



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

August 28, 2026

Licensee
Honest Care LLC
8381 6th Street Northeast
Spring Lake Park, MN 55432

RE: Project Number(s) SL40767015

Dear Licensee:

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

The Minnesota Department of Health completed an initial survey on August 5, 2026, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

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

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 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 - 0810 - 144g.45 Subd. 2 (b-F) - Fire Protection And Physical Environment - \$500.00

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

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

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

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under

this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by MDH within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

To submit a hearing request, please visit:

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

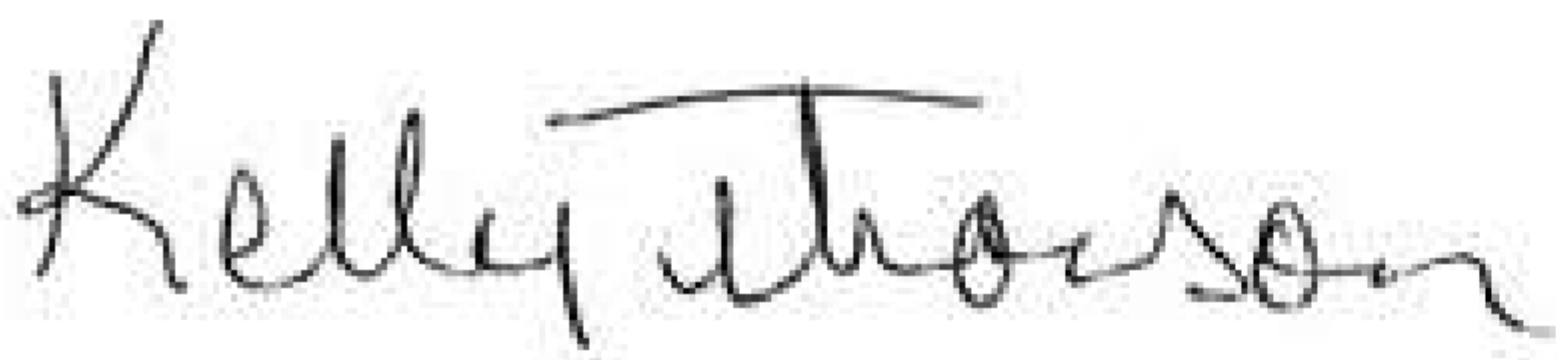
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration or a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **<https://forms.office.com/g/Bm5uQEPhVa>**. Your input is important to us and will enable MDH to improve its processes and communication with providers.

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

If you have any questions, please contact me.

Sincerely,

A handwritten signature in black ink that reads "Kelly Thorson". The signature is written in a cursive, flowing style.

Kelly Thorson

State Evaluation Team

Email: Kelly.Thorson@state.mn.us

Telephone: 320-223-7336 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40767	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/05/2026
NAME OF PROVIDER OR SUPPLIER HONEST CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 8381 6TH ST NE SPRING LAKE PARK, MN 55432			
(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: SL40767015-0 On August 3, 2026, through August 5, 2026, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there was one resident; one 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 Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
0 650 SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of	0 650			

Minnesota Department of Health

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

TITLE

(X6) DATE

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0 650	Continued From page 1 each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records contained the required content for three of three employees (unlicensed personnel/house manager (ULP/HM)-C, ULP-D, and ULP-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect	0 650			

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0 650	Continued From page 2 a large portion or all of the residents). The findings include: During the entrance conference on August 3, 2026, at 10:09 a.m., licensed assisted living director/registered nurse (LALD/RN)-A stated the licensee was aware of the required contents of the employee record. ULP/HM-C ULP/HM-C was hired on October 1, 2025, to provide direct care services. On August 4, 2026, at 8:55 a.m., the surveyor observed ULP/HM-C administer scheduled medications to R2. ULP/HM-A's employee record lacked evidence of competency evaluation for oral medications. ULP-D ULP-D was hired on October 1, 2025, to provide direct care services to residentss. On August 5, 2026, at 8:07 a.m., the surveyor observed ULP-D administer scheduled medications to R2. ULP-D employee record lacked evidence of competency evaluation for oral medications. ULP-E ULP-E was hired on December 6, 2025, to provide direct care services to residents. ULP-E's employee record lacked evidence of competency evaluation for oral medications. On August 4, 2026, at 9:04 a.m., ULP/HM-C	0 650			

