



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

June 24, 2026

Licensee
Caring Nurses LLC
7601 Regent Avenue North
Brooklyn Center, MN 55443

RE: Project Number(s) SL33551016

Dear Licensee:

On May 19, 2026, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on February 27, 2026. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the February 27, 2026 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on February 27, 2026, found not corrected at the time of the May 19, 2026, follow-up survey and/or subject to penalty assessment are as follows:

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

The details of the violations noted at the time of this follow-up survey completed on May 19, 2026 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

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

DOCUMENTATION OF ACTION TO COMPLY

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

IMPOSITION OF FINES

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

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

§ 144G.20;
Level 5: a fine of \$5,000 per violation, in addition to any enforcement mechanism authorized in
§ 144G.20.

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

REQUESTING A HEARING

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

To submit a hearing request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

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

We urge you to review these orders carefully. If you have questions, please contact Stephanie Jones de Palma at 651-201-4320.

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

Sincerely,

A handwritten signature in black ink, reading "Stephanie Jones de Palma". The signature is fluid and cursive, with the first name "Stephanie" being the most prominent.

Stephanie Jones de Palma, Supervisor
State Evaluation Team
Email: stephanie.jones.de.palma@state.mn.us
Telephone: 651-201-4320 Fax: 1-866-890-9290

KKM

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33551	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 05/19/2026
NAME OF PROVIDER OR SUPPLIER CARING NURSES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 7601 REGENT AVENUE NORTH BROOKLYN CENTER, MN 55443			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
{0 000}	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS SL33551016-1 On May 18, 2026, the Minnesota Department of Health conducted a follow-up survey for the above provider to follow-up on orders issued pursuant to a license order follow up completed on Febuary 27, 2026. As a result of the follow-up survey, the following orders were issued and/or reissued.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
{0 480} SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	{0 480}			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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STATE FORM 6899 5LBE12 If continuation sheet 3 of 13

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{0 550}	Continued From page 3 This MN Requirement is not met as evidenced by:	{0 550}	Not reviewed during this survey.		
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by:	{0 680}			
{0 730} SS=F	144G.43 Subd. 3 Contents of resident record	{0 730}	Not reviewed during this survey.		

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{0 730}	Continued From page 4 Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and	{0 730}			

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{0 730}	Continued From page 5 any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by:	{0 730}	Not reviewed during this survey.		
{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, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	{0 775}			

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{0 775}	Continued From page 6	{0 775}			
	Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated May 18, 2026, for the specific violations related the physical environment under Minnesota Statute 144G.				
{01470} SS=F	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; (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	{01470}			

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{01470}	Continued From page 7 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 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:	{01470}			
{01500} SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual	{01500}	Not reviewed during this survey.		

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{01500}	Continued From page 8 training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication;	{01500}			

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{01500}	Continued From page 9 (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by:	{01500}	Not reviewed during this survey.		
{01530} SS=F	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160	{01530}			

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{01530}	Continued From page 10 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by:	{01530}	Not reviewed during this survey.		
{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	{01620}			

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{01620}	Continued From page 11 the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of 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:	{01620}			
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{01620}	Continued From page 12	{01620}			
{01910} SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by:	{01910}			
			Not reviewed during this survey.		

Physical Environment Inspection Report

ASSISTED LIVING | ASSISTED LIVING WITH DEMENTIA CARE

Project No: SL33551016-1	Date: 5/18/2026
Facility Name: CARING NURSES LLC	
Facility Address: 7601 Regent Ave North Brooklyn Park MN 55444	

☒ **TAG IDENTIFICATION: 0775**

SCOPE/ SEVERITY: Level 2; Widespread

1. Each assisted living facility must comply with the provisions of the Minnesota State Fire Code (MSFC) in Minnesota Rules chapter 7511. [Minn. Stat. 144G.45 subd. 2]
2. Smoking shall be prohibited where conditions are such as to make smoking a hazard, and in spaces where flammable or combustible materials are stored or handled. [Minn. Stat. 144G.45 subd. 2; MSFC 310.2]

Comments: Surveyor observed unsafe smoking in multiple areas of the facility. Cigarette butts and ash were found inside the attached garage and in the basement common-area window well.

