



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

March 9, 2026

Licensee

Michaela Residential Care LLC

312 74th Ave North

Brooklyn Park, MN 55444

RE: Project Number(s) SL41375015

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 February 19, 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 . . ."

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility.**

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>

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **<https://forms.office.com/g/Bm5uQEPhVa>**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,



Jess Schoenecker, Supervisor
State Evaluation Team
Email: Jess.Schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

CLN

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41375	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/19/2026
NAME OF PROVIDER OR SUPPLIER MICHAELA RESIDENTIAL CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 312 74TH AVE N BROOKLYN PARK, MN 55444			
(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#41375015 On February 17, 2026, through February 19, 2026, 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 were 0 residents; 0 receiving services under the Provisional Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment	0 550			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 550	Continued From page 1 All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post the required information related to the grievance procedure and contact information for the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances and the contact information for the Office of Ombudsman for Long-Term Care and Mental Health and Developmental Disabilities (OOLTC). This had the potential to affect 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	0 550			

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0 550	Continued From page 2 a large portion or all of the residents). The findings include: On February 17, 2026, at approximately 10:40 a.m., during a facility tour, the common areas shared by residents, staff, and visitors, lacked a posting of the grievance procedure to include the name, telephone number, and e-mail contact information for the individuals who were responsible for handling resident grievances and the contact information for the OOLTC. On February 17, 2026, at approximately 10:45 a.m., director in residency/clinical nurse supervisor (DIR/CNS)-A acknowledged the required content was not posted in the common areas. DIR/CNS-A stated it was an oversight, and the licensee would post the grievance procedure with the required information. The licensee's Complaint and Investigation Process policy, undated, indicated the licensee would provide the residents with written information about how to address concerns and questions related to the residents' care and services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550			
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and	0 640			

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0 640	Continued From page 3 suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment as required. This had the potential to affect 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). The findings include: On February 17, 2026, at approximately 10:40 a.m., during a facility tour, the common areas shared by residents, staff, and visitors, lacked a posting of information for reporting suspected crime and maltreatment to include the 911 emergency number and the reporting number for the Minnesota Adult Abuse Reporting Center	0 640			

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0 640	Continued From page 4 (MAARC). On February 17, 2026, at approximately 10:45 a.m., director in residency/clinical nurse supervisor (DIR/CNS)-A acknowledged the required content was not posted in the common areas. DIR/CNS-A stated it was an oversight, and the licensee would post the information for reporting suspected crime and maltreatment to include the 911 emergency number and the reporting number for MAARC. The licensee's 2.44 Vulnerable Adult Maltreatment - Prevention & Reporting policy, dated July 7, 2025, indicated contact information for MAARC and the 911 emergency number would be posted in the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640			
0 650 SS=D	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of 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	0 650			

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0 650	Continued From page 5 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 interview and record review, the licensee failed to ensure employee records included all required content for one of one employee (director in residency/clinical nurse supervisor (DIR/CNS)-A). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: DIR/CNS-A was hired on July 7, 2025. On February 17, 2026, at approximately 10:15 a.m., during the entrance conference, DIR/CNS-A stated DIR/CNS-A was responsible for all orientation requirements for the licensee. DIR/CNS-A's employee record lacked documentation of a completed orientation to	0 650			

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0 650	Continued From page 6 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; and -Consumer advocacy services; On February 17, 2026, at approximately 2:15 p.m., DIR/CNS-A stated they completed the initial orientation, and the missing employee record content was an oversight by licensee. The licensee's Employee Records policy, undated, indicated each employee record would include records of orientation to the facility, the licensee, and employee roles and responsibilities. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650			
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	0 680			

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0 680	Continued From page 7 (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on 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 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 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On February 17, 2026, at approximately 11:30 a.m., director in residency/clinical nurse supervisor (DIR/CNS)-A 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	0 680			

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0 680	Continued From page 8 content below: -missing resident quarterly review; -missing Hazard Vulnerability Analysis (HVA) assessment; -process for EP collaboration; -development of all policies/procedures (P/P) based on HVA assessment; -arrangement of other facilities; -roles under a waiver declared by secretary; -communication plan; and -EP training and testing program. On February 17, 2026, at approximately 2:30 p.m., DIR/CNS-A acknowledged the licensee's EPP lacked the above listed required content. DIR/CNS-A stated the licensee was not aware of the HVA assessment and all the requirements of Appendix Z. The licensee's Emergency Preparedness policy, dated June 1, 2025, 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. The licensee's Missing Resident policy, dated June 1, 2025, indicated the licensee would review the missing resident plan at least quarterly and document any changes to the plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
01530 SS=F	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De-	01530			

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01530	Continued From page 9 (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter;	01530			

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01530	Continued From page 10 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure all employees received two hours of mental illness and de-escalation training within the first 120 working hours of employment for supervisors of direct care staff as required for one of one director in residency/clinical nurse supervisor (DIR/CNS)-A. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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 February 17, 2026, at 10:20 a.m., during the entrance conference, DIR/CNS-A stated they worked at the facility every day with hours that varied. DIR/CNS-A also stated they were responsible for all orientation requirements for the licensee. DIR/CNS-A was hired on July 7, 2025, to provide direct care to residents and supervise employees. The licensee's Provision Assisted Living License was issued December 18, 2024. DIR/CNS-A's employee record included the required eight hours of dementia training but lacked the required two hours of mental illness and de-escalation training within 120 hours of	01530			

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01530	Continued From page 11 working for the licensee. On February 17, 2026, at 2:00 p.m., DIR/CNS-A verified the initial mental illness and de-escalation training was not completed for DIR/CNS-A. DIR/CNS-A stated it was an oversight by the licensee and they were unaware of the mental illness and de-escalation training requirements for supervisors and employees. DIR/CNS-A further stated the licensee would ensure any new employee would be provided the two hours of mental illness and de-escalation training during orientation. The licensee's Dementia Care Training policy, undated, indicated supervisors of direct care staff would complete at least eight hours of initial dementia training within 120 working hours of employment start date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530			
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41375	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/19/2026
NAME OF PROVIDER OR SUPPLIER MICHAELA RESIDENTIAL CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 312 74TH AVE N BROOKLYN PARK, MN 55444		
(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
01620	Continued From page 12 distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by:	01620			

Minnesota Department of Health

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01620	Continued From page 13 Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident monitoring and reassessment of no more than 14 days after 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 July 7, 2025. R1's Initial Assessment was completed on July 7, 2025, with the next assessment due within 14 days or by July 21, 2025. R1's record did not include a 14-day assessment after the July 7, 2025, assessment. On February 17, 2026, at 12:30 p.m., director in residency/clinical nurse supervisor (DIR/CNS)-A stated R1's 14-day assessment was not completed and was an oversight by the licensee. The licensee's Nursing Assessment and Reassessment of Residents policy, undated, indicated licensee would complete resident reassessment no more than 14 days after initiation of services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	01620			

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01620	Continued From page 14 (21) days	01620			



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

Food & Beverage Inspection Report

Page: 1

Establishment Info

Michaela Residential Care LLC
312 74th Ave N
Brooklyn Park, MN 55444
Hennepin County
Parcel:

Phone:

License Info

License: HFID 41375

Risk:
License:
Expires on:
CFPM: ESTHER G FARES
CFPM #: CFPM-57104; Exp:
03/11/2028

Inspection Info

Report Number: F1005261045
Inspection Type: Full - Single
Date: 2/18/2026 Time: 10:00 AM
Duration: 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

INSPECTION COMPLETED WITH PERSON IN CHARGE AND EMAILED TO HRD NURSING EVALUATOR CARL SAMROCK.

ESTABLISHMENT CURRENTLY HAS NO RESIDENTS LIVING THERE AND THERE WAS NO FOOD IN THE REFRIGERATOR.

