Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

May 2, 2025

Licensee
Dream Care Center LLC
3029 Park Avenue
Minneapolis, MN 55407

RE: Project Number(s) SL40107015

Dear Licensee:

This is your **official notice** that you have been **granted your assisted living facility license.** Your license effective and expiration dates remain the same as on your provisional license. Your updated status will be listed on the license certificate at renewal and **this letter serves as proof** in the meantime. If you have not received a letter from us with information regarding renewing your license within 60 days prior to your expiration date, please contact us at (651) 201-5273 or by email at Health.assistedliving@state.mn.us.

The Minnesota Department of Health completed an initial survey on April 2, 2025, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

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

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

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

0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00
0780 - 144g.45 Subd. 2 (a) (1) - Fire Protection And Physical Environment - $500.00

The total amount you are assessed is $1,000.00. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

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

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

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

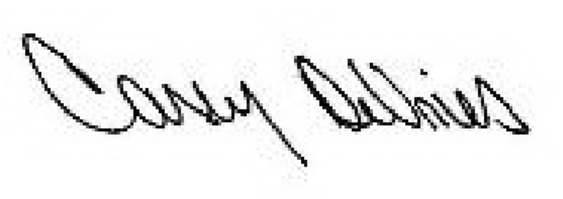
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration or a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms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

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

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

If you have any questions, please contact me.

Sincerely,



Casey DeVries, Supervisor
State Evaluation Team
Email: casey.devries@state.mn.us
Telephone: 651-201-5917 Fax: 1-866-890-9290

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40107	A. BUILDING: _____ B. WING _____	04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DREAM CARE CENTER LLC	3029 PARK AVENUE MINNEAPOLIS, MN 55407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL40107015-0 On March 31, 2025, through April 2, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there was one resident; one receiving services under the Provisional Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470		

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0 470	Continued From page 1 determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a staffing plan for determining its staffing level that included an evaluation completed by the clinical nurse supervisor (CNS) at least twice a year (as indicated in Minnesota Administrative Rule 4659.0180). This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a	0 470		

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0 470	Continued From page 2 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On March 31, 2025, at 9:44 a.m., during a facility tour, the surveyor did not observe a staffing plan posted in any location in the facility. On March 31, 2025, at 10:07 a.m., during the survey entrance conference, licensed assisted living director (LALD)-D stated the licensee's shifts for Monday through Thursday were from 6:00 a.m., until 6:00 p.m., and 6:00 p.m., until 6:00 a.m. LALD-D stated the shifts Friday through Sunday were from 6:00 a.m., until 2:00 p.m., 2:00 p.m., until 10:00 p.m., and 10:00 p.m., until 6:00 a.m., and one unlicensed personnel (ULP) worked per shift. On April 1, 2025, at 11:22 a.m., CNS-C stated the staff schedule posted on the wall was the staffing plan. CNS-C stated they were unaware they were required to create a staffing plan that assessed the needs of the residents and had to be evaluated twice a year. The staffing scheduled lacked a plan for determining staffing levels and lacked evidence the schedule was developed by the CNS. The licensee's Staffing policy dated November 13, 2023, indicated the CNS would prepare and implement a 24-hour daily staffing plan that ensure adequate staffing to meet residents needs	0 470		

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0 470	Continued From page 3 at all times and would be evaluated twice a year. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
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 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	0 480		

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0 480	Continued From page 4 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 and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include:	0 480		

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0 480	Continued From page 5 Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated March 31, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 500 SS=F	144G.41 Subd. 2 Policies and procedures Each assisted living facility must have policies and procedures in place to address the following and keep them current: (1) requirements in section 626.557, reporting of maltreatment of vulnerable adults; (2) conducting and handling background studies on employees; (3) orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; (4) handling complaints regarding staff or services provided by staff; (5) conducting initial evaluations of residents' needs and the providers' ability to provide those services; (6) conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; (7) orientation to and implementation of the assisted living bill of rights; (8) infection control practices; (9) reminders for medications, treatments, or	0 500		