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

Comments: The facility continued to allow cigarettes to be discarded on top of cardboard boxes and on the wooden wheelchair ramp inside the garage. These unsafe disposal practices were observed during the survey in an area used for storage and resident access, where combustible materials were present.

4. Extension cords and flexible cords shall not be a substitute for permanent wiring and shall be listed and labeled in accordance with UL 817. Extension cords and flexible cords shall not be affixed to structures, extended through walls, ceilings or floors, or under doors or floor coverings, nor shall such cords be subject to environmental damage or physical impact. Extension cords shall be used only with portable appliances. Extension cords marked for indoor use shall not be used outdoors. [Minn. Stat. 144G.45 subd. 2; MSFC 604.5]

Comments: The surveyor observed that the facility was continuing to operate a refrigerator in the garage using an extension cord that staff had fastened to the structure with plastic staples and nails.



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

March 27, 2026

Licensee

Caring Nurses LLC

7601 Regent Avenue North

Brooklyn Center, MN 55443

RE: Project Number(s) SL33551016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on February 27, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement;

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

Level 3: a fine of \$1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

Level 4: a fine of \$3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

Level 5: a fine of \$5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

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

pursuant to this survey:

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

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

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

REQUESTING A HEARING

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

To submit a hearing request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration or a hearing, but not both. If you wish to contest tags without fines in

Caring Nurses LLC

March 27, 2026

Page 3

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,

A handwritten signature in black ink, appearing to read "Casey DeVries". The signature is written in a cursive, flowing style.

Casey DeVries, Supervisor

State Evaluation Team

Email: Casey.DeVries@state.mn.us

Telephone: 651-201-5917 Fax: 1-866-890-9290

CLN

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33551	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/27/2026
NAME OF PROVIDER OR SUPPLIER CARING NURSES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 7601 REGENT AVENUE NORTH BROOKLYN CENTER, MN 55443			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL33551016-0 On February 23, 2026, through February 27, 2026, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were four residents: all of whom were receiving services under the Assisted Living 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 License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food		0 480		

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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

Minnesota Department of Health

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0 480	Continued From page 2 and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated February 24, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer	0 480			

Minnesota Department of Health

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0 480	Continued From page 3 to the FBEIR for any compliance dates.	0 480			
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post the required information related to the grievance procedure and reporting contact information. 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).	0 550			

Minnesota Department of Health

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0 550	Continued From page 4 The findings include: On February 24, 2026, at approximately 10:55 a.m., during the facility tour, the licensee lacked the following postings posted anywhere in the licensee's facility: - Contact information for the Office of Ombudsman for Long Term Care (OOLTC); - Office of Ombudsman for Mental Health and Developmental Disabilities (OMHDD); - Minnesota Adult Abuse Reporting Center (MAARC); - Contact information for the Office of Health Facility Complaints (OHFC). On February 24, 2026, at 11:57 a.m., via telephone, clinical nurse supervisor (CNS)-C stated the required contact information mentioned above should be there. Housing manager (HM)-A stated they had a second board with all the required postings, but it came down and maintenance was going to replace it. CNS-C stated they did not know what happened to the postings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies	0 680			

Minnesota Department of Health

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

Minnesota Department of Health

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0 680	Continued From page 6 The licensee's EPP last updated August 1, 2023, lacked evidence of the following required content: - annual review of the EPP; - process for EP collaboration; - names and contact information; - emergency officials contact information; - methods for sharing information; and - arrangements with other facilities. On February 26, 2026, at 10:17 a.m., via telephone, licensed assisted living director (LALD)-D stated they did not know why the above-mentioned topics were missing from the EPP. LALD-D stated, "I did list out the phone numbers, maybe the updated version did not make it to the house". Although requested, the licensee did not provide the updated revision dates for EPP. The licensee's undated Emergency Management Policy indicated the licensee will have an identified plan in place to ensure the safety and well-being of residents and employees during periods of an emergency or a disaster that disrupts facility services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone	0 730			

Minnesota Department of Health

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0 730	Continued From page 7 number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and	0 730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33551	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/27/2026
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0 730	Continued From page 8 (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a discharge summary with required content that complied with Minnesota Rule 4659.0120 Subp. 9, for one of one resident (R4) discharged from the licensee. 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: R4 was admitted to the licensee on May 21, 2025, and discharged from the licensee on August 28, 2025. R4's diagnoses included major neurocognitive disorder, cannabis use disorder, history of alcohol use, and traumatic brain injury (TBI). R4's assessment completed on August 6, 2025, indicated, R4 received assistance with bathing reminders and cues, dressing reminders and cues, medication administration, housekeeping, and laundry. On February 26, 2026, at 9:46 a.m., via email correspondence, licensed assisted living director	0 730			

