Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF INITIAL LICENSE DENIAL

Electronically Delivered

January 14, 2026

Licensee
Caring Connection Homes LLC
872 8th Avenue Northwest
New Brighton, MN 55112

RE: Denial of License Number 418560
Health Facility Identification Number (HFID) 41288
Initial survey; Project Number SL41288015

Dear Licensee:

The Minnesota Department of Health (MDH) completed an initial survey on December 5, 2025, for the purpose of assessing compliance with state licensing statutes and determine issuance of an initial license to the above-mentioned provider. Based on the survey, MDH found you not in substantial compliance with the laws pursuant to Minnesota Statute, Chapter 144G. As a result, your authority to continue to operate under a provisional license or be approved for an assisted living facility license is being denied.

STATE CORRECTION ORDERS
The enclosed State Form documents the state licensing orders. The Department of Health documents state 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 . . ."

REQUEST FOR RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.16, Subd. 4, you may request a reconsideration by the Minnesota Department of Health. The request for reconsideration process must be conducted internally by the Minnesota Department of Health and Chapter 14 does not apply. **This is your only ability to request a reconsideration under this enforcement action.**

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

Note requests for reconsideration must be received by the department within 15 calendar days of the date of this notice.

REQUIREMENTS FOR NOTIFICATION AND TRANSFER OF RESIDENTS
You must comply with the requirements for notification and coordinated move of residents noted in Minn. Stat. § 144G.52 and Minn. Stat. § 144G55. Additionally, please provide the information described in Minn. Stat. § 144G.20, Subd. 15 (a) (1), (2), (3), (4) and (5) to this department's contact, Jess Schoenecker, via email at: Jess.Schoenecker@state.mn.us. Also provide this information to the lead agencies as defined in section 256B.0911, county adult protection and case managers, and the ombudsman for long-term care **no later than January 17, 2026.**

Pursuant to Minn. Stat § 144G.16, Subd. 5 (3), a provisional licensee whose license is denied is permitted to continue operating as an assisted living facility during the period of time when a transfer of assisted living facility resident(s) from the provisional licensee to a new assisted living facility provider is in process.

Additionally, pursuant to Minn. Stat. § 144G.16, Subd. 5 (1), you may continue operating during the reconsideration process.

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

If you have any additional questions, please do not hesitate to contact Jess Schoenecker, Supervisor, at Jess.Schoenecker@state.mn.us. Jess Schoenecker can also be reached by office phone at 651-201-3789.

Sincerely,

Rick Michals, J.D.
Executive Regional Operations Manager

Minnesota Department of Health
Health Regulation Division

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41288	A. BUILDING: _____ B. WING _____	12/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING CONNECTION HOMES LLC	872 8TH AVE NW NEW BRIGHTON, MN 55112

(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 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: SL#41288015 On December 1, 2025, through December 5, 2025, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there was 1 resident; 1 receiving services under the Provisional Assisted Living license. On December 3, 2025, an immediate correction order was issued for tag identification 0495. During the course of the survey, the licensee took action to mitigate the imminent risk. Noncompliance remained and the scope and level remain unchanged.	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 SUBDIVISION 1-3.	
0 460 SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request	0 460		

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0 460	Continued From page 1 assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide a means for residents to request assistance for health and safety needs 24 hours a day, seven days a week. This had the potential to affect all current residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	0 460		

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0 460	Continued From page 2 On December 1, 2025, at approximately 11:50 a.m., during the entrance conference, house manager/unlicensed personnel (HM/ULP)-C stated the licensee did not have a call light or pendant system residents could use to summon staff. HM/ULP-C also stated residents would verbally call out to the licensee's staff if needed assistance. On December 1, 2025, at approximately 12:20 p.m., during facility tour, the surveyor observed the facility was a two-level home with a main floor and lower level. The surveyor also observed no pendants, call light system, or means to request assistance were available in the residents' rooms. The licensee's Criteria for Admission policy, undated, indicated the licensee would provide a means for residents to request assistance for health and safety needs 24 hours a day, seven days a week. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 460		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for 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	0 470		

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0 470	Continued From page 3 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 ensure a current staffing schedule was posted as required and to ensure the clinical nurse supervisor (CNS) reviewed the staffing plan at least twice a year potentially affecting all the licensee's current 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 failure that has affected or has potential to affect a large portion or all of the residents).	0 470		