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0 650	Continued From page 3 stated ULP/HM-C's orientation and training consisted of computer education through Educare (online education platform), medication administration and skills training followed by competency test-outs with clinical nurse supervisor/licensed assisted living director (CNS/LALD)-B prior to direct care services being provided. On August 4, 2026, at 2:54 p.m., CNS/LALD-B stated instruction regarding medication administration was provided to employees and all employees completed successful competency test-outs. CNS/LALD-B further stated competency documentation was not completed however it should have been. The licensee's Personnel Records policy dated July 22, 2025, indicated employee files contained competency evaluations completed by the employee. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0190, Subp. 6, effective October 2022, the licensee must maintain a record of staff training and competency required under this part and Minnesota Statutes, chapter 144G, that documents the following information for each competency evaluation, training, retraining, and orientation topic: (1) facility name, location, and license number; (2) name of the training topic or training program, and the training methodology, such as classroom style, web-based training, video, or one-to-one training; (3) date of the training and competency evaluation, and the total amount of time of the training and competency evaluation; (4) name and title of the instructor and the instructor's signature, and the name and title of	0 650			

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0 650	Continued From page 4 the competency evaluator, if different from the instructor, and the evaluator's signature with a statement attesting that the employee successfully completed the training and competency evaluation; and (5) name and title of the staff person completing the training, and the staff person's signature with statement attesting that the staff person successfully completed the training as described in the training documentation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650			
0 660 SS=E	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	0 660			

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0 660	Continued From page 5 review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) and Minnesota Department of Health (MDH), including completion of a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test for two of three employees (unlicensed personnel (ULP)-D and ULP-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During the entrance conference on August 3, 2026, at 9:37 a.m., licensed assisted living director/registered nurse (LALD/RN)-A stated the licensee was familiar with current minimum assisted living requirements. The licensee's Facility TB Risk Assessment Worksheet for Health Care Settings Licensed by MDH was completed on January 28, 2026, and the facility was determined to be a low risk level. ULP-D ULP-D was hired on October 1, 2025, to provide assisted living services to residents. On August 5, 2026, at 8:07 a.m., the surveyor	0 660			

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0 660	Continued From page 6 observed ULP-D administer scheduled medications to R2. ULP-D's employee record included evidence of ULP-D's first, negative, TST completed on August 22, 2025. ULP-D's record lacked evidence of ULP-D having completed a second, negative, TST. ULP-E ULP-E was hired December 6, 2025, to provide assisted living services to residents. ULP-E's employee record included evidence of ULP-E's first, negative TST completed on January 30, 2026. ULP-E's record lacked evidence of ULP-D having completed a second, negative, TST. On August 5, 2026, at 10:29 a.m., LALD/RN-A stated LALD/RN-A was aware that employees who completed TST upon hire were required to complete a two-step testing process. LALD/RN-A further stated the ULP-D and ULP-E were not given directive to complete a second step due to oversight by LALD/RN-A. The licensee's Tuberculosis Screening/Prevention policy dated July 22, 2025, indicated [licensee] observed the recommended precautions related to TB prevention as identified for the Centers for Disease Control and Prevention (CDC) and the Minnesota Department of Health (MDH). The policy further indicated employees completed baseline symptom and TB history screening at the time of hire followed by a two-step TST or blood test.	0 660			

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0 660	Continued From page 7 The MDH TB Screening and Education Requirements for Assisted Living Facilities and Home Care Providers dated February 3, 2022, indicated baseline TB screening is required at the time of hire for all health care personnel in Minnesota. Baseline TB screening includes assessing for current symptoms of active TB disease; assessing TB history; and testing for the presence of infection with Mycobacterium TB by administering either a two-step TB skin test or a single TB blood test. 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	0 680			

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0 680	Continued From page 8 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 observation, 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 residents receiving services under the provisional assisted living license. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's undated EPP lacked the following required content: - maintain and annual EPP updates; - process for emergency preparedness collaboration; - policies and procedures for subsistence needs for staff and residents; - policies and procedures for volunteers; - names and contact information; and - emergency officials contact information. On August 3, 2026, at 2:14 p.m., licensed	0 680			

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0 680	Continued From page 9 assisted living director/registered nurse (LALD/RN)-A stated the licensee reviewed the licensee's missing resident policy quarterly during quality improvement (QI) meetings however, documentation of the policy review was not included in the June 2026 QI meeting minutes. LALD/RN-A further stated LALD/RN-A had not added contact information for local and state resources or specified subsistence needs for residents and staff in the event of a shelter in place or evacuation event. LALD/RN-A stated the licensee had not indicated whether the licensee would utilize volunteers. The licensee's Emergency Preparedness policy dated July 22, 2025, indicated the licensee developed a plan to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupted services. The licensee's Missing Resident policy dated July 22, 2025, indicated the licensee's missing resident procedure was reviewed by the licensee's director and clinical nurse supervisor (CNS) as least quarterly. Minnesota Administrative Rule 4659.0100 dated August 11, 2021, indicated assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.72, or successor requirements. This part referenced documents, specifications, methods, and standards in State Operations Manual Appendix Z - Emergency Preparedness for All Provider and Certified Supplier Types: Interpretive Guidance. No further information was provided.	0 680			

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0 680	Continued From page 10	0 680			
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 11 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated August 4, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	0 810			
0 930 SS=C	144G.50 Subd. 2 (d-e; 1-4) Contract information (d) The contract must include a description of the facility's complaint resolution process available to residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints. (e) The contract must include a clear and	0 930			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40767	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/05/2026
NAME OF PROVIDER OR SUPPLIER HONEST CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 8381 6TH ST NE SPRING LAKE PARK, MN 55432			
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0 930	Continued From page 12 conspicuous notice of: (1) the right under section 144G.54 to appeal the termination of an assisted living contract; (2) the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer; (3) contact information for the Office of Ombudsman for Long-Term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints; (4) the resident's right to obtain services from an unaffiliated service provider; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to execute a written assisted living contract with all required content for one of one resident (R2). This had the potential to affect all residents who received assisted living services. This practice resulted in a level one violation (a violation that will cause only 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 potential to affect a large portion or all of the residents). The findings include: During the entrance conference on August 3, 2026, at 9:37 a.m., licensed assisted living director/registered nurse (LALD/RN)-A stated the licensee was familiar with current minimum assisted living requirements.	0 930			

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0 930	Continued From page 13 R2 was admitted to the licensee on November 24, 2025. R2's Service Plan dated November 24, 2025, indicated R2's services included medication management, meals, daily blood pressure monitoring, behavior management, housekeeping, laundry, and linens. On August 4, 2026, at 8:27 a.m., the surveyor observed unlicensed personnel/house manager (ULP/HM)-C administer R2's scheduled morning medications. R2's [licensee] Assisted Living Contract was signed on November 24, 2025. R2's assisted living contract lacked including or addressing the following: - the right under section 144G.54 to appeal the termination of an assisted living contract; - the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer; and - contact information for the Office of Health Facility Complaints. On August 4, 2026, at 2:02 p.m., LALD/RN-A stated LALD/RN-A referred to state statute for the content which was required to be included in resident contracts. LALD/RN-A further stated the licensee's contract template was purchased from a third party and LALD/RN-A was under the impression that all required content was included. LALD/RN-A acknowledged the above listed content was missing from the licensee's current contract.	0 930			