Minnesota Department of Health

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0 730	Continued From page 9 (LALD)-D provided the surveyor with the following documents for R4: - R4's incident report dated August 28, 2025; - R4's discharge summary printed on February 26, 2026; and - R4's Minnesota Adult Abuse Reporting Center report submitted on August 29, 2025. R4's Discharge-Transfer Summary printed on February 26, 2026, contained R4's diagnoses, allergies, service initiation, primary physician information, code status, a support network, finance/ care decisions, and discharge reason. R4's discharge summary lacked the following required information: - a summary of the resident's stay that included courses of illnesses, treatments and therapies, and pertinent lab, radiology, and consultation results; and - a final summary of the resident's status from the latest assessment or review under Minnesota Statutes, section 144G.70, if applicable, that includes the resident status, including baseline and current mental, behavioral, and functional status. On February 26, 2026, at 1:42 p.m., clinical nurse supervisor (CNS)-C stated R4 eloped out of the facility and was found deceased a week later. CNS-C stated the elopement was reported. CNS-C stated they had completed the discharge summary to the best of their knowledge, "it is again, an oversight. We just put the discharge date." The Licensee's undated Resident Records policy dated read, "A discharge summary, including service termination notice and related documentation, when applicable".	0 730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33551	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/27/2026
NAME OF PROVIDER OR SUPPLIER CARING NURSES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 7601 REGENT AVENUE NORTH BROOKLYN CENTER, MN 55443			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 730	Continued From page 10 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730			
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, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated 2/24/2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7)	0 775			

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0 775	Continued From page 11 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 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.	0 810			

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0 810	Continued From page 12 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated 2/24/2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 810			
01470 SS=F	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; (3) handling of emergencies and use of	01470			

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01470	Continued From page 13 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 incidence of dementia, falls, hospitalizations,	01470			

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01470	Continued From page 14 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 observation, interview, and record review, the licensee failed to ensure staff completed an orientation to assisted living facility licensing requirements and regulations before providing services for two of three employees (housing manager (HM)-A, unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: HM-A HM-A was hired on November 1, 2016, to provide direct care to residents. On February 24, 2026, at 12:10 p.m., the surveyor observed HM-A administer medication to R2.	01470			

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01470	Continued From page 15 HM-A's employee record included a training record entitled Minnesota Comprehensive Home Care License for Assisted Living- Orientation Checklist and Requirements. The training record indicated the following Home Care Orientation 144A.4796, subp. 2 topics were completed on November 20, 2017: - overview of home care licensure; - introduction and review of policies and procedures related to home care provisions; - compliance with and reporting of maltreatment of vulnerable adults; - handling client complaints; reporting of complaints and where to report complaints including information on the OHFC and CEP; - consumer advocacy services; - review of types of home care services the employee will be providing and providers scope of licensure; and - handling emergencies and use of emergency services. HM-A's employee record lacked evidence of orientation to assisted living regulations for the following topics: - an overview of Minnesota statute chapter 144G.08 to 144G.95; - the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; - a review of the types of assisted living services the staff members will be providing and the facility's category of licensure. ULP-B ULP-B was hired on September 11, 2015, to	01470			

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01470	Continued From page 16 provide direct care to residents. ULP-B's employee record included a LMS Training Summary dated January 1, 2022, to February 25, 2026. The training summary included the following topics: - the Minnesota assisted living bill of rights; - reporting maltreatment; - person centered care; and - how to handle a health care emergency. ULP-B's employee records lacked evidence of orientation to assisted living regulations for the following topics: - an overview of Minnesota statute chapter 144G.08 to 144G.95; - handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; - a review of the types of assisted living services the staff member will be providing and the facility's category of licensure; and - 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. On February 26, 2026, at 10:04 a.m., via telephone, licensed assisted living director (LALD)-D stated the ULPs did not complete the orientation as there was no way for them to go back in time to their date of hire and correct it. The surveyor explained to LALD-D that regardless of an employee's date of hire, when Minnesota Assisted Living law went into effect in 2021, the licensee was required to ensure their	01470			