THERMAL STRIPS FOR THE DISHWASHER WERE ON SITE AND THE PIC HAD RUN ONE THROUGH THE DISHWASHER EARLIER THAT MORNING. THE STRIP INDICATED A UTENSIL SURFACE TEMPERATURE OF AT LEAST 160 DEGREES F.

DISCUSSED DATE MARKING, GLOVE USE, COOKING TEMPERATURES, CROSS-CONTAMINATION, AND EMPLOYEE ILLNESS.

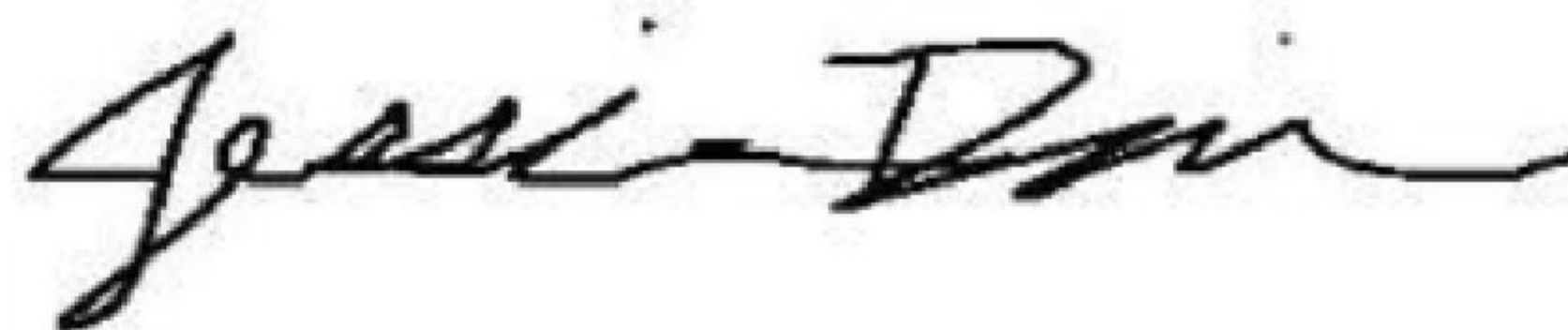
KITCHEN IS RESIDENTIAL AND FOOD IS PREPARED FOR SAME DAY SERVICE.

FLOORING IS LAMINATE AND CABINETS ARE WOOD WITH HOLLOW BASE. ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT SUCH A TIME THEY ARE FOUND TO BE A CONCERN OR RISK OF CONTAMINATION, THEY WILL BE ORDERED TO BE REPLACED AND BROUGHT UP TO CODE.

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 F1005261045 from 2/18/2026

ESTHER FARES
PIC


Jessica Davis, REHS
Public Health Sanitarian 3

651-201-3961
jessica.davis@state.mn.us



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

Temperature Observations/Recordings

Page: 1

Establishment Info	Inspection Info
Michaela Residential Care LLC	Report Number: F1005261045
Brooklyn Park	Inspection Type: Full
County/Group: Hennepin County	Date: 2/18/2026
	Time: 10:00 AM

Equipment Temperature: Product/Item/Unit: AMBIENT; Temperature Process: Cold-Holding

Location: KITCHEN REFRIGERATOR at 40 Degrees F.

Comment:

Violation Issued?: No



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St Paul, MN 55164

Sanitizer Observations/Recordings

Page: 1

Establishment Info

Michaela Residential Care LLC
Brooklyn Park
County/Group: Hennepin County

Inspection Info

Report Number: F1005261045
Inspection Type: Full
Date: 2/18/2026
Time: 10:00 AM

Sanitizing Equipment: Product: Hot Water; **Sanitizing Process:** DISHWASHER

Location: Equal To 160 Degrees F.

Comment: AT LEAST 160 DEGREES F WITH THERMAL STRIP

Violation Issued?: No