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0 930	Continued From page 14 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 930			
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part	01620			

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01620	Continued From page 15 of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted comprehensive assessments following the uniform assessment tool (UAT) that included all required content for one of one residents (R2). 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:	01620			

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01620	Continued From page 16 During the entrance conference on August 3, 2026, at 9:46 a.m., clinical nurse supervisor/ licensed assisted living director (CNS/LALD)-B the licensee completed a pre-admission assessment of potential residents and upon admission of a resident, the licensee completed a comprehensive nursing assessment on the day of admission, within 14 days after admission, and every 90 days or with a change of condition. R2 was admitted to the licensee on November 24, 2025. R2's diagnoses included Paranoid Schizophrenia (mental health condition characterized by a mix of hallucinations, delusions, and disorganized thinking and behavior centered on intense fear, persecutory delusions, and auditory hallucinations), depression, chronic back pain, and pulmonary hypertension (elevated blood pressure in arteries carrying blood from a person's heart to the lungs). R2's Service Plan dated November 24, 2025, indicated R2's services included medication management, meals, daily blood pressure monitoring, behavior management, housekeeping, laundry, and linens. On August 4, 2026, at 8:27 a.m., the surveyor observed unlicensed personnel/house manager (ULP/HM)-C administer R2's scheduled morning medications. R2's record included a 90-day Assessment completed on May 29, 2026. The assessment lacked addressing spiritual and cultural preferences. On August 4, 2026, at 2:13 p.m. CNS/LALD-B	01620			

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01620	Continued From page 17 stated CNS/LALD-B was unaware of the uniform assessment tool and its contents. The licensee's Comprehensive Nursing Assessment policy dated July 22, 2025, indicated an RN conducted a comprehensive nursing assessment utilizing the UAT for all residents who were admitted to the licensee. The licensee's Assessment and Reassessment policy dated July 22, 2025, indicated an RN completed resident reassessment of needs no more than 14 days after initiation of services and ongoing assessments within 90 days of the previous assessment and as needed based on changes in resident condition. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0140, Subp. 2, effective October 2022, a nursing assessment or reassessment under Minnesota Statutes, section 144G.70, subdivision 2, paragraphs (b) and (c), must be conducted on a prospective resident or resident receiving any of the assisted living services identified in Minnesota Statutes, section 144G.08, subdivision 9, clauses (6) to (12). B. The nursing assessment or reassessment under item A must: (1) address part 4659.0150, subpart 2, items A to N; (2) be conducted in person unless an exception under Minnesota Statutes, section 144G.70, subdivision 2, paragraph (b), applies; (3) be conducted using a uniform assessment tool that complies with part 4659.0150; and (4) be in writing, dated, and signed by the registered nurse who conducted the assessment. No further information was provided.	01620			

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01620	Continued From page 18	01620			
	TIME PERIOD FOR CORRECTION: Twenty-one (21) days				
01710 SS=F	144G.71 Subd. 3 Individualized medication monitoring and reas A registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the registered nurse (RN) failed to reassess a resident for appropriate medication management services when resident's status changed for one of one resident (R2) who received medication management 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, 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: During the entrance conference on August 3, 2026, at 9:41 a.m., licensed assisted living	01710			