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0 470	Continued From page 4 The findings include: The licensee held a provisional assisted living facility license for a capacity of 5 residents and had a current census of 1 resident. STAFF SCHEDULE On December 1, 2025, at approximately 12:40 p.m., during a tour of the facility, the surveyor observed a posted staff schedule on a bulletin board located in the living room with the dates of October 13, 2025, through October 19, 2025. The licensee lacked a current posted daily staffing schedule after redacting direct-care staff member's resident assignments, at the beginning of each work shift in a central location. On December 1, 2025, at approximately 12:50 p.m., house manager/unlicensed personnel (HM/ULP)-C acknowledged the staffing schedule was not current and was unsure why it was not updated by the licensee. STAFFING PLAN On December 1, 2025, at approximately 12:45 p.m., during a tour of the facility, the surveyor observed a posted staffing plan undated, on a bulletin board in the main level living room that indicated weekly staffing from Sunday through Saturday was as follows: -7:00 a.m. to 3:00 p.m., one ULP; -3:00 p.m. to 11:00 p.m., one ULP; -11:00 p.m. to 7:00 a.m., one ULP; -licensed assisted living director (LALD) on site five days a week and on call 24/7; -CNS onsite one day a week and on call 24/7; and -backup registered nurse (RN) on call 24/7 and available when CNS was not available.	0 470		

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0 470	Continued From page 5 On December 2, 2025, at approximately 9:00 a.m., CNS-B stated the licensee had a staffing plan developed but was not reviewed. CNS-B also stated the licensee was unaware the staffing plan needed to be reviewed twice a year. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 470		
0 495 SS=I	144G.41 Subdivision. 1 (13) Minimum Requirements (13) provide staff access to an on-call registered nurse 24 hours per day, seven days per week. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a registered nurse was available 24 hours a day, seven days a week to provide consultation to staff performing delegated nursing tasks and services when the licensee hired clinical nurse supervisor (CNS)-B to perform all nursing tasks and CNS-B simultaneously held a full-time teaching position at a nursing school that required supervised clinicals with students which would not allow CNS-B to be available 24 hours per day, 7 days per week, to address the licensee's emergencies or concerns. This had the potential to affect all residents and staff. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident), and was issued at a widespread scope (when problems	0 495	During the course of the survey, the licensee took action to mitigate the imminent risk. Noncompliance remained and the scope and level remain unchanged.	

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0 495	Continued From page 6 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 held a provisional assisted living facility license staffed with five personnel - licensed assisted living director/unlicensed personnel (LALD/ULP)-A, clinical nurse supervisor (CNS)-B, house manager/unlicensed personnel (HM/ULP)-C, unlicensed personnel (ULP)-D, and backup registered nurse (RN)-E. The licensee was licensed for a bed capacity of five residents and had a current census of one resident. Prior to facility entrance and during the phone call on December 1, 2025, at approximately 11:00 a.m., LALD/ULP-A stated CNS-B had a full-time job teaching at a nursing school and would be unavailable today until 6:00 p.m. At approximately 11:10 a.m., CNS-B joined the phone call and verified the full-time teaching position, and they would be unavailable until 6:00 p.m. During the entrance conference on December 1, 2025, at approximately 12:00 p.m., HM/ULP-C stated CNS-B comes on site one day a week for the licensee. HM/ULP-C also stated the licensee hired RN-E as a backup nurse. On December 1, 2025, at approximately 12:05 p.m., surveyor requested HM/ULP-C to call the backup nurse RN-E to come on site. HM/ULP-C stated she does not have the contact information for RN-E and would have to text LALD/ULP-A for RN-E's contact information. On December 1, 2025, at approximately 12:20	0 495		

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0 495	Continued From page 7 p.m., LALD/ULP-A responded by text to HM/ULP-C that RN-E was unavailable to be contacted or be on site today due to an emergency. On December 1, 2025, at approximately 12:45 p.m., during a tour of the facility, the surveyor observed a posted staffing plan on a bulletin board in the main level living room that indicated weekly staffing from Sunday through Saturday was as follows: -7:00 a.m. to 3:00 p.m., one ULP; -3:00 p.m. to 11:00 p.m., one ULP; -11:00 p.m. to 7:00 a.m., one ULP; -LALD on site five days a week and on call 24/7; -CNS onsite one day a week and on call 24/7; and -backup registered nurse (RN) on call 24/7 and available when CNS was not available. On December 2, 2025, at approximately 9:00 a.m., CNS-B verified the posted staffing plan was the licensee's current staffing plan. R1 was admitted on September 16, 2025. R1's diagnoses included schizophrenia and type 2 diabetes. R1's signed Service Plan dated October 3, 2025, indicated R1 received assistance with medication administration, blood glucose monitoring, managing of self-injurious behavior, housekeeping, laundry, and meals. R1's medication orders dated November 13, 2025, included: -Jardiance (empagliflozin) 25 milligram (mg) tablet (take one tablet at bedtime for type 2 diabetes);	0 495		