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0 500	Continued From page 6 exercises, if provided; (10) conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; (11) ensuring that nurses and licensed health professionals have current and valid licenses to practice; (12) medication and treatment management; (13) delegation of tasks by registered nurses or licensed health professionals; (14) supervision of registered nurses and licensed health professionals; and (15) supervision of unlicensed personnel performing delegated tasks. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement current policies and procedures as required. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On March 31, 2025, at 8:05 a.m., the surveyor emailed the licensee that an onsite assisted living facility survey would be initiated on March 31, 2025, at approximately 9:30 a.m. The email indicated the licensee's policies and procedures	0 500		

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0 500	Continued From page 7 would need to be available for review. The licensee failed to provide the following policies and procedures during or after the survey process: -conducting and handling background studies on employees. On April 1, 2025, at 12:20 p.m., licensed assisted living director (LALD)-D stated they were aware the licensee was required to have a policy on background studies. LALD-D stated they purchased their policies from a consultant company, and it was an oversight for not having that policy. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 500		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by:	0 510		

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0 510	Continued From page 8 Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program to comply with accepted health care, medical, and nursing standards for infection control. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On March 31, 2025, at 9:44 a.m., the surveyor observed a bathroom with no paper towels. House manager (HM)-B stated it was a communal bathroom for residents, staff, and visitors. On April 1, 2025, 12:13 p.m., clinical nurse supervisor (CNS)-C stated that they were responsible for the infection control practices for the assisted living facility (ALF). CNS-C stated there should be paper towels in the bathroom, and they did not have a reason for there not being paper towels in the bathroom. The Center for Disease Control (CDC) About Hand Hygiene for Patients in Healthcare Settings website dated February 27, 2024, recommended using paper towels to dry hands after hand hygiene. The licensee's Infection Control policy dated November 13, 2023, indicated [licensee] would observe the recommended precautions for	0 510		

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0 510	Continued From page 9 assisted living as identified by the CDC. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post the 911 emergency number in common areas and near telephones provided by the assisted living facility. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic	0 640		

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0 640	Continued From page 10 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On March 31, 2025, at 9:44 a.m., during a facility tour, on a countertop in the kitchen on the main level, the surveyor observed a landline telephone. There was no 911 telephone number posted near the landline telephone. On March 31, 2025, at 9:50 a.m., house manager (HM)-B stated the landline telephone was used by residents. On April 1, 2025, at 12:24 p.m., licensed assisted living director (LALD)-D stated they were aware the 911 posting was required to be posted by the landline telephone. LALD-D stated it was an oversight for not posting that information. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees,	0 660		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 660	Continued From page 11 contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included baseline testing and screening within 90 days of hire for one of three employees (house manager (HM)-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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: HM-B was hired on February 12, 2024, as house manager and to provide direct care services to residents. HM-B's employee record lacked a TB history and symptom screening tool completed upon hire. On April 1, 2025, at 11:52 a.m., clinical nurse supervisor (CNS)-C stated all employees were screened for TB and a copy should be kept in the	0 660		

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0 660	Continued From page 12 employee file. CNS-C stated they were unsure why HM-B's TB screening was missing. The licensee's Tuberculosis Screening/Prevention policy dated November 13, 2023, indicated baseline screening was required for all health care workers at the time of hire. The Minnesota Department of Health Tuberculosis Prevention and Control Program dated July 2013 recommended a TB screening was required for all healthcare workers, which consisted of assessment for current symptoms of active TB disease, assessing TB history, testing for the presence of infection Mycobacterium tuberculosis by administered either a two-step tuberculosis skin test (TST), or single interferon gamma release assay (a blood test to determine if a person has been infected with TB). The Center for Disease Control (CDC) Clinical Testing Guidance for Tuberculosis: Health Care Personnel dated May 17, 2019, recommended all United States health care personnel should have a completed a TB risk assessment, symptom evaluation, TB testing for tuberculosis, with additional working for TB disease with a positive test results or symptoms compatible with TB disease. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following	0 680		

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0 680	Continued From page 13 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: Based on interview and record review, the licensee failed to maintain a written emergency preparedness (EP) plan with all the required content as defined in the Centers for Medicare and Medicaid Services (CMS) Appendix Z. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	0 680		