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01710	Continued From page 19 director/registered nurse (LALD/RN)-A stated the licensee provided medication management services to the licensee's residents. R2 was admitted to the licensee on November 24, 2025. R2's diagnoses included Paranoid Schizophrenia (mental health condition characterized by a mix of hallucinations, delusions, and disorganized thinking and behavior centered on intense fear, persecutory delusions, and auditory hallucinations), depression, chronic back pain, and pulmonary hypertension (elevated blood pressure in arteries carrying blood from a person's heart to the lungs). R2's Service Plan dated November 24, 2025, indicated R2's services included medication management, meals, daily blood pressure monitoring, behavior management, housekeeping, laundry, and linens. On August 3, 2026, at 10:38 a.m., during a tour of the facility with LALD/RN-A, the surveyor observed an open bottle of Tylenol 650 milligrams (mg) on R2's bedside table. R2's Med (medication) Admin (administration) Summary-Month (MAR) dated July 1, 2026, through July 31, 2026, indicated R2 self-administered Tylenol (pain reliever), two times daily as needed. R2's record included R2's 90-day Assessment dated May 29, 2026, which contained R2's medication management plan. R2's medication management plan indicated R2 was unable to safely self-administer medication.	01710			

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01710	Continued From page 20 R2's record lacked an Individualized Medication Management Plan (IMMP) which reflected a change in R2's medication management services and reflected R2's ability to self-administer R2's Tylenol as needed. On August 4, 2026, at 10:17 a.m., R2 stated R2 self-administered two tablets of Tylenol 650 mg every morning after breakfast and every night before bed for knee pain. On August 4, 2026, at 1:47 p.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-B stated R2's medication management assessment was marked unable to self-administer medication in error. The licensee's undated Medication Management Program policy indicated at the time of assessment, the RN determined with the resident and the resident's representative(s) what medication management services were to be provided. The policy further indicated the RN, along with the resident and the resident's designated representative or legal representative, discussed the resident's medication self-management abilities. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01710			
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is	01820			

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01820	Continued From page 21 managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure current written or electronically recorded prescriptions were obtained for one of one resident (R2) who received medication management 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, 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: During the entrance conference on August 3, 2026, at 9:41 a.m., licensed assisted living director/registered nurse (LALD/RN)-A stated the licensee provided medication management services to the licensee's residents. R2 was admitted to the licensee on November 24, 2025. R2's diagnoses included Paranoid Schizophrenia (mental health condition characterized by a mix of hallucinations, delusions, and disorganized thinking and behavior centered on intense fear, persecutory delusions, and auditory hallucinations), depression, chronic back pain, and pulmonary hypertension (elevated blood pressure in arteries carrying blood from a person's heart to the lungs).	01820			

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01820	Continued From page 22 R2's Service Plan dated November 24, 2025, indicated R2's services included medication management, meals, daily blood pressure monitoring, behavior management, housekeeping, laundry, and linens. On August 3, 2026, at 10:38 a.m., during a tour of the facility with LALD/RN-A, the surveyor observed an open bottle of Tylenol Arthritis 650 milligrams (mg) on R2's bedside table. R2's Med (medication) Admin (administration) Summary-Month (MAR) dated July 1, 2026, through July 31, 2026, indicated R2 self-administered Tylenol (pain reliever), two times daily as needed. R2's Physician Standing Orders dated December 16, 2025, included acetaminophen 650 mg every four hours as needed for pain and included specific instructions which read, "If any of the interventions are used for more than 72 consecutive hours or used more than 2 times in a 7 day period, a specific physician's order must be obtained." R2's record lacked a prescription order for Tylenol. On August 4, 2026, at 10:17 a.m., R2 stated R2 self-administered two tablets of Tylenol 650 mg every morning after breakfast and every night before bed for knee pain. On August 4, 2026, at 1:47 p.m., clinical nurse supervisor/ licensed assisted living director (CNS/LALD)-B stated CNS/LALD-B assumed R2's Tylenol was covered under R2's signed standing orders however because it was used	01820			

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01820	Continued From page 23 daily a long-term order from the provider was required after 72 hours of consecutive use. The licensee's Medication Orders policy dated July 22, 2025, indicated over the counter medications were included on the resident's medication profile and annually renewed by the resident's physician. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820			
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the required notice to visitors was posted at the main entry way of the establishment to display statutory language to disclose electronic monitoring activity, potentially affecting all residents, staff, and visitors of the licensee. This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when	03090			

