Electronically Delivered

September 15, 2025

Licensee
Totalcare Assisted Living Services
2730 Winnetka Avenue North
New Hope, MN 55428

RE: Project Number(s) SL25459016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 30, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

STATE CORRECTION ORDERS

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

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 - 0780 - 144g.45 Subd. 2 (a) (1) - 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

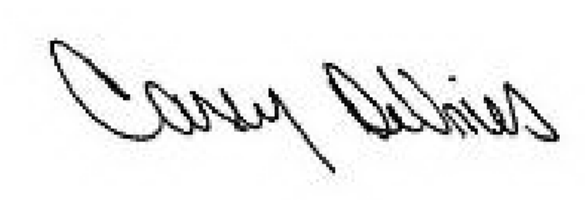
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25459	A. BUILDING: _____ B. WING _____	07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOTALCARE ASSISTED LIVING SERVICES	2730 WINNETKA AVENUE NORTH NEW HOPE, MN 55428

(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: SL25459016-0 On July 28, 2025, through July 30, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were nine residents; nine receiving services under the 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 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		

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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		

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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 had the potential to affect all residents of the assisted living facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated July 28, 2025, for the specific Minnesota Food Code deficiencies. The Inspection Report was provided to the licensee on July 28, 2025. TIME PERIOD FOR CORRECTION: Please refer	0 480		

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0 480	Continued From page 3 to the FBEIR for any compliance dates.	0 480		
0 550 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 information directing individuals to the Office of Health Facility Complaints (OHFC) at the Minnesota Department of Health (MDH) if they had complaints about the facility or person providing services. 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	0 550		

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0 550	Continued From page 4 of the residents). The findings include: On July 28, 2025, at 10:29 a.m., during the facility tour with administrator (A)-E, the surveyor observed the licensee's grievance posting lacked information directing individuals to the OHFC if they had complaints about the facility or person providing services. The surveyor inquired if the OHFC information was posted anywhere else in the facility, A-E stated no. A-E stated they thought the posting they had covered all of the required information; they were not familiar with OHFC. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision.	0 660		

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0 660	Continued From page 5 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to update their tuberculosis (TB) facility risk assessment annually. 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: The licensee's TB risk assessment was completed on July 25, 2024. On July 29, 2025, at 12:23 p.m., licensed assisted living director (LALD)-D stated clinical nurse supervisor (CNS)-A must have just missed updating the TB risk assessment. LALD-D stated CNS-A was currently working on it and would bring it to the surveyor soon. On July 29, 2025, at 12:30 p.m., CNS-A provided an updated TB risk assessment completed on July 29, 2025, during the survey. CNS-A stated they must have overlooked updating the TB risk assessment. The Minnesota Department of Health TB FAQ, last updated on July 1, 2025, indicated, "Each provider licensed by MDH is required to complete a TB risk assessment annually. Completion of	0 660		

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0 660	Continued From page 6 this assessment will assist providers in the development of an infection control committee and in determining the frequency of screening." The licensee's Tuberculosis Screening/Prevention policy dated January 1, 2025, indicated, "The Administrator is responsible for conducting the formal TB Risk Assessment and updating it annually." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are	0 680		

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0 680	Continued From page 7 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 develop a written emergency preparedness plan (EPP) with all the required content for staff, residents, and visitors to view. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On July 29, 2025, at 11:14 a.m., the surveyor reviewed the licensee's Emergency Preparedness Manual. The EPP lacked the following: -arrangements/contracts to re-establish utility services; -missing resident policy review every three months; -include a process for cooperation and collaboration with local, tribal, regional, State and Federal EP to maintain integrated response; -includes policies/procedures (P/P) for at minimum food, water, and pharmaceutical supplies. -address role of facility under a waiver declared by the Secretary in accordance with section 1135	0 680		