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0 680	Continued From page 14 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: The licensee's emergency disaster preparedness plan dated September 2024, lacked evidence of the following required content: - policies and procedures for medical documents; - policies and procedures for volunteers; - names/contact information for staff, entities providing services under agreement, residents physicians, other facilities, and volunteers; - methods for sharing information, and; - long-term care (LTC) family notifications. On April 1, 2025, at 12:25 p.m., licensed assisted living director (LALD)-D stated they were responsible for the EP plan for the facility. LALD-D stated they were new to the facility and were hired on December 23, 2024. LALD-D stated they had not been able to review the EP plan and was unsure what content was missing. The licensee's Emergency Preparedness policy dated November 13, 2024, indicated licensee would have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		

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0 780	Continued From page 15	0 780		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that were interconnected so that the actuation of one alarm caused all alarms in the dwelling unit to actuate. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 780		

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0 780	Continued From page 16 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On a facility tour on April 1, 2025, from 10:30 a.m. to 1:30 p.m., with licensed assisted living director (LALD)-D. Surveyor observed hard-wired smoke alarm in bedroom 2 and in the 2nd floor hallway was not interconnected with hard-wired alarms throughout the facility. Smoke alarms were not interconnected so activation of one alarm activates all alarms throughout the facility During a facility tour on April 1, 2025, at 12:30 p.m., LALD-D, verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Two (2) days	0 780		
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	0 810		

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0 810	Continued From page 17 emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 810		

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0 810	Continued From page 18 The findings include: On March 18, 2025, licensed assisted living director (LALD)-D provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP, titled "Fire Policy", 2022, failed to include the following: STAFF ACTIONS: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate) but the plan was designed for a building with life safety systems such as fire doors and smoke compartments. RESIDENT ACTIONS: The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. On April 1, 2025, at 12:30 p.m., LALD-D stated they understood the areas of their policy that were incomplete and would work on bringing them into compliance. The policy reviewed was an unedited policy purchased from a third-party provider that was not specific to the facility. UNIQUE AND UNUSUAL RESIDENT NEEDS: The facility uses an electronic care plan website for standard resident evacuation procedures. The	0 810		

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0 810	Continued From page 19 FSEP does not include instructions on how to use or what do in the loss of power/internet event for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. TRAINING: The licensee failed to provide evacuation training to residents at least once per year. LALD-D lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan. The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. Staff does only web-based training at the time of hire, LALD-D stated they keep only electronic records of training. No other training documentation was provided. On April 1, 2025, at 12:30 p.m., LALD-D stated they understood the requirements for training residents and staff and would implement a training program that was compliant with statute requirements. DRILLS: The licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. Record review of licensee's evacuation drill logs, showed drills conducted on 1/24, 3/24, 6/24, 8/24, 10/24 and 12/24. No other documentation was provided. On April 1, 2025, at 12:30 p.m., LALD-D stated there were no additional documented drills for the facility and would document fire drills that are compliant with statute requirements.	0 810		

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0 810	Continued From page 20 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01370 SS=E	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries	01370		

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01370	Continued From page 21 between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency evaluations were completed for all required skill areas, prior to providing services, for two of three employees (unlicensed personnel (ULP)-A, ULP-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-A ULP-A was hired on October 2, 2024, to provide direct care services. ULP-A's employee record lacked evidence for the following: Training: - documentation requirements for all services provided. Demonstration of Competency:	01370		

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01370	Continued From page 22 - standby assistance techniques and how to perform them. ULP-E ULP-E was hired on February 17, 2025, to provide direct care services. ULP-E's employee record lacked evidence of the following: Training: - documentation requirements for all services provided; - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; and - awareness of commonly used health technology equipment and assistive devices. On April 1, 2025, at 12:01 p.m., clinical nurse supervisor (CNS)-C stated they were responsible for staff training. CNS-C stated staff were required to complete the training and competencies before performing cares independently. CNS-C stated they were unsure if the documentation was mis-placed. The licensee's Staff Competency policy dated April 10, 2023, indicated residents would receive quality services delivered by staff who were educated and competent in the delivery of assisted living services. The policy indicated the CNS was responsible for assessment competency throughout the orientation process. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		