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0 495	Continued From page 8 -Glucophage (metformin) 1000 mg tablet (take one tablet two times daily for type 2 diabetes); -Prozac (fluoxetine) 20 mg capsule (take 60 mg once daily for depression); -Zyprexa (olanzapine) 15 mg tablet (take one tablet at bedtime for schizophrenia); and -Desyrel (trazodone) 100 mg tablet (take one tablet at bedtime for major depression). R1's most recent RN Mental Illness Assessment dated September 30, 2025, indicated severe major depressive disorder, paranoid, and history of suicidal ideation. R1's most recent RN Vulnerability Assessment dated September 30, 2025, indicated R1 was at risk to abuse themselves, had a history of suicidal ideation, and had a history of three suicidal attempts with the most recent attempt in 2024. The licensee's Criteria for Admission policy, undated, indicated the licensee would provide staff access to an on-call registered nurse available 24 hours per day, seven days per week. The licensee's On-Call policy, undated, indicated the licensee would ensure RN coverage was always available, and the RN must be available to come on site if necessary. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	0 495		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality	0 580		

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0 580	Continued From page 9 management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to implement and maintain a quality management program (QMP) appropriate to the size of the facility and relevant to the type of services provided. This had the potential to affect all current residents, staff, and visitors. 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 December 1, 2025, at approximately 11:20 a.m., during the entrance conference, house manager/unlicensed personnel (HM/ULP)-C stated the licensee provided ongoing QMP areas were identified, but no meeting minutes, tracking, or specific improvement projects would be documented.	0 580		

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0 580	Continued From page 10 On December 1, 2025, at approximately 5:32 p.m., during a phone interview, licensed assisted living director/unlicensed personnel (LALD/ULP)-A verified no meeting minutes, tracking, or specific improvement projects would be documented on the licensee's QMP. LALD/ULP-A also stated the licensee was unaware of this requirement. The licensee's Quality Management Program policy, undated, indicated a QMP would be implemented, and documentation would be provided upon request. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 580		
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the	0 630		

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0 630	Continued From page 11 licensee failed to develop an individual abuse prevention plan (IAPP) with the required content for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 on September 16, 2025. On December 2, 2025, at approximately 9:30 a.m., clinical nurse supervisor (CNS)-B stated R1's IAPP was included in R1's Assessment. R1's Assessment dated September 30, 2025, indicated R1 was at risk to be abused and did not include: - the resident's susceptibility to abuse by another individual, including other vulnerable adults; and - statements of specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. On December 2, 2025, at approximately 9:45 a.m., CNS-B confirmed R1's IAPP did not address the above noted areas of risk or include statements of specific measures to be taken to minimize risks. CNS-B stated the licensee was unaware of the required contents of the IAPP and the IAPP was completed based on the questions shown in the health record.	0 630		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING CONNECTION HOMES LLC	872 8TH AVE NW NEW BRIGHTON, MN 55112

(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
0 630	Continued From page 12 The licensee's Abuse Prevention Plans policy, undated, indicated the licensee developed IAPPs that included the resident's susceptibility to be abused by another individual, including other vulnerable adults, the resident's risk of abusing other vulnerable adults, and specific measures to minimize the risk of abuse to that person and other vulnerable adults. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
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. 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 and	0 660		

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0 660	Continued From page 13 control program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) when the licensee failed to complete a TB history and symptom screen for four of four employees (licensed assisted living director/unlicensed personnel (LALD/ULP)-A, clinical nurse supervisor (CNS)-B, house manager/ULP (HM/ULP)-C, ULP-D) and failed to complete TB testing for two of four employees (LALD/ULP-A, ULP-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a 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 completed a facility TB risk assessment on September 5, 2025. LALD/ULP-A LALD/ULP-A had a hire date of June 27, 2024. LALD/ULP-A's employee record included one TB skin test dated June 13, 2025, but lacked documentation of a completed second TB skin test. LALD/ULP-A's employee record also lacked a TB history and symptom screen at time of LALD/ULP-A's hire. CNS-B CNS-B had a hire date of November 10, 2025. CNS-B's employee record included a TB test	0 660		

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0 660	Continued From page 14 dated September 18, 2025, but lacked documentation of a completed TB history and symptom screen at time of CNS-B's hire. HM/ULP-C HM/ULP-C had a hire date of September 16, 2023. HM/ULP-C's employee record included a TB test dated September 10, 2025, but lacked documentation of a completed TB history and symptom screen at time of HM/ULP-C's hire. ULP-D ULP-D had a hire date of June 27, 2024. ULP-D's employee record included one TB skin test dated October 17, 2025, but lacked documentation of a completed second TB skin test. ULP-D's employee record also lacked a TB history and symptom screen at time of ULP-D's hire. On December 2, 2025, at approximately 9:45 a.m., CNS-B verified all four employee records lacked a TB history and symptom screen upon hire. CNS-B stated the licensee was unsure why a TB history and symptom screen was not performed for any employee of the licensee at hire and was unaware of the second TB skin test requirement. CNS-B also stated the licensee would have all employees complete a TB history and symptom screen. The licensee's Tuberculosis Screening policy, undated, indicated baseline screening was completed at time of hire for all direct care providers and testing results would be kept in each employee medical file.	0 660		

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0 660	Continued From page 15 The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and the CDC guidelines, indicated an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record. 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	0 680		

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0 680	Continued From page 16 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 have a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all visitors, employees, and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On December 1, 2025, at approximately 2:00 p.m., house manager/unlicensed personnel (HM/ULP)-C provided a binder and stated the contents were the licensee's EPP. The licensee's EPP, undated, lacked an individualized plan to include all the required content below: -missing resident quarterly review; -missing hazard and vulnerability assessment (HVA);	0 680		

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0 680	Continued From page 17 -emergency preparedness (EP) program resident population -process for EP collaboration; -development of all policies/procedures (P/P) based on HVA assessment; -roles under a waiver declared by secretary; -development of communication plan; and -EP training and testing program. On December 2, 2025, at approximately 9:50 a.m., clinical nurse supervisor (CNS)-B acknowledged the licensee's EPP lacked the above listed required content. CNS-B stated the licensee was not aware of the HVA and all the requirements of Appendix Z. The licensee's Hazard Vulnerability Analysis policy, undated, indicated the licensee would perform an all-hazards assessment to identify possible emergency events the facility could experience that could interfere with the delivery of care and services. The licensee's Emergency Management policy, undated, indicated the licensee would have an identified EPP 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		
0 690 SS=F	144G.43 Subdivision 1 Resident record (a) Assisted living facilities must maintain records for each resident for whom it is providing services. Entries in the resident records must be	0 690		

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0 690	Continued From page 18 current, legible, permanently recorded, dated, and authenticated with the name and title of the person making the entry. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure entries in a resident record was authenticated with the name and title of the person completing the 14-day assessment of one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 on September 16, 2025. R1's record included a 14-day assessment that was completed on September 30, 2025, and was not authenticated with the name and title of the person completing the 14-day assessment for R1. Clinical nurse supervisor (CNS)-B was hired November 10, 2025, for the licensee. On December 2, 2025, at 9:50 a.m., CNS-B stated R1's assessment was completed by a previous CNS for the licensee and CNS-B was unaware that R1's 14-day assessment was not authenticated and was unsure why.	0 690		

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0 690	Continued From page 19 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 690		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated December 1, 2025, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7)	0 775		

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0 775	Continued From page 20 days	0 775		
0 800 SS=D	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 ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated December 1, 2025, for the specific violations related the physical environment under Minnesota	0 800		

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0 800	Continued From page 21 Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.	0 810		

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0 810	Continued From page 22 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated December 1, 2025, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office	0 910		

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0 910	Continued From page 23 box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for one of one resident (R1). 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: R1's Assisted Living Contract was signed on September 16, 2025. R1's Assisted Living Contract lacked inclusion of the licensee's Health Facility Identification (HFID) number. On December 1, 2025, at approximately 5:32 p.m., during a phone interview, licensed assisted living director/unlicensed personnel (LALD/ULP)-A stated the licensee was not aware of the requirement to have HFID number on the contract, but would implement the requirement. The licensee's Assisted Living Contracts policy,	0 910		