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0 680	Continued From page 8 of the Act; -develop P/P to address: system of medical documentation that preserves resident information, protects confidentiality, and secures/maintains availability of records; -communication plan must include contact information for the following: -federal, state, tribal, regional & local EP staff -state licensing and certification agency -MN Office of Ombudsman for Long Term Care; -method for sharing information and medical documentation for residents under the facility's care, as necessary, with other health care providers to maintain continuity of care; -means, in event of evacuation, to release resident information as permitted under 45 CFR 164.510(b)(1)(ii) -means of providing information about general condition/ location of residents under the facility's care as permitted under 45 CFR 164.510(b)(4) -training program must include all of the following: -initial training in EP P/P to all new and existing staff, individuals providing services under arrangement, and volunteers consistent with their expected role -provide EP training at least annually -maintain documentation of all EP training -demonstrate staff knowledge of EP; and On July 29, 2025, at 11:35 a.m., the surveyor reviewed the missing information for the licensee's EPP with licensed assisted living director (LALD)-D and administrator (A)-E. LALD-D stated they would send the surveyor the missing information as they had not added it to their EPP binder. On July 29, 2025, at 11:42 a.m., via email, LALD-D sent additional EPP documents, the	0 680		

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0 680	Continued From page 9 email indicated, "Just FYI- I attached a few of the documents from updated plan from other locations, was not in the book. Has now been printed and updated New Hope "red book" thanks Hopely, we will not have too many holes in the plan." The licensee's Emergency Preparedness policy, undated, indicated, "There have been an unprecedented number of emergencies in the United States in the past few years. Tornadoes, hurricanes, wildfires, chemical spills, active shooters, earthquakes and flooding have all impacted community-based care. Private homes and assisted living facilities have had to evacuate quickly. Some neighborhoods have become inaccessible for caregivers to enter. Through all these experiences, health care providers have learned the importance of being adequately prepared. All staff must be equipped to make decisions on patient safety and know the agency's procedure in managing patient care during an emergency." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 775 SS=E	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee	0 775		

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0 775	Continued From page 10 failed to maintain facility in compliance with Minnesota State Fire Code under Minnesota Rules Chapter 7511. This had the potential to affect some 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On July 30, 2025, from approximately 11:20 a.m. to 1:15 p.m., the surveyor toured the facility with maintenance (M)-F, the surveyor observed the following: Both closets along the living room in resident room 6 were packed full of stored items and clothing, which were stacked up to or above sprinkler heads. The stored materials will likely obstruct the sprinkler heads and may limit function during an activation, and/or accidentally damage the bulb of the sprinkler and cause unwanted activation. Sprinkler heads should be maintained free of obstruction with proper clearance. The unit door to resident room 7 did not have a functional self-closer to pull the door shut automatically. Self-closers should be maintained in functional working order to ensure proper containment of smoke during a fire emergency. Resident room 7 had multiplug adapters in use,	0 775		

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0 775	Continued From page 11 which were not properly rated for continuous use and may pose risk of fire hazard. No carbon monoxide alarm was provided in resident room 9. M-F indicated that the carbon monoxide alarm was removed by the resident, but that it would be replaced. M-F acknowledged the noted deficiencies during the tour and later licensed assisted living director (LALD)-D also acknowledged the noted deficiencies during survey and expressed that they would correct the deficiencies. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) 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	0 780		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25459	A. BUILDING: _____ B. WING _____	07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOTALCARE ASSISTED LIVING SE	2730 WINNETKA AVENUE NORTH NEW HOPE, MN 55428

(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
0 780	Continued From page 12 (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 interconnected smoke alarms throughout the facility. 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). The findings include: On July 30, 2025, from approximately 11:20 a.m. to 1:15 p.m., the surveyor toured the facility with maintenance (M)-F, the surveyor observed the following: Occupied Sleeping Rooms: Resident room 5 was missing smoke alarms from bedroom and hallway near the bathroom. Hardwired smoke alarm mounts were present without corresponding alarms. M-F replaced one of the alarms during the tour. Smoke alarms	0 780		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25459	A. BUILDING: _____ B. WING _____	07/30/2025