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01380	Continued From page 23	01380		
01380 SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency evaluations were completed for all required skill areas, prior to providing services, for one of three employees (unlicensed personnel (ULP)-A). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).	01380		

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01380	Continued From page 24 The findings include: ULP-A was hired on October 2, 2024, to provide direct care services. ULP-A's employee record lack evidence of the following: Training: - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel. Demonstration of Competency: - blood glucose (checking sugar level), and; - continuous positive airway pressure (CPAP) (a machine that maintains a constant stream of oxygen while sleeping). On April 1, 2025, at 8:40 a.m., ULP-A stated they remembered being shown by the clinical nurse supervisor (CNS)-C how to perform the blood glucose checks. On April 1, 2025, at 12:01 p.m., CNS-C stated they were responsible for staff training. CNS-C stated staff were required to complete the training and competencies before performing cares independently. CNS-C stated they were unsure if the documentation was mis-placed. The licensee's Staff Competency policy dated April 10, 2023, indicated residents would receive quality services delivered by staff who were educated and competent in the delivery of assisted living services. The policy indicated the CNS was responsible for assessment competency throughout the orientation process. No further information was provided.	01380		

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01380	Continued From page 25 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
01420 SS=E	144G.62 Subd. 2 Delegation of assisted living services (b) When the registered nurse or licensed health professional delegates tasks to unlicensed personnel, that person must ensure that prior to the delegation the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each resident and is able to demonstrate the ability to competently follow the procedures and perform the tasks. If the unlicensed personnel has not regularly performed the delegated assisted living task for a period of 24 consecutive months, the unlicensed personnel must demonstrate competency in the task to the registered nurse or appropriate licensed health professional. The registered nurse or licensed health professional must document instructions for the delegated tasks in the resident's record. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted training and competency evaluations for two of three unlicensed personnel (ULP)-A, ULP-E) who performed delegated tasks. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a	01420		

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	40107	A. BUILDING: _____ B. WING _____	04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DREAM CARE CENTER LLC	3029 PARK AVENUE MINNEAPOLIS, MN 55407

(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
01420	Continued From page 26 limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 was admitted to the facility January 20, 2025, and began receiving assisted living services. R1's Signed Service plan dated July 29, 2024, indicated R1 received assistance with continuous positive airway pressure (CPAP) (a machine that maintains a constant stream of oxygen while sleeping). R1's medical record contained a document titled, "[licensee] Provider Contract [R1]" dated August 19, 2024. The signed document by a medical provider indicated R1 should receive CPAP. The instructions were to assist R1 with setup, wash, add distilled water, turn on and place CPAP on at bedtime, assist R1 to take off CPAP in the morning. R1's Treatment Administration Record dated March 1, 2025, through March 31, 2025, indicated ULP-A had assisted R1 with the CPAP 62 times. ULP-A ULP-A was hired on October 2, 2024, to provide direct care services. On April 1, 2025, at 8:40 a.m., ULP-A stated the RN did not provide them with training on the CPAP machine. ULP-A's personnel record lacked a training and skill competency for performing CPAP	01420		

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01420	Continued From page 27 administration and maintenance. ULP-E ULP-E was hired on February 17, 2025, to provide direct care services. ULP-E's personnel record lacked a training and skill competency for performing CPAP administration and maintenance. On April 1, 2025, at 11:56 a.m., and 12:01 p.m., clinical nurse supervisor (CNS)-C stated they trained staff on the CPAP machine. CNS-C stated they were responsible for training staff. CNS-C stated staff were required to complete the training and competencies before performing cares independently. CNS-C stated they were unsure if the documentation was mis-placed. The licensee's Delegation of Assisted Living Tasks policy dated November 13, 2023, indicated the registered nurse or licensed health professional was responsible for appropriately delegating tasks to staff who were competent and possess the knowledge and skills consistent with the complexity of the tasks. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01420		
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living	01440		

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01440	Continued From page 28 facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN) conducted direct supervision of staff performing a delegated task within 30 days of providing services for one of three unlicensed personnel ((ULP)-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	01440		