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0 910	Continued From page 24 undated, indicated the contract would include the license number of the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 910		
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or	01470		

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01470	Continued From page 25 other relevant advocacy services; and (9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, 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 orientation with all the required content was completed for four of four employees (licensed assisted living director/unlicensed personnel (LALD/ULP)-A, clinical nurse supervisor (CNS)-B, house manager/ULP (HM/ULP)-C, ULP-D). This practice resulted in a level two violation (a	01470		

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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
01470	Continued From page 26 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 December 1, 2025, at approximately 5:35 p.m., per phone interview, LALD/ULP-A stated he was responsible for all orientation requirements for the licensee. LALD/ULP-A LALD/ULP-A was hired on June 27, 2024. LALD/ULP-A's employee record lacked documentation of a completed orientation to assisted living regulations with the required content related to: -Overview of Assisted Living statutes; -Reporting maltreatment of vulnerable adults or minors; -Assisted Living Bill of Rights; -Handling of resident complaints, reporting of complaints, where to report; -Review of types of Assisted living services the employee will provide and provider's scope of license; -Principles of person-centered planning/service delivery; and -Orientation to each specific resident and services provided. CNS-B CNS-B was hired on November 10, 2025.	01470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41288	A. BUILDING: _____ B. WING _____	12/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING CONNECTION HOMES LLC	872 8TH AVE NW NEW BRIGHTON, MN 55112

(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
01470	Continued From page 27 CNS-B's employee record lacked documentation of a completed orientation to assisted living regulations with the required content related to: -Overview of Assisted Living statutes; -Review of provider's policies and procedures; -Reporting maltreatment of vulnerable adults or minors; -Assisted Living Bill of Rights; -Handling of resident complaints, reporting of complaints, where to report; -Review of types of Assisted living services the employee will provide and provider's scope of license; -Principles of person-centered planning/service delivery; and -Orientation to each specific resident and services provided. HM/ULP-C HM/ULP-C was hired on September 16, 2025. HM/ULP-C's employee record lacked documentation of a completed orientation to assisted living regulations with the required content related to: -Overview of Assisted Living statutes; -Review of provider's policies and procedures; -Handling emergencies and using emergency services; -Reporting maltreatment of vulnerable adults or minors; -Assisted Living Bill of Rights; -Handling of resident complaints, reporting of complaints, where to report; -Consumer advocacy services; -Review of types of Assisted living services the employee will provide and provider's scope of license; -Principles of person-centered planning/service delivery; and	01470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41288	A. BUILDING: _____ B. WING _____	12/05/2025

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CARING CONNECTION HOMES LLC	872 8TH AVE NW NEW BRIGHTON, MN 55112

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01470	Continued From page 28 -Orientation to each specific resident and services provided. ULP-D ULP-D was hired on October 6, 2025. ULP-D's employee record lacked documentation of a completed orientation to assisted living regulations with the required content related to: -Overview of Assisted Living statutes; -Review of provider's policies and procedures; -Reporting maltreatment of vulnerable adults or minors; -Assisted Living Bill of Rights; -Handling of resident complaints, reporting of complaints, where to report; -Review of types of Assisted living services the employee will provide and provider's scope of license; -Principles of person-centered planning/service delivery; and -Orientation to each specific resident and services provided. On December 2, 2025, at 10:00 a.m., CNS-B stated the licensee was unsure why the orientation was based on home care requirements versus assisted living requirements. CNS-B also stated the licensee was unaware of all the required orientation for employees upon hire. The licensee's Facility Employee Orientation policy, undated, indicated the required orientation content would be provided to new employees. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41288	A. BUILDING: _____ B. WING _____	12/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING CONNECTION HOMES LLC	872 8TH AVE NW NEW BRIGHTON, MN 55112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01530 SS=F	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation	01530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41288	A. BUILDING: _____ B. WING _____	12/05/2025

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01530	Continued From page 30 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 all employees received eight hours of initial dementia care training and two hours of mental illness and de-escalation training within the first 160 working hours of employment for direct care employees as required for three of three employees (licensed assisted living director/unlicensed personnel (LALD/ULP)-A, house manager/ULP (HM/ULP)-C, ULP-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a 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: LALD/ULP-A LALD/ULP-A was hired on June 27, 2024, to provide direct care to the residents working full time (40 hours a week). LALD/ULP-A had a total of 0 hours completed within 160 hours of working for the licensee. LALD/ULP-A's personnel record lacked the required eight hours of dementia care training and two hours of mental illness and de-escalation training within 160 hours of working for the	01530		