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01470	Continued From page 17 staff were oriented to the appropriate statutes. On February 26, 2026, at 12:44 p.m., via telephone, LALD-D stated both HM-A and ULP-B provide direct care services such as assisting residents with activities of daily living and medication administration. The licensee's undated Facility Employee Orientation policy read, "MN Statute: 144G.63, Subd. 1 and 2 FACILITY EMPLOYEE ORIENTATION POLICY: All employees of the Assisted Living Facility, including those who provide direct care, supervision of direct care, or management of services for the Facility, shall complete an orientation on topics required by Minnesota statutes and rules for assisted living. If any volunteers provide services to assisted living residents, they also will receive required orientation. PURPOSE: To comply with the home care licensure law To assure that all employees providing or supervising direct care have completed orientation SPECIAL INSTRUCTIONS: 1. The state required orientation to home care must include the following: a. An overview of Minnesota's home care law (MN Statutes 144A.43 to 144.4798) b. An introduction and review of all of facility's policies and procedures related to the provision of home care services c. Handling of emergencies and use of emergency services d. Reporting the maltreatment of vulnerable minors or adults under Minnesota Statutes 626.556 and 626.557.	01470			

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01470	Continued From page 18 e. The home care bill of rights (Minnesota Statutes 144A.44): 1) Overview of the home care statute and licensure rules 2) Handling of emergencies and use of emergency services 3) Reporting the maltreatment of vulnerable minors or adults 4) Assisted Living Bill of Rights 5) Handling of residents' complaints and reporting of complaints to the Office of Health Facility Complaints 6) Consumer advocacy services of the 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 and other relevant advocacy services 7) A review of the types of services the employee will be providing and the scope of the facility's services under the specific license". No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470			
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557;	01500			

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01500	Continued From page 19 (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations,	01500			

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01500	Continued From page 20 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 observation, interview, and record review, the licensee failed to ensure employees received at least eight hours of annual training for each 12 months of employment for three of three employees (housing manager (HM-A), unlicensed personnel (ULP)-B, ULP-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: HM-A HM-A was hired on November 1, 2016, to provide direct care to residents. On February 24, 2026, at 12:10 p.m., the surveyor observed HM-A administer medication to R2. HM-A's employee record included a training record entitled Minnesota Comprehensive Home Care License for Assisted Living- Orientation	01500			

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01500	Continued From page 21 Checklist and Requirements, completed in year 2017. HM-A's employee record also included a Clinical LMS-Training Record. The Clinical LMS-Training Record indicated HM-A completed an Age-Related Hearing Loss and Health Impacts on December 7, 2025. HM-A's employee record lacked eight hours of annual training completed for each 12 months of employment, to include: - reporting maltreatment of vulnerable adults; - assisted living bill of rights; - infection control techniques; - effective approaches to use to problems solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; - review of provider policies and procedures; and - principles of person-centered planning/service delivery. ULP-B ULP-B was hired on September 11, 2015, to provide direct care to residents. ULP-B's employee record included Educare (training software) transcript for courses completed between December of 2020, and July of 2021, and a LMS Training Summary dated January 1, 2022, to February 25, 2026. The training summary included the following topics: - the Minnesota assisted living bill of rights, completed on February 18, 2025; - infection control techniques, completed on August 7, 2025; - reporting maltreatment, completed on August 7, 2025; - person centered care completed on August 7, 2025; and	01500			

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01500	Continued From page 22 - how to handle a health care emergency, completed on August 7, 2025. ULP-B's employee record lacked the following required topics of annual training completed for each 12 months of employment: - effective approaches to use to problems solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; and - review of provider policies and procedures. ULP-F ULP-F was hired on February 5, 2024, to provide direct care to residents. ULP-F's employee record included an Educare transcript last completed in December of 2023. ULP-F's employee record lacked eight hours of annual training completed for each 12 months of employment for year 2024, and year 2025, to include: - reporting maltreatment of vulnerable adults; - assisted living bill of rights; - infection control techniques; - effective approaches to use to problems solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; - review of provider policies and procedures; and - principles of person-centered planning/service delivery. On February 26, 2026, at 10:00 a.m., via telephone, licensed assisted living director (LALD)-D stated annual training, dementia training, and mental illness trainings were assigned to all employees but they did not know	01500			