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01440	Continued From page 29 ULP-E was hired on February 17, 2025, to provide direct care services. ULP-E's employee record lacked record of 30-day supervision. On April 1, 2025, at 11:56 a.m., and 12:01 p.m., clinical nurse supervisor (CNS)-C stated they were responsible for training staff. CNS-C stated they would observe staff perform the cares then document staff were competent. CNS-C stated they used a template provided by the licensed assisted living director to document the 30-day supervision for the demonstration of competency. CNS-C stated they were not aware of all the requirements to go back for the 30-day supervision. The licensee's Supervision: Unlicensed Staff policy dated November 13, 2023, indicated direct supervision of home health aides performing delegated tasks will be provided within 30 days after the individual begins working for the assisted living provider. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		
01500 SS=D	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		

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01500	Continued From page 30 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 31 (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: Based on interview and record review, the licensee failed to ensure an employee received at least eight hours of annual training for each 12 months of employment for one of three employees (house manager (HM-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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: HM-B was hired on February 12, 2024, as house manager and to provide direct care services. HM-B's employee record lacked the following training: - reporting maltreatment of vulnerable adults or minors; - assisted living bill of rights; - infection control techniques;	01500		

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01500	Continued From page 32 - 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's policies and procedures; - principles of person-centered planning/service delivery, and; - two hours of dementia training. On April 1, 2025, at 12:12 p.m. clinical nurse supervisor (CNS)-C stated the licensee used Educare (a software training program) for the annual training. CNS-C stated the licensed assisted living director (LALD) was in charge of assigning the Educare training. On April 1, 2025, at 12:33 p.m., LALD-D stated the licensee used Educare for the annual training. LALD-C stated they were aware of the annual training requirements by staff in a "broad sense." LALD-D stated they were unsure why the required training was missing. The licensee's Staff Orientation and Education policy dated November 13, 2023, indicated staff would receive at least eight hours of annual training. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
01530 SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements:	01530		

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01530	Continued From page 33 (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care 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 employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure direct-care staff received at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date for two of three employees (unlicensed personnel (ULP)-A, house manager (HM)-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	01530		

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01530	Continued From page 34 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-A ULP-A was hired on October 2, 2024, to provide direct care services. ULP-A's Employee Timesheet indicated from February 2, 2025, through March 3, 31, 2025, ULP-A had worked 384 hours. ULP-A's employee file contained an Educare (a software training program) transcript that indicated ULP-A had completed six hours of dementia training. ULP-A's employee file lacked the reaming two hours of dementia training. HM-B HM-B was hired on February 12, 2024, as house manager and to provide direct care services. HM-B's Employee Timesheet indicated from February 3, 2025, through March 30, 2025, HM-B had worked 320 hours. HM-B's employee file contained an Educare transcript that indicated HM-B had completed five hours of dementia training. HM-B's employee file lacked the reaming three hours of dementia training. On April 1, 2025, at 12:39 p.m., licensed assisted living director (LALD)-D stated they were responsible for ensuring the required training was completed for staff. LALD-D stated they were unsure how many hours each staff member was	01530		

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01530	Continued From page 35 required to have related to dementia care training. The licensee's Dementia Education dated November 13, 2023, indicated direct care employees were required to have eight hours of dementia care training with 160 hours of employment start date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01700 SS=F	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to	01700		

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01700	Continued From page 36 manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on observation, interview, and record view, the licensee failed to assess and review medication indications, side effects, contraindications, and allergic or adverse reactions for one of one resident (R1) who exhibited side effects from an antipsychotic medication. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 was admitted to the facility January 20, 2025, and began receiving assisted living services. R1's diagnoses included schizoaffective disorder (a condition where a person experiences hallucinations, delusions, and disorganized thinking, combined with a mood disorder), antisocial personality disorder, hyperlipidemia (high cholesterol), hypertension (high blood pressure), poor urinary stream (slow urine drainage), insomnia (trouble sleeping), myalgia (general pain), inflammatory polyarthropathy	01700		