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	41288	A. BUILDING: _____ B. WING _____	12/05/2025

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CARING CONNECTION HOMES LLC	872 8TH AVE NW NEW BRIGHTON, MN 55112

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01530	Continued From page 31 licensee. HM/ULP-C HM/ULP-C was hired on September 16, 2025, to provide direct care to the residents working full time (40 hours a week). HM/ULP-C had a total of 0 hours completed within 160 hours of working for the licensee. HM/ULP-C's personnel record lacked the required eight hours of dementia care training and two hours of mental illness and de-escalation training within 160 hours of working for the licensee. ULP-D ULP-D was hired on October 6, 2025, to provide direct care to the residents working full time (40 hours a week). ULP-D had a total of 0 hours completed within 160 hours of working for the licensee. ULP-D's personnel record lacked the required eight hours of dementia care training and two hours of mental illness and de-escalation training within 160 hours of working for the licensee. On December 2, 2025, at 9:30 a.m., clinical nurse supervisor (CNS)-B verified the initial dementia care training, mental illness and de-escalating training was not completed for all employees of the licensee. CNS-B stated the licensee thought the dementia training requirement only applied to assisted living facilities with a dementia care license. The licensee's Dementia Care Training policy, undated, indicated the licensee would meet the dementia care training requirements of direct care employees by completing at least eight	01530		

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01530	Continued From page 32 hours of initial dementia training within 160 working hours of employment start date and direct care. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to finalize a written service plan	01640		

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01640	Continued From page 33 (SP) within 14 calendar days after the initiation of services for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 on September 16, 2025. R1's signed SP dated October 3, 2025, indicated R1 received assistance with medication administration, blood glucose monitoring, managing of self-injurious behavior, housekeeping, laundry, and meals. R1's SP was finalized 17 days after the initiation of services. R1 lacked a written SP finalized no later than 14 days after the initiation of services, to document the agreement, between the licensee and R1, on services to be provided. On December 2, 2025, at approximately 9:50 a.m., clinical nurse supervisor (CNS)-B confirmed R1's SP was not finalized within 14 days of R1's start of service. CNS-B stated the licensee was unaware of this requirement. The licensee's SP policy, undated, indicated a SP would be finalized with each resident no later than 14 calendar days after start of service. No further information was provided.	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01640	Continued From page 34 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		

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

Caring Connection Homes LLC
872 8th Ave NW
New Brighton, MN 55112
Ramsey County
Parcel:

Phone:

License Info

License: HFID 41288

Risk:
License:
Expires on:
CFPM: Delah Deah
CFPM #: 53551; Exp: 10/15/2017

Inspection Info

Report Number: F1025251222
Inspection Type: Full - Single
Date: 10/27/2025 Time: 2:00 PM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery:

No orders were issued for this inspection report.

Food & Beverage General Comment

Food thermometer and temperature strips for dishwasher available
Discussed employee health and hygiene, handwashing, date marking for TCS foods, cooking temperatures for meat and frozen meals, sanitizing food contact surfaces, alternative means of sanitizing surfaces, food source, pest control

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 F1025251222 from 10/27/2025

Delah

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

Caring Connection Homes LLC
New Brighton
County/Group: Ramsey County

Inspection Info

Report Number: F1025251222
Inspection Type: Full
Date: 10/27/2025
Time: 2:00 PM

Food Temperature: Product/Item/Unit: Meat, pkg**; Temperature Process:** Cold holding
Location: Refrigerator at 41 Degrees F.
Comment: Reported no other coolers or freezers
If installed, place freezer in an area where it is not under utility lines or exposed to potential contamination
Violation Issued?: No

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL41288015-0	**Date:** December 1, 2025
Facility Name: CARING CONNECTION HOMES LLC	
Facility Address: 872 8TH AVENUE NW, NEW BRIGHTON, MN 55112	

☒ **TAG IDENTIFICATION: 0775**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Seven (7) days

1. Each assisted living facility must comply with the provisions of the Minnesota State Fire Code (MSFC) in Minnesota Rules chapter 7511. [Minn. Stat. 144G.45 subd. 2]