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01500	Continued From page 23 why the employees did not complete them. LALD-D stated they did have a system to check if all training was completed, which included pulling employees off the work schedule if the employees did not complete the required training, but they had not been doing that due to short staffing. On February 26, 2026, at 12:44 p.m., via telephone, LALD-D stated HM-A, ULP-B, and ULP-F provided direct care services such as assisting residents with activities of daily living and medication administration. The licensee's undated Survey Plan of Correction Documentation for the survey completed on December 6, 2023, read, "f. 144G.63 Subd. 5 Required annual training i. We continue to review all employee records and are setting up a system to notify us ahead of time when an employee has training hours coming due. We are collecting all training documentation to make sure our paperwork is in order." The licensee's undated Annual Training Requirements policy indicated all staff providing direct care services will complete at least eight (8) hours of education for each twelve (12) months of employment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500			
01530 SS=F	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De-	01530			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33551	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/27/2026
NAME OF PROVIDER OR SUPPLIER CARING NURSES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 7601 REGENT AVENUE NORTH BROOKLYN CENTER, MN 55443		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01530	Continued From page 24 (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter;	01530			

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01530	Continued From page 25 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure direct care employees received at least eight hours of initial dementia care training within 160 working hours of their employment start date; two hours of initial training on mental illness and de-escalation topics within 160 hours of start date; and two hours of training on topics related to dementia and one hour of training related to mental illness and de-escalation annually for three of three employees (housing manager (HM)-A, unlicensed personnel (ULP)-B, ULP-F). 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: HM-A HM-A was hired on November 1, 2016, to provide direct care services to residents. On February 24, 2026, at 12:10 p.m., the surveyor observed HM-A administer medication to R2. HM-A's employee record included a training record entitled Minnesota Comprehensive Home Care License for Assisted Living- Orientation	01530			

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01530	Continued From page 26 Checklist and Requirements, completed in year 2017. HM-A's employee record also included a Clinical LMS-Training Record completed on December 7, 2025. HM-A's employee record lacked the following required training documents: - at least eight hours of initial dementia care training within 160 working hours of their employment start date; - two hours of initial training on mental illness and de-escalation topics within 160 hours of start date, effective August 1, 2025; and - two hours of training on topics related to dementia annually. ULP-B ULP-B was hired on September 11, 2015, to provide direct care services to residents. ULP-B's employee record included Educare (training software) transcript for courses completed between December 2020 and July 2021. The Educare transcript indicated ULP-B had completed one training of 0.75 hours on March 2, 2021, out of 10 dementia trainings assigned to them. ULP-B's employee record also included a LMS Training Summary dated January 1, 2022, to February 25, 2026. The training summary indicated five trainings related to dementia and one training related to mental illness were assigned to them; ULP-B completed none of the trainings. ULP-B's employee records lacked the following - 7.25 hours of initial dementia care training within 160 working hours of their employment start date; - two hours of initial training on mental illness and de-escalation topics within 160 hours of start date (effective July 1, 2025); - two hours of training on topics related to dementia annually; and	01530			

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01530	Continued From page 27 - one hour of training related to mental illness and de-escalation annually (effective July 1, 2025). ULP-F ULP-F was hired on February 5, 2024, to provide direct care to residents. ULP-F's employee record included an Educare transcript last completed in December 2023. ULP-F's transcript indicated ULP-F had completed eight hours of dementia training dated December 20, 2023, through December 22, 2023. ULP-F's employee record lacked the following required training: - two hours of initial training on mental illness and de-escalation topics within 160 hours of start date (effective July 1, 2025); - two hours of training on topics related to dementia annually; and - one hour of training related to mental illness and de-escalation annually (effective July 1, 2025). On February 26, 2026, at 10:00 a.m., via telephone, licensed assisted living director (LALD)-D stated annual training, dementia training, and mental illness trainings were assigned to all employees but they did not know why the employees did not complete them. LALD-D stated they did have a system to check if all training was completed, which included pulling employees off the work schedule if the employees did not complete the required training, but they had not been doing that due to short staffing. LALD-D stated all the above-mentioned employees had worked for the licensee for more than 160 hours. On February 26, 2026, at 12:44 p.m., via telephone, LALD-D stated HM-A, ULP-B, and ULP-F, provided direct care services such as	01530			

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01530	Continued From page 28 assisting residents with activities of daily living and medication administration. The licensee's undated Dementia Care Training policy indicated direct care employees must have completed at least eight hours of initial training on required topics in 160 hours from employment. Until this training is complete, the employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements or a supervisor meeting the requirements must be available for consultation with the new employee until the training requirement is complete. The policy did not mention mental illness training and annual dementia training requirement for direct care employees. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530			
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	01620			

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01620	Continued From page 29 distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of 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:	01620			

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01620	Continued From page 30 Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident assessment and reassessment, not to exceed 14 calander days from the date of admission and 90 calendar days from the last date of the assessment for two of three residents (R1, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On February 21, 2026, at 11:40 a.m., during the entrance conference, via telephone, clinical nurse supervisor (CNS)-C stated the licensee was in the process of migrating to Residex (electronic software system) for assessments and documentation. CNS-C stated unlicensed personnel still documented on paper and the nurses were using Residex. R1 R1 was admitted to the licensee on May 21, 2025, with diagnoses that included diabetes, asthma, depression, generalized anxiety disorder (GAD), history of alcohol use, paranoid schizophrenia, psychosis, schizoaffective disorder, seizure disorder, suicide attempt, and history of traumatic brain injury (TBI). R1's signed Service Plan (Waiver)- Addendum to Contract with effective date of February 11, 2026,	01620			

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01620	Continued From page 31 indicated R1 received services for medication administration, supervision with recording vital signs, and transportation assistance as needed. R1 had two assessments completed on Residex dated May 11, 2025, and February 24, 2026 (during the survey). On February 26, 2026, at 9:06 a.m., via telephone, CNS-C stated R1 used to live in a licensee's sister facility which was now closed, so they had to move R1 to the licensee's facility. CNS-C stated they did paper assessment for R1's 90-day assessments. The surveyor inquired about the assessment completed on February 25, 2026. CNS-C stated they did complete that assessment remotely, but they had 90-day assessments completed for R1 on paper and on time. The surveyor requested to see the paper assessments. On February 26, 2026, at 9:26 a.m., via email correspondence, the surveyor requested licensed assisted living director (LALD)-D to provide R1, R2, and R3's 14-day assessment and their last three 90-day assessments. On February 26, 2026, at 9:47 a.m., via email correspondence, LALD-D provided R1's paper assessments completed on August 1, 2025, November 1, 2025, and February 3, 2026. R1's record lacked a 14-day assessment which was supposed to be completed by June 4, 2025. The 90-day assessment completed on November 1, 2025, was supposed to be completed by October 30, 2025, the 90-day assessment completed on February 3, 2026, was supposed to be completed by January 30, 2026.	01620			

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01620	Continued From page 32 R3 R3 was admitted to the licensee on May 22, 2025, with diagnoses including schizoaffective disorder, adjustment disorder, aggressive behavior, adult antisocial personality disorder, asthma, bipolar disorder, depression, generalized anxiety disorder, homicidal ideation, hypertension, substance use disorder, suicidal ideation, and TBI (traumatic brain injury), and wandering. R3's admission assessment completed on May 11, 2025, indicated R3 received assistance with medication administration and reminders and cues from staff to take a daily shower and to dress appropriately. R3 had an admission assessment completed on Residex dated May 11, 2025. On February 26, 2026, at 12:29 p.m., via email correspondence, LALD-D provided R3's paper assessments completed on August 1, 2025, November 1, 2025, and February 3, 2026. R3's record lacked a 14-day assessment which was supposed to be completed by June 5, 2025. The 90-day assessment completed on November 1, 2025, was supposed to be completed by October 30, 2025, the 90-day assessment completed on February 3, 2026, was supposed to be completed by January 30, 2026. On February 26, 2026, at 1:37 p.m., clinical nurse supervisor (CNS)-C stated they have not completed the 14-day assessment for any of the residents. CNS-C stated, "I did not complete 14-day assessment, it slipped my mind, they [referring to all residents] are not new to the company, and they had a 14-day assessment at	01620			