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TOTALCARE ASSISTED LIVING SE	2730 WINNETKA AVENUE NORTH NEW HOPE, MN 55428

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0 780	Continued From page 13 should be maintained and operable. The smoke alarm in the bedroom of resident room 7 was not interconnected such that its activation sets off the other smoke alarms in the unit. The smoke alarm in the bedroom hallway near the bathroom was not functional when tested.The interconnection of the alarms should be maintained, and alarms should be maintained in proper working order. A smoke alarm was missing from a hardwired smoke alarm mount in the bedroom in resident room 8. Smoke alarms should be maintained and present where required and power supply should be maintained. A smoke alarm was missing from a hardwired smoke alarm mount in the bedroom in resident room 9. Smoke alarms should be maintained and present where required and power supply should be maintained. Unoccupied Sleeping Rooms: All smoke alarms were missing from resident room 3. Hardwired smoke alarm mounts were present without corresponding alarms. Smoke alarms should be maintained present and in proper working order. All smoke alarms were missing from resident room 11. Hardwired smoke alarm mounts were present without corresponding alarms. Smoke alarms should be maintained present and in proper working order. During the facility tour interview on July 30, 2025, M-F verified the above listed fire protection and physical environment observations while	0 780		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25459	A. BUILDING: _____ B. WING _____	07/30/2025

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TOTALCARE ASSISTED LIVING SE	2730 WINNETKA AVENUE NORTH NEW HOPE, MN 55428

(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
0 780	Continued From page 14 accompanying on the tour. Later during survey, licensed assisted living director (LALD)-D also acknowledged the noted deficiencies and expressed that they would correct the deficiencies. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 800 SS=E	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. 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 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	0 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25459	A. BUILDING: _____ B. WING _____	07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOTALCARE ASSISTED LIVING SE	2730 WINNETKA AVENUE NORTH NEW HOPE, MN 55428

(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
0 800	Continued From page 15 occurred repeatedly; but is not found to be pervasive). The findings include: On July 30, 2025, from approximately 11:20 a.m. to 1:15 p.m., the surveyor toured the facility with maintenance (M)-F, the surveyor observed the following: An outlet in resident room 3 has a broken and cracked outlet cover. The outlet cover should be replaced and maintained. The bathroom walls in resident room 3 are damaged with chipping and peeling paint and holes present. Walls should be maintained in proper and sanitary condition. The bathroom walls and ceiling in resident room 4 were discolored and damaged. Walls should be maintained in proper and sanitary condition. The bathroom walls in resident room 5 are damaged with chipping and peeling paint. Walls should be maintained in proper and sanitary condition. An outlet in the hallway near resident room 9 has a broken and cracked outlet cover. The outlet cover should be replaced and maintained. M-F acknowledged the noted deficiencies during the tour and later licensed assisted living director (LALD)-D also acknowledged the noted deficiencies during survey and expressed that they would correct the deficiencies. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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TOTALCARE ASSISTED LIVING SE	2730 WINNETKA AVENUE NORTH NEW HOPE, MN 55428

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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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	0 810		

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	25459	A. BUILDING: _____ B. WING _____	07/30/2025

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0 810	Continued From page 17 review, the licensee failed to develop the fire safety and evacuation plan with required content. 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). The findings include: On July 30, 2025, at approximately 12:40 p.m., 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. The licensee FSEP failed to include the following: The FSEP failed to identify specific fire protection actions for residents. There was no section in the provided documents that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency Record review indicated that the licensee failed to provide and document adequate training with residents on the FSEP. Residents should be offered training on proper actions during an evacuation at least once per year. No records of resident training were provided. During an interview on July 30, 2025, at	0 810		