2. Required egress window openings in rooms of care facilities licensed or registered by the state of Minnesota shall have a minimum net clear opening area of 4.5 square feet (648 square inches). Opening height and width dimensions shall not be less than 20 inches. The net clear opening dimensions shall be the result of normal operation of the opening. [Minn. Stat. 144G.45 subd. 2; MSFC 1104.26.2, 1104.26.6.1]

   Comments: Egress window measurements in unoccupied resident sleeping rooms:
   Room one - the clear open area of window #1 measured 27 inches width, 22.75 inches height, with a total clear area of 614 square inches. A storm window obstructed window #2 which prevented the surveyor from being able to measure the clear open area of the window.
   Room three - the clear open area of the window measured 27 inches width, 22.75 inches height, with a total clear area of 614 square inches.
   The windows were opened by house manager (HM)-C and measured by the surveyor.

3. The means of egress shall be maintained free of obstructions or impediments to full instant use in case of fire or other emergency. [Minn. Stat. 144G.45 subd. 2; MSFC 1031.2]

   Comments:
   - An exit sign was posted at the basement door, and this door was labeled as an emergency exit on the posted floor plan. A path from the basement door to the public right-of-way was not maintained free of snow.
   - A chain lock was installed on the door leading from the main floor to the basement. The lock was installed on the side of the door that was not accessible to the building occupants in the basement.

4. Extension cords and flexible cords shall not be subject to environmental damage or physical impact. [Minn. Stat. 144G.45 subd. 2; MSFC 604.5]

   Comments: A power strip was used to supply power in the basement living room. The power strip cord ran across the living room floor in an area where building occupants would walk.

5. Portable electric space heaters shall be plugged directly into an approved receptacle. [Minn. Stat. 144G.45 subd. 2; MSFC 604.10.2]

   Comments: A portable space heater was plugged into a power strip in the kitchen office.

6. Portable electric space heaters shall not be operated within three feet of any combustible material. [Minn. Stat. 144G.45 subd. 2; MSFC 604.10.4]

   Comments: Space heaters were used in the kitchen office and occupied resident sleeping room 4. Three feet of clearance from combustible materials was not maintained.

7. Open-wiring splices shall be prohibited. [Minn. Stat. 144G.45 subd. 2; MSFC 604.6]

   Comments: Capped wires were exposed in the closet of unoccupied resident room five and in the basement employee storage room.

☒ **TAG IDENTIFICATION: 0800**

SCOPE/ SEVERITY: Level 2; Isolated **TIME PERIOD OF CORRECTION:** Seven (7) days

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1. The physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment are 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. [Minn. Stat. 144G.45 subd.2]

   Comments:
   - In occupied resident sleeping room four, the ceiling was stained and soiled over a large area of the ceiling surface. The drywall soffit for the heating and ventilation system was partially separated from the ceiling above the bed.
   - In unoccupied resident room five, the cover was missing from the light fixture in the closet.
   - One side of the handrail was loose for the basement stairs.

DEPARTMENT OF HEALTH

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Twenty One (21) days

1. Each assisted living facility shall develop and maintain fire safety and evacuation plans that include employee actions to be taken in the event of a fire or similar emergency. [Minn. Stat. 144G.45 subd.2]

   Comments: The licensee failed to develop a site-specific fire safety and evacuation plan (FSEP). The FSEP had been created using templates from third party platforms and failed to include employee actions relative to the facility's building layout and environmental risks.

2. Each assisted living facility shall develop and maintain fire safety and evacuation plans that include fire protection procedures necessary for residents. [Minn. Stat. 144G.45 subd.2]

   Comments: The licensee failed to develop fire safety and evacuation instructions for residents. Fire protections procedures were limited to directing residents to stoop or crawl to avoid smoke.

3. Each assisted living facility shall develop and maintain fire safety and evacuation plans that include 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. [Minn. Stat. 144G.45 subd.2]

   Comments: The licensee failed to develop site specific evacuation procedures for the building occupants and the individualized unique needs of residents.

4. Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. [Minn. Stat. 144G.45 subd.2]

   Comments: Records were not provided to support new hire employees received site specific fire safety and evacuation plan training. The documentation emailed to the surveyor was not legible.

5. Evacuation drills are required for employees 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. [Minn. Stat. 144G.45 subd.2]

   Comments: Two fire drills were recorded on the 2025 drill evacuation form, dated September 30th and November 28th. The simulated drill conditions and the names of the employees who participated were not documented.