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01620	Continued From page 33 the other house so that is my fault." CNS-C stated it was an oversight that the 90-day assessments were completed late. The licensee's undated Nursing assessment and Reassessment of Residents policy indicated resident reassessment, and monitoring must be conducted no more than 14 calendar days after initiating services. On-going reassessment and monitoring will be conducted as needed based on changes in the needs of the residents and cannot exceed 90 calendar days from the last assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620			
01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable,	01910			

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01910	Continued From page 34 quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide documentation of disposition of medications for one of one discharged resident (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R4 was admitted to the licensee on May 21, 2025, and discharged from the licensee on August 28, 2025. R4's diagnoses included major neurocognitive disorder, cannabis use disorder, history of alcohol use, and traumatic brain injury (TBI). R4's assessment completed on August 6, 2025, indicated, R4 received assistance with bathing reminders and cues, dressing reminders and cues, medication administration, house keeping, and laundry. On February 26, 2026, at 9:46 a.m., via email correspondence, licensed assisted living director (LALD)-D provided the surveyor with the following	01910			

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01910	Continued From page 35 documents for R4: - R4's incident report dated August 28, 2025; - R4's discharge summary printed on February 26, 2026; and - R4's Minnesota Adult Abuse Reporting Center report submitted on August 29, 2025. R4's record lacked a medication disposition form. On February 26, 2026, at 11:52 a.m., via email correspondence, LALD-D indicated they did not find a copy of medication disposition form for R4. On February 26, 2026, at 1:42 p.m., clinical nurse supervisor (CNS)-C stated they disposed of R4's medication and they completed the paper disposition form, and they did not know why the disposition form was missing from the record. The licensee's undated Resident Records policy read, "4. Record Retention. Following the resident's discharge or termination of services, an assisted living facility must retain a resident's record for at least five years or as otherwise required by state and federal regulations. Arrangements must be made for secure storage and retrieval of resident records if the facility ceases to operate." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910			



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

Caring Nurses LLC
7601 Regent Avenue North
Brooklyn Park, MN 55443
Hennepin County
Parcel:

Phone:

License Info

License: HFID 33551

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

Inspection Info

Report Number: F1063261044
Inspection Type: Full - Single
Date: 2/24/2026 Time: 12:15 PM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 2
Total Priority 2 Orders: 2
Total Priority 3 Orders: 1
Delivery:

New Order: 2-100 Supervision

2-102.12AMN Priority Level: Priority 3 CFP#: 2

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

COMMENT: REPEAT 2/24/2026

NO CFPM EMPLOYED AT THE ESTABLISHMENT. COMPLY WITH RULE. CFPM CERTIFICATION INFORMATION SENT WITH REPORT.

Comply By: 5/26/2026 Originally Issued On: 2/24/2026

! New Order: 2-200 Employee Health

2-201.11C Priority Level: Priority 1 CFP#: 3

MN Rule 4626.0040C The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority at the specific request of the regulatory authority.

COMMENT: NO EMPLOYEE ILLNESS LOG AVAILABLE DURING INSPECTION. COMPLY WITH RULE. COPY OF ILLNESS LOG SENT WITH REPORT.

Comply By: 2/24/2026 Originally Issued On: 2/24/2026

! New Order: 3-300B Protection from Contamination: cross-contamination, eggs

3-302.11A(1) Priority Level: Priority 1 CFP#: 15

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

COMMENT: RAW SHELL EGGS IN REFRIGERATOR STORED ON TOP SHELF ABOVE GRAPES. DISCUSSED FOOD STORAGE WITH OPERATOR AND EGGS WERE MOVED TO BOTTOM SHELF BELOW READY-TO-EAT FOODS.

Comply By: 2/24/2026 Originally Issued On: 2/24/2026

New Order: 4-300 Equipment Numbers and Capacities

4-302.12A Priority Level: Priority 2 CFP#: 36

MN Rule 4626.0705A Provide a readily accessible food temperature measuring device to ensure attainment and maintenance of food temperatures.

COMMENT: NO FOOD THERMOMETER AVAILABLE. A NEW ONE IS BEING PURCHASED PER STAFF.

Comply By: 3/3/2026 Originally Issued On: 2/24/2026

New Order: 4-300 Equipment Numbers and Capacities

4-302.13B Priority Level: Priority 2 CFP#: 48

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

COMMENT: HOT WATER SANITIZING DISHWASHER IS USED AT THE FACILITY. NO TEST KIT MEETING THE ABOVE REQUIREMENT WAS AVAILABLE. COMPLY WITH RULE.

Comply By: 2/24/2026 Originally Issued On: 2/24/2026

Food & Beverage General Comment

The inspection was completed with the operator and reviewed with MDH Nurse Evaluator Dee Mosissa.

The establishment has a residential kitchen and serves food prepared on the same day.

The establishment has smooth painted walls and ceiling, vinyl tiled floor, solid tile & stainless steel countertops, and wooden cabinetry.

The kitchen has a 2-basin sink. There is also a separate porcelain sink in the kitchen designated for handwashing.

A residential dish machine is used for ware washing. The dish machine should be run on the sanitize/high temperature cycle.

Discussed hand washing, glove use, ware washing, food storage & temperatures, food source, final cook temperatures, cleaning, serving highly susceptible populations, and employee illness policy.

Contact Health Regulation Division for plan review approval when facility/kitchen undergoes remodeling, major equipment additions, or changes of equipment due to a menu change.

If any customer complains of illness, establishment is required to notify the Minnesota Department of Health and provide the foodborne illness hotline phone number to the customer: 1-877-366-3455

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 F1063261044 from 2/24/2026

Joyce Garty
Operator



Laura Yang,
Public Health Sanitarian 1
651-201-3581
laura.yang@state.mn.us



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

Temperature Observations/Recordings

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Establishment Info	Inspection Info
Caring Nurses LLC	Report Number: F1063261044
Brooklyn Park	Inspection Type: Full
County/Group: Hennepin County	Date: 2/24/2026
	Time: 12:15 PM

Food Temperature: **Product/Item/Unit:** Macaroni Salad; **Temperature Process:** Cold-Holding
Location: Refrigerator at 39 Degrees F.
Comment:
Violation Issued?: No



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

Sanitizer Observations/Recordings

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Establishment Info

Inspection Info

Caring Nurses LLC
Brooklyn Park
County/Group: Hennepin County

Report Number: F1063261044
Inspection Type: Full
Date: 2/24/2026
Time: 12:15 PM

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

Physical Environment Inspection Report

ASSISTED LIVING | ASSISTED LIVING WITH DEMENTIA CARE

Project No: SL33551016	Date: 2/24/2026
Facility Name: Caring Hands LLC	
Facility Address: 7601 Regent Ave North Brooklyn Park MN 55444	

☒ TAG IDENTIFICATION: 0775

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Seven (7) days

1. Each assisted living facility must comply with the provisions of the Minnesota State Fire Code (MSFC) in Minnesota Rules chapter 7511. [Minn. Stat. 144G.45 subd. 2]
2. Smoking shall be prohibited where conditions are such as to make smoking a hazard, and in spaces where flammable or combustible materials are stored or handled. [Minn. Stat. 144G.45 subd. 2; MSFC 310.2]

Comments: Surveyor observed evidence of unsafe smoking in multiple locations around the facility.

- Cigarette butts and ash located inside the attached garage.
- Window well outside resident room 3 had discarded cigarette butts.
- Window well in basement common area had discarded cigarette butts.

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

Comments: Cigarettes were discarded on top of cardboard boxes and on the wooden wheelchair ramp inside the garage.

4. Extension cords and flexible cords shall not be a substitute for permanent wiring and shall be listed and labeled in accordance with UL 817. Extension cords and flexible cords shall not be affixed to structures, extended through walls, ceilings or floors, or under doors or floor coverings, nor shall such cords be subject to environmental damage or physical impact. Extension cords shall be used only with portable appliances. Extension cords marked for indoor use shall not be used outdoors. [Minn. Stat. 144G.45 subd. 2; MSFC 604.5]

Comments: It was observed that a refrigerator in the garage was being powered by an extension cord that was attached to the structure with plastic staples.

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Two (2) days

1. Each assisted living facility shall develop and maintain fire safety and evacuation plans that are readily available at all times within the facility. [Minn. Stat. 144G.45 subd.2]

Comments: Surveyor requested the facility's fire safety and evacuation plan (FSEP) at the time of survey. Facility's Manager (FM)-E stated that the plan was not readily available to provide on-site but was able to provide it on a later date. The FSEP shall always be readily available.