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0 810	Continued From page 18 approximately 1:00 p.m., the surveyor explained the requirements for resident trainings, and FSEP documentation. LALD-D stated they understood the requirements. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 950 SS=F	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated	0 950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 950	Continued From page 19 representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have residents elect or decline a designated representative for one of one resident (R2). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R2 was admitted to the licensee on August 1, 2022. R2's Service Plan dated September 10, 2023, indicated R2 received medication administration services and blood glucose (BG) management. On July 29, 2025, at 10:16 a.m., via email, licensed assisted living director (LALD)-D provided R2's designated representative form which was blank. On July 29, 2025, at 10:33 a.m., LALD-D stated they would look to see if they had a completed designated representative form for R2. LALD-D stated they didn't think the form needed to be completed if the resident did not have a designated representative. On July 29, 2025, at 10:58 a.m., LALD-D	0 950		

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	25459	A. BUILDING: _____ B. WING _____	07/30/2025

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0 950	Continued From page 20 provided a designated representative form for R2 completed on July 29, 2025, with a designated representative elected. LALD-D stated most of their residents did not have designated representatives and did not have the form completed. LALD-D stated R2's designated representative form was completed today (July 29, 2025) during the survey; they stated none of their residents had a completed form and they would have the rest of their residents complete one. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 950		
02320 SS=F	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure unlicensed personnel (ULP), under the direction of the registered nurse (RN), followed appropriate insulin administration procedures for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or	02320		

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02320	Continued From page 21 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: R2 was admitted to the licensee on August 1, 2022. R2's Service Plan dated September 10, 2023, indicated R2 received medication administration services and blood glucose (BG) management. R2's Medication Administration Summary (medication administration record (MAR)) for July 2025, indicated R2 was administered Novolog insulin on July 1-6, 8-25, 27-29, 2025. On July 28, 2025, at 12:16 p.m., the surveyor observed ULP-B check R2's blood glucose (BG) level with a result of 181. R2's MAR indicated ULP-B was to administer 4 units (u) of insulin per R2's Novolog sliding scale. ULP-B applied a needle to R2's Novolog insulin pen and dialed it to 4u, they then prepared R2's injection site with an alcohol wipe. Without priming the insulin pen, ULP-B reached out to hand the Novolog insulin pen to R2 for self-administration; the surveyor stopped ULP-B and inquired if ULP-B had primed the insulin pen with 2u of insulin. ULP-B stated they did not know what the surveyor meant by priming the insulin pen. The surveyor explained an insulin pen should be primed with 2u of insulin to remove the air in the needle to ensure the full dose of insulin was administered. ULP-B again did not prime the insulin pen and handed it to R2	02320		

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02320	Continued From page 22 to self-administer the Novolog insulin; R2 self-administered the insulin. On July 28, 2025, at 12:27 p.m., clinical nurse supervisor (CNS)-A stated they did not teach ULPs to prime insulin pens. CNS-A stated they were told by the pharmacy priming insulin pens wastes insulin which was expensive. CNS-A stated they completely understood why an insulin pen should be primed and was only doing it based off of the guidance of the pharmacist. CNS-A stated, going forward, they would educate their staff to prime insulin pens after they applied a new needle. The manufacturer instructions for the Novolog FlexPen, revised in February 2023, indicated: "Giving the air-shot before each injection Before each injection small amounts of air may collect in the cartridge during normal use. To avoid injecting air and to ensure proper dosing: E. Turn the dose selector to select 2 units (see diagram E). F. Hold your NovoLog® FlexPen® with the needle pointing up. Tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge (see diagram F). G. Keep the needle pointing upwards, press the push-button all the way in (see diagram G). The dose selector returns to 0. A drop of insulin should appear at the needle tip. If not, change the needle and repeat the procedure no more than 6 times." The licensee's Medication & Treatments policy dated January 1, 2025, in reference to insulin administration, indicated, "9. Prime the pen by dispensing/wasting 2 units before administration of prescribed units."	02320		

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02320	Continued From page 23 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		

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

Food & Beverage Inspection Report

Establishment Info

Totalcare Assisted Living
2730 Winnetka Ave N
New Hope, MN 55428
Hennepin County
Parcel:

Phone:

License Info

License: HFID 25459

Risk:
License:
Expires on:
CFPM: Andrew Anyaogu
CFPM #: 118379; Exp: 08/03/2026

Inspection Info

Report Number: F7963251030
Inspection Type: Full - Single
Date: 7/28/2025 Time: 12:50:55 PM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 1
Total Priority 2 Orders: 1
Total Priority 3 Orders: 0
Delivery: Emailed

! New Order: 3-500B Microbial Control: hot and cold holding
3-501.16A2 *Priority Level: Priority 1 CFP#: 22*
MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.
COMMENT: MULTIPLE TCS FOOD ITEMS FOUND ABOVE 41 DEG F (SEE TEMPERATURE LOG). REPAIR/ADJUST REFRIGERATOR SO IT MAINTAINS FOODS AT 41 DEG F OR COLDER.
Comply By: 7/28/2025 Originally Issued On: 7/28/2025

New Order: 4-300 Equipment Numbers and Capacities
4-302.12B *Priority Level: Priority 2 CFP#: 36*
MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.
COMMENT: ESTABLISHMENT DOES NOT HAVE A FOOD THERMOMETER. OBTAIN A THIN PROBE THERMOMETER FOR TAKING FOOD TEMPERATURES.
Comply By: 7/28/2025 Originally Issued On: 7/28/2025

Food & Beverage General Comment

MET WITH ANDREW ANYAOGU. DISCUSSED THE FOLLOWING-

-EMPLOYEE ILLNESS POLICY AND LOG
-VOMIT/FECAL CLEAN-UP
-REPORTABLE DISEASES
-HIGHLY SUSCEPTIBLE POPULATION RESTRICTIONS
-DISHWASHER TESTING
-FOOD THERMOMETERS
-COOKING OF RAW PROTEINS

THIS IS AN APARTMENT BUILDING. IT USES A LOWER UNIT AS KITCHEN/DINING ROOM AND IS FURNISHED WITH RESIDENTIAL STOVE, REFRIGERATOR, DISHWASHER, ETC.
THE FACILITY HAS TEXTURED CEILINGS, PAINTED WALLS, CERAMIC TILE FLOOR, WOOD PAINTED CABINETS AND LAMINATE COUNTERTOPS.

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 F7963251030 from 7/28/2025

Andrew Anyaogu
PIC

Peggy Spadafore,
Public Health Sanitarian Supervisor
651-201-3979
peggy.spadafore@state.mn.us

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

Temperature Observations/Recordings

Establishment Info

Totalcare Assisted Living
New Hope
County/Group: Hennepin County

Inspection Info

Report Number: F7963251030
Inspection Type: Full
Date: 7/28/2025
Time: 12:50:55 PM

Food Temperature: Product/Item/Unit: MILK**; Temperature Process:**
Location: REFRIGERATOR at 46 Degrees F.
Comment:
Violation Issued?: Yes

Food Temperature: Product/Item/Unit: SOUR CREAM**; Temperature Process:**
Location: REFRIGERATOR at 43 Degrees F.
Comment:
Violation Issued?: Yes

Food Temperature: Product/Item/Unit: LUNCH MEAT**; Temperature Process:**
Location: REFRIGERATOR DRAWER at 41 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: MILK**; Temperature Process:**
Location: STOREROOM REFRIGERATOR at 38 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

Establishment Info

Totalcare Assisted Living
New Hope
County/Group: Hennepin County

Inspection Info

Report Number: F7963251030
Inspection Type: Full
Date: 7/28/2025
Time: 12:50:55 PM

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

Minnesota (MDH) Version
EH Manager; RPT: F7963251030

Food Establishment Inspection Report

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

No. of Risk Factor/Intervention/Violations	1	Date: 7/28/2025
No. of Repeat Risk Factor/Intervention/Violations		Time: 12:50:55 PM
Score (optional)		Dur: min