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03090	Continued From page 24 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: During the entrance conference on August 3, 2026, at 9:37 a.m., licensed assisted living director/registered nurse (LALD/RN)-A stated the licensee was familiar with current minimum assisted living requirements. On August 3, 2026, at 9:23 a.m., the surveyor observed a sign posted on the exterior main entrance door which read, "WARNING Security Cameras In Use." On August 3, 2026, at 10:34 a.m., the surveyor toured the facility with LALD/RN-A and did not observe a sign regarding electronic monitoring to include the required verbiage. The licensee lacked a posting which included the required verbiage regarding electronic monitoring. On August 5, 2026, at 11:14 a.m., LALD/RN-A stated LALD/RN-A was aware of the specific verbiage indicated in statute to be used for notice of electronic monitoring however, LALD/RN-A thought the sign posted on the exterior of the facility would be sufficient. The licensee's Electronic Monitoring policy dated July 22, 2025, indicated [licensee] posted a sign at the facility's entrance which read, "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." No further information was provided.	03090			

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03090	Continued From page 25 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090			



St Cloud District Office
Minnesota Department of Health
4140 Thielman Lane, Suite 101
St Cloud, MN 56301
Phone: 651-201-4500

Food & Beverage Inspection Report

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Establishment Info

HONEST CARE LLC
8381 6TH ST NE
Spring Lake Park, MN 55432
Anoka County
Parcel:

Phone:

License Info

License: HFID 40767

Risk:
License:
Expires on:
CFPM: Amina Said
CFPM #: 55356; Exp: 12/30/2027

Inspection Info

Report Number: F1051261204
Inspection Type: Full - Single
Date: 8/3/2026 Time: 11:00:00 AM
Duration: 30 minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

No orders were issued for this inspection report.

Food & Beverage General Comment

MET WITH THE NURSE EVALUATOR, ALLISON SKILLINGSTAD.

DISCUSSED THE FOLLOWING WITH THE FOOD SERVICE MANAGER, AMINA:

EMPLOYEE ILLNESS LOG
VOMIT CLEAN-UP PROCEDURES
HANDWASHING & GLOVE USE/DISPOSAL
NOROVIRUS

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 St Cloud District Office inspection report number F1051261204 from 8/3/2026

Amina Said
Food Service Manager

Kai Yang,
Public Health Sanitarian 1
320-640-3532
kai.yang@state.mn.us



St Cloud District Office
Minnesota Department of Health
4140 Thielman Lane, Suite 101
St Cloud, MN 56301

Temperature Observations/Recordings

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Establishment Info

HONEST CARE LLC
Spring Lake Park
County/Group: Anoka County

Inspection Info

Report Number: F1051261204
Inspection Type: Full
Date: 8/3/2026
Time: 11:00:00 AM

Food Temperature: **Product/Item/Unit:** AMERICAN SAUSAGE; **Temperature Process:** Cold-Holding

Location: Upright Cooler at 41 Degrees F.

Comment:

Violation Issued?: No

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL40767015-0	Date: August 4, 2026
Facility Name: HONEST CARE LLC	
Facility Address: 8381 6TH ST NE, SPRING LAKE PARK, MN 55432	

☒ 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 (FSEP) that include employee actions to be taken in the event of a fire or similar emergency. [Minn. Stat. 144G.45 subd.2]

Comments: The FSEP failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks.
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 FSEP did not identify specific fire protection actions for residents. There was no section in the plan that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency.
3. 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: The licensed assisted living director/registered nurse (LALD/RN)-A failed to provide training to employees on the FSEP upon hire and at least twice per year. The LALD/RN-A provided one staff training from June 10, 2026, the facility has been licensed since February 2025.
4. 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: The LALD/RN-A provided evacuation drill documents and the documents provided showed drills didn't occur for 3rd (NOC) shift at all.