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01700	Continued From page 37 (inflammation of multiple joints), gastrointestinal (GI) hemorrhage (a bleed in the GI tract), iron deficiency anemia (low iron in the blood), Type 2 diabetes (a condition where the body has problems regulating blood sugar), obstructive sleep apnea (airway is blocked that causes brief pauses in breathing during sleep), localized edema (swelling), extrapyramidal and movement disorder (known as medication induced movement disordered caused by antipsychotic medications which causes conditions such as dystonia which was involuntary muscle contractions and tardive dyskinesia (TD) which was involuntary, repetitive movements often involving the face and tongue, and osteoarthritis. R1's Signed Service plan dated July 29, 2024, indicated R1 received assistance with medication administration. R1's medication administration record indicated R1 received the following antipsychotic medication: risperidone 50 milligram (mg)/2 milliliters (ml) every 14 days. On March 31, 2025, at 10:04 a.m., during an interview with R1, the surveyor observed R1's mouth moving in a circular pattern, opening and closing between spoken sentences several times, observed R1's tongue push out and move in between R1's lips from one side to the other side several times, and observed R1's head move back and forth several times. The surveyor observed R1's movements appeared to be involuntary. R1's Assessment dated March 25, 2025, in the physical section for musculoskeletal read, "denies active musculoskeletal issues." In the neurological assessment it read, "denies active	01700		

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01700	Continued From page 38 neurological issues." In the speech section the assessment read, "no language barrier." R1's record lacked evidence the registered nurse (RN) had assessed for the side effects of the antipsychotic medications that the licensee was administering to R1. On March 31, 2025, at 2:29 p.m., and April 1, 2025, at 11:15 a.m., clinical nurse supervisor (CNS)-C stated R1 received the risperidone every two weeks. CNS-C stated as part of the assessment for R1, they would assess how R1 was doing and compare that assessment to R1's normal baseline. CNS-C stated they had not observed the dyskinetic movements when talking with R1. CNS-C stated they discussed the side effects with R1 and would only document in R1's assessment if they observed the TD movements. CNS-C stated their assessment of R1 should have noted the nurse assessed R1 for the TD side effects. CNS-C stated they were unsure if the licensee had a policy related to antipsychotic medications. CNS-C stated a nurse charting standard was if it was not documented, it was not done. The Food and Drug Administration (FDA) Highlights of Prescribing Information for Risperdal dated July 2009, included tardive dyskinesia in the warning and precautions section and indicated TD is a syndrome of potentially irreversible, involuntary, dyskinetic movements. The document indicated due to risk of TD, the need for continued treatment should be reassessed periodically. The licensee's Assessment of Medications dated November 13, 2023, policy indicated the registered nurse (RN) would assess the following, indication for medications, effectiveness, side	01700		

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01700	Continued From page 39 effects, immediate desired effects, unusual and expected effects, actual or potential drug interactions, duplicate drug therapy, non-adherence with drug therapy, drug therapy currently associated with laboratory monitoring, allergic reactions, changes in condition that contraindicate continued administration of the medication, any difficulties with taking the medication, and residents preferences. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700		

Minnesota Department of Health

625 Robert Street North
St Paul
651-201-4500

Type: Full
Date: *03/31/25*
Time: 12:25:00
Report: 7994251090

Food and Beverage Establishment Inspection Report

Location:
DREAM CARE CENTER LLC
3029 PARK AVENUE
Minneapolis, MN55407
Hennepin County, 27

Establishment Info:
ID #: 0044101
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/25

Operator:

Phone #:
ID #:

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

The following orders were issued during this inspection.

4-200 Equipment Design and Construction

4-201.11GMN

MN Rule 4626.0506G Discontinue serving TCS foods that are held for more than same-day service in an adult or child care center or boarding establishment or provide equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

CURRENTLY FACILITY HOLDS FOODS OVER OCCASIONALLY. SPOKE WITH MANAGER ABOUT THE NEED TO ONLY DO SAME DAY SERVICE OF FOODS.

Comply By: 03/31/25

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

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

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

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

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

Type: Full
Date: *03/31/25*
Time: 12:25:00
Report: 7994251090
DREAM CARE CENTER LLC

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 7994251090 of 03/31/25.

Certified Food Protection Manager: Mohamud M Abdi

Certification Number: 114515 Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed: _____
Mohamud M Abdi

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