Establishment:	Address:	City/State:	Zip:	Phone:
Totalcare Assisted Living	2730 Winnetka Ave N	New Hope, MN	55428	
License/Permit #:	**Permit Holder:**	**Purpose of Inspection:**	**Est. Type:**	**Risk Category:**
HFID 25459		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Designated compliance status (IN, OUT, N/O, N/A) for each numbered item

IN=in compliance **OUT**=not in compliance **N/O**=not observed **N/A**=not applicable

Mark "X" in appropriate box for COS and/or R

COS=corrected on-site during inspection **R**=repeat violation

	Compliance Status		COS	R
	Supervision			
1	IN	Person in charge present, demonstrate knowledge and performs duties		
2	IN	Certified Food Protection Manager		
	Employee Health			
3	IN	knowledge, responsibiities, and reporting		
4	IN	Proper use of restriction and exclusion		
5	IN	Response to vomiting, diarrheal events		
	Good Hygienic Practices			
6	IN	Proper eating, tasting, drinking, tobacco use		
7	IN	No discharge from eyes, nose, and mouth		
	Preventing Contamination by Hands			
8	IN	Hands clean and properly washed		
9	IN	No bare hand contact with RTE foods, alternatives		
10	IN	Adequate handwashing sinks supplied and access		
	Approved Source			
11	IN	Food obtained from approved source		
12	N/O	Food Received at proper temperature		
13	IN	Food in good condition, safe & unadulterated		
14	N/A	Records available: shellstock tags, parasite dest.		
	Protection From Contamination			
15	IN	Food separated and protected		
16	IN	Food-contact surfaces; cleaned & sanitized		
17	IN	Proper Disposition of returned, previously served, reconditioned,& unsafe food		

	Compliance Status		COS	R
	Time/Temperature Control for Safety			
18	N/O	Proper cooking time & temperatures		
19	N/O	Proper reheating procedures for hot holding		
20	N/O	Proper cooling time and temperature		
21	N/O	Proper hot holding temperatures		
22	OUT	Proper cold holding temperatures		
23	IN	Proper date marking & disposition		
24	N/A	Time as public health control;procedures & record		
	Consumer Advisory			
25	N/A	Consumer advisory provided for raw or undercooked foods		
	Highly Susceptible Populations			
26	IN	Pasteurized foods used; prohibited foods not offered		
	Food/Color Additives and Toxic Substances			
27	N/A	Food additives; approved & properly used		
28	N/A	Toxic substances properly identified;stored;used		
	Conformance with Approved Procedures			
29	N/A	Compliance with variance, specialized processes & HACCP plan		

Risk factors are improper practices or procedures identified as the most prevalent contributing factors of foodborne illness or injury. Public Health Interventions are control measures to prevent foodborne illness or injury

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" or OUT in box if numbered item is **not** in compliance Mark "X" in appropriate box for COS and/or R **COS**=corrected on-site during inspection **R**=repeat violation

			COS	R
		Safe Food and Water		
30	N/A	Pasteurized eggs used where required		
31		Water & ice from approved source		
32	N/A	Variance obtained for specialized processing methods		
		Food Temperature Control		
33		Proper cooling methods used; adequate equipment for temperature control		
34	N/O	Plant food properly cooked for hot holding		
35	N/O	Approved thawing methods used		
36	X	Thermometers provided & accurate		
		Food Identification		
37		Food properly labeled; original container		
		Prevention of Food Contamination		
38		Insects, rodents, & animals not present; no unauthorized person		
39		Contamination prevented during food prep, storage, & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
		Proper Use of Utensils		
43		In-use utensils; Properly stored		
44		Utensils, equipment & linens; properly stored, dried, handled		
45		Single-use & single-service articles, properly stored and used		
46		Gloves used properly		
		Utensils, Equipment and Vending		
47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48		Warewashing facilities: installed, maintained, used; test strips		
49		Non-food contact surfaces clean		
		Physical Facilities		
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities; properly constructed, supplied & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing and plan review		

Person in Charge (signature)

Inspector (signature) Peggy Spurley

Follow-up: Follow-up Date: