality Management policy dated August 1, 2024, indicated the facility ensures transparency and accountability by documenting all quality assurance activities, findings, and improvements. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 580		
0 660 SS=E	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on 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), which included a two-step tuberculin skin test (TST) or	0 660		

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0 660	Continued From page 3 other evidence of TB screening such as a blood test for two of four employees, clinical nurse supervisor (CNS)-C, and unlicensed personnel (ULP)-D. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a 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: The facility's TB risk assessment was completed on January 20, 2025, and was determined to be a low risk level. CNS-C CNS-C was hired on September 3, 2024, to provide direct care services to residents and supervision of staff. CNS-C's record contained a two-step TST, the first step indicated a positive result, and the second step indicated a negative result. On June 12, 2025, at 9:00 a.m., licensed assisted living director in residence (LALDR)-A stated she did not realize the first step was positive and will more than likely have ULP-D go do another two-step TST or a QuantiFERON Gold blood test to update her record. ULP-D ULP-D was hired on April 1, 2025, to provide	0 660		

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0 660	Continued From page 4 direct care services to residents. ULP-D's record contained a first step TST reading that indicated a negative result. ULP-D's record lacked the second step of the two-step TST. On June 10, 2025, at 11:15 a.m., LALDR-A stated she did not realize that ULP-D only had the first step of the two-step TST and would need get the second step. The licensee's undated Tuberculosis Testing Protocols policy indicated when using the Mantoux TST for baseline testing of health care personnel upon hire, the two- step approach should be followed. Administer the first TST. Review the result: - Positive result: If the first TST result is positive, consider the individual as TB infected. No second TST is needed, but further evaluation for TB disease is required. - Negative result: If the first TST result is negative, a second TST is needed. Retest the individual within 1 to 3 weeks after the first TST is read. The Minnesota Department of Health guidelines Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, and based on CDC guidelines, indicated an employee may begin working with patients (residents) after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the health care worker (HCW) starts working with patients. It also indicated a HCW with documentation of a previous positive	0 660		

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0 660	Continued From page 5 test or IGRA will need to have the following documented in their record before direct patient contact: - Test result; - Assessment for current TB symptoms; and - Chest x-ray to rule out infectious TB disease. No further information was 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	0 680		

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0 680	Continued From page 6 requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all residents, employees, and visitors to the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On June 9, 2025, at 10:30 a.m., licensed assisted living director in residence (LALDR)-A provided the surveyor with a binder that contained the EPP and indicated the contents were the full EPP and no other binders existed. The licensee's undated EPP lacked the required content: - missing resident quarterly review; - description of the population served by licensee; - a process for emergency preparedness (EP) collaboration with tribal, regional, state and federal officials/organizations; - the development of policies/procedures to address: - subsistence needs for staff and residents; - procedures for tracking staff and residents; - procedures for sheltering; - procedures for medical documents;	0 680		

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0 680	Continued From page 7 - use of volunteers; and - roles under a waiver declared by Secretary. - names and contact information for staff, entities providing services, resident physicians, other facilities, and volunteers; - emergency officials contact information; - primary and alternate means for communication; - methods for sharing medical documentation for residents under the facility's care, as necessary, with other health care providers to maintain continuity of care; - means to providing information about the facility's occupancy, needs, and it's ability to provide assistance, to the authority having jurisdiction, the incident command center, or designee; - method for sharing information from the emergency plan, that the facility has determined appropriate, with residents and their families/representatives; - develop and maintain EP training and testing program; and - exercises to test the EPP at least twice per year, including unannounced drills using the EPP. On June 9, 2025, at 1:00 p.m., licensed assisted living director in residency (LALDR)-A stated she agreed some of the required information was missing and she was newer to assisted living and did not realize all those items were missing from the EPP plan. The licensee's undated Disaster Planning and Emergency Preparedness policy indicated the emergency preparedness coordinator is responsible for the implementation and maintenance of the EPP. Leadership must ensure resources are allocated to meet the requirements of this policy. All staff are	0 680		

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0 680	Continued From page 8 responsible for understanding and adhering to their roles within the EPP. Per Assisted Living Facilities: Minnesota Rules Chapter 4659, 4659.0110, Subd. 4. Review missing resident plan. The assisted living director and clinical nurse supervisor must review the missing person plan at least quarterly and document any changes to the plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with Minnesota State Fire Code in Minnesota Rules chapter 7511. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a 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).	0 775		

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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
0 775	Continued From page 9 The findings include: On June 10, 2025, at approximately 9:30 a.m. the surveyor toured the facility with licensed assisted living director in residency (LALDR)-A. The following was observed. 1. The egress window in bedroom 1 was blocked by bedroom furniture. All means of egress shall be free from obstructions that would prevent its use. 2. An appropriate non-combustible dispenser was not provided for discarding used cigarette butts in the designated smoking area. Where smoking is permitted, suitable noncombustible ash trays or match receivers shall be provided. On June 10, 2025, LALDR-A acknowledged the above deficiencies during the facility tour. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 775		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique	0 810		

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	40941	A. BUILDING: _____ B. WING _____	06/10/2025

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0 810	Continued From page 10 or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 810		

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0 810	Continued From page 11 The findings include: On June 10, 2025, the surveyor observed the fire evacuation diagrams did not include the identification of the path of egress. Exit plan diagrams must be correctly labeled to reduce confusion and potential obstructions to egress in a fire or similar emergency. On June 10, 2025, licensed assisted living director in residency (LALDR)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP failed to include the following: 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 plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate) but the plan was designed for a building with life safety systems such as fire alarm systems. The policy had not been updated to provide complete actions for employees to take in the event of a fire or similar emergency at the licensed facility which did not have life safety systems. The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency.	0 810		

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0 810	Continued From page 12 On June 10, 2025, LALDR-A stated they would update the policies to bringing them into compliance with statute requirements. TRAINING: The licensee failed to provide evacuation training to residents capable of assisting in their own evacuation, at least once per year. LALDR-A lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan. The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. The licensee's training records indicated staff were trained upon hire, and on 9-3-24. No other training documentation was provided. On June 10, 2025, LALDR-A stated they understood the requirements for training residents and staff and would implement a training program that was compliant with statute requirements. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
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	01060		

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01060	Continued From page 13 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 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 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with	01060		

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01060	Continued From page 14 required content for an emergency relocation for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R1 was admitted to the licensee and started receiving assisted living services on September 3, 2024. R1's record indicated R1 went to the emergency room and was admitted to the hospital on December 27, 2024, after a brief hospitalization R1 was discharged back to the licensee on January 20, 2025. R1's record lacked an emergency relocation notification to include : - 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 Office of Ombudsman for Long-Term Care - 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	01060		

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01060	Continued From page 15 information for the agency to which the resident may submit an appeal. - notification to the resident, legal representative, and designated representative - notification to the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. On June 9, 2025, at 3:25 p.m., licensed assisted living director in residence (LALDR)-A stated she was not aware of the emergency relocation notification that needed to be provided to the resident or that the Ombudsman should be notified if the resident has been gone from the facility more than four days. The licensee's undated Emergency Relocation policy, indicated all relocations will be documented, including reason, destination, and resident status. Staff will conduct post-relocation follow-ups to ensure resident well-being. The facility will comply with all state and federal emergency relocation requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01470 SS=E	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person;	01470		

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01470	Continued From page 16 (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased	01470		

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01470	Continued From page 17 incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received orientation to assisted living licensing requirements and regulations prior to providing services for two of three employees (licensed assisted living director in residence (LALDR)-A and clinical nurse supervisor (CNS)-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 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: LALDR-A began employment on September 3, 2024, to provide direct services to residents and oversee the facility. LALDR-A's employee record lacked documented	01470		

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01470	Continued From page 18 evidence of the following orientation topics: - Overview of Assisted Living statutes; - Handling emergencies and using emergency services; - Handling of resident complaints; - Consumer advocacy services; - Review of types of Assisted Living services the employee will provide and provider's scope of license; and - Principals of person-centered planning/service delivery. CNS-C began employment on September 3, 2024, to provide direct care services to residents and supervision of staff. CNS-C's employee record lacked documented evidence of the following orientation topics: - Overview of Assisted Living statutes; - Review of provider's policies and procedures; - Assisted Living Bill of Rights; - Handling emergencies and using emergency services; - Handling of resident complaints; - Consumer advocacy services; - Review of types of Assisted Living services the employee will provide and provider's scope of license; and - Principals of person-centered planning/service delivery. On June 10, 2025, at 11:45 a.m. LALDR-A stated she forgot to assign the correct classes to herself but will get the classes completed to come into compliance. LALDR-A stated CNS-C had not completed any orientation because she did not realize the nurse was required to complete this training. The licensee's Staff Orientation policy dated	01470		

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01470	Continued From page 19 August 1, 2024, indicated employees must successfully complete all required orientation modules before assuming full job duties. Supervisors ensure orientation is completed and provide ongoing support. Orientation records are maintained in employee personnel files for compliance tracking. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's	01620		

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01620	Continued From page 20 needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN) conducted ongoing assessments not to exceed 90 calendar days from the last date of assessment for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	01620		

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01620	Continued From page 21 or has the potential to affect a large portion or all of the residents). The findings include: R1 was admitted on September 3, 2024. R1's diagnoses included schizophrenia, unspecified psychosis, and peptic ulcer. R1's service plan dated September 3, 2024, indicated R1's services included medication administration, behavioral management, dressing assistance, bathing assistance, housekeeping, laundry, and meals. R1's record included an admission assessment dated September 3, 2024, a 14-day assessment dated September 16, 2024, a 90-day assessment dated January 20, 2025, and a change of condition/return from hospital assessment dated February 18, 2025. R1's record lacked a 90-day assessment that was due on December 2, 2024, and a 90-day assessment that was due on April 20, 2025. R1's record indicated a hospitalization on December 27, 2024. R1 discharged from the hospital and returned to the licensee's facility on January 20, 2025. R1's 90-day assessment was completed on January 20, 2025, upon her return from the hospitalization. A second assessment labeled return from hospital was completed on February 18, 2025. On June 9, 2025, at 3:10 p.m., licensed assisted living director in residence (LALDR)-A stated the	01620		

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01620	Continued From page 22 90-day assessment due on December 2, 2024 was not completed due to R1's refusal and increased behaviors which led to R1's hospitalization on December 27, 2024. LALDR-A stated when R1 returned to the facility on January 20, 2025, the nurse completed the return from hospital assessment, but it was mislabeled as a 90-day assessment. LALDR-A stated when the registered nurse realized the mistake she completed a new assessment on February 18, 2025, and labeled it the return from hospital assessment. LALDR-A stated they were new to using this electronic charting system and this was why the dates and assessment labels were incorrect. LALDR-A stated the assessment due on April 20, 2025, was not completed because they did not realize the assessments were due every 90-days they thought after the initial 90-days it went to annual assessments. The licensee's Assessment, Reviews, and Monitoring policy dated August 1, 2024, indicated regular assessments, reviews, and monitoring are essential to identifying changes in residents' health, safety, and well-being. These processes are conducted to ensure that service plans are current, appropriate, responsive to the needs of each resident, and in compliance with Minnesota Chapter 144G. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

Liberty Care LLC
10820 Direct River Dr NW
Coon Rapids, MN 55433
Anoka County
Parcel:

Phone:

License Info

License: HFID 40941

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

Inspection Info

Report Number: F1025251027
Inspection Type: Follow-up - Single
Date: 6/10/2025 Time: 5:00 PM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery:

No orders were issued for this inspection report.

Food & Beverage General Comment

Received email confirmation of new cutting boards and stainless cookware purchased to replace wood and cookware with damaged non-stick coating

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 F1025251027 from 6/10/2025

Establishment Representative

Casey Kipping, MA RS
Public Health Sanitarian 3
651-201-4513
casey.kipping@state.mn.us