



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

May 18, 2026

Licensee

Unity Trust Home Care

7333 Dupont Avenue North

Brooklyn Park, MN 55444

RE: Project Number(s) SL37041016

Dear Licensee:

On April 7, 2026, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on December 11, 2025. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the December 11, 2025 survey.

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.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on December 11, 2025, found not corrected at the time of the April 7, 2026, follow-up survey and/or subject to penalty assessment are as follows:

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

0830-Local Laws Apply-144g.45 Subd. 3 - \$500.00

The details of the violations noted at the time of this follow-up survey completed on April 7, 2026 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$1,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

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.

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

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

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

To submit a hearing request, please visit:

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

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

We urge you to review these orders carefully. If you have questions, please contact Stephanie Jones de Palma at 651-201-4320.

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.

Sincerely,

A handwritten signature in black ink, reading "Stephanie Jones de Palma". The signature is fluid and cursive, with a large, sweeping initial 'S'.

Stephanie Jones de Palma, Supervisor
State Engineering Services Section
Email: stephanie.jones.de.palma@state.mn.us
Telephone: 651-201-4320 Fax: 1-866-890-9290

CLN

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37041	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 04/07/2026
NAME OF PROVIDER OR SUPPLIER UNITY TRUST HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 7333 DUPONT AVENUE NORTH 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 FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS SL37041016-0 On April 6, 2026, the Minnesota Department of Health conducted a deck follow-up survey for the above provider to follow-up on orders issued pursuant to a survey completed on December 10, 2025. As a result of the follow-up survey, the following orders were issued and/or reissued.	{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.		
{0 330} SS=F	144G.30 Subd. 4 Information provided by facility (a) The assisted living facility shall provide	{0 330}			

Minnesota Department of Health

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

TITLE

(X6) DATE

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{0 330}	Continued From page 1 accurate and truthful information to the department during a survey, investigation, or other licensing activities. (b) Upon request of a surveyor, assisted living facilities shall within a reasonable period of time provide a list of current and past residents and their legal representatives and designated representatives that includes addresses and telephone numbers and any other information requested about the services to residents. This MN Requirement is not met as evidenced by:	{0 330}	Not reviewed during this survey.		
{0 480} SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part	{0 480}			

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{0 480}	Continued From page 2 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by:	{0 480}	Not reviewed during this survey.		
{0 510} SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and	{0 510}			

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{0 510}	Continued From page 3 maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by:	{0 510}			
{0 570} SS=C	144G.42 Subdivision 1 Display of license The original current license must be displayed at the main entrance of each assisted living facility. The facility must provide a copy of the license to any person who requests it. This MN Requirement is not met as evidenced by:	{0 570}	Not reviewed during this survey.		
{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	{0 660}	Not reviewed during this survey.		

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{0 660}	Continued From page 4 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:	{0 660}	Not reviewed during this survey.		
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site.	{0 680}			

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{0 680}	Continued From page 5 (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by:	{0 680}	Not reviewed during this survey.		
{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:	{0 775}			
{0 780} SS=D	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to	{0 780}			

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{0 810}	Continued From page 7 (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record 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	{0 810}			

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{0 810}	Continued From page 8 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 April 6, 2026, for the specific violations related the physical environment under Minnesota Statute 144G.	{0 810}			
{0 830} SS=F	144G.45 Subd. 3 Local laws apply Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements, except a facility with a licensed resident capacity of six or fewer is exempt from rental licensing regulations imposed by any town, municipality, or county. 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.	{0 830}			

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{0 830}	Continued From page 9 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 April 6, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) Days	{0 830}			
{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 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:	{0 910}			

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{0 910}	Continued From page 10	{0 910}	Not reviewed during this survey.		
{0 970} SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by:	{0 970}	Not reviewed during this survey.		
{01460} SS=D	144G.63 Subdivision 1 Orientation of staff and supervisors (a) All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility, except as provided in paragraph (b). (b) A staff person is not required to repeat the orientation required under subdivision 2 if the staff person transfers from one licensed assisted living facility to another facility operated by the same licensee or by a licensee affiliated with the same corporate organization as the licensee of the first facility, or to another facility managed by the same entity managing the first facility. The	{01460}			

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{01460}	Continued From page 11 facility to which the staff person transfers must document that the staff person completed the orientation at the prior facility. The facility to which the staff person transfers must nonetheless provide the transferred staff person with supplemental orientation specific to the facility and document that the supplemental orientation was provided. The supplemental orientation must include the types of assisted living services the staff person will be providing, the facility's category of licensure, and the facility's emergency procedures. A staff person cannot transfer to an assisted living facility with dementia care without satisfying the additional training requirements under section 144G.83. This MN Requirement is not met as evidenced by:	{01460}	Not reviewed during this survey.		
{01500} SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective	{01500}			

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{01500}	Continued From page 12 gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions.	{01500}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37041	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 04/07/2026
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{01500}	Continued From page 13	{01500}	Not reviewed during this survey.		
{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	{01530}			

Minnesota Department of Health

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{01530}	Continued From page 14 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; This MN Requirement is not met as evidenced by:	{01530}	Not reviewed during this survey.		
{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;	{01620}			

Minnesota Department of Health

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{01620}	Continued From page 15 (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}			
{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	{01640}	Not reviewed during this survey.		

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{01640}	Continued From page 16 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:	{01640}	Not reviewed during this survey.		
{01760} SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan.	{01760}			

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{01760}	Continued From page 17	{01760}			
	This MN Requirement is not met as evidenced by:		Not reviewed during this survey.		
{01830} SS=D	144G.71 Subd. 14 Renewal of prescriptions Prescriptions must be renewed at least every 12 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter 152.	{01830}			
	This MN Requirement is not met as evidenced by:		Not reviewed during this survey.		
{01890} SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug.	{01890}			
	This MN Requirement is not met as evidenced by:		Not reviewed during this survey.		
{02320} SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in	{02320}			

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

UNITY TRUST HOME CARE

7333 DUPONT AVENUE NORTH
BROOKLYN PARK, MN 55444

Minnesota Department of Health
STATE FORM



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

January 15, 2026

Licensee

Unity Trust Home Care

7333 Dupont Avenue North

Brooklyn Park, MN 55444

RE: Project Number(s) SL37041016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on December 11, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement;

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;

Level 3: a fine of \$1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

Level 4: a fine of \$3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

Level 5: a fine of \$5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

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

pursuant to this survey:

St - 0 - 0330 - 144g.30 Subd. 4 - Information Provided By Facility - \$500.00

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - \$500.00

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - \$500.00

St - 0 - 0810 - 144g.45 Subd. 2 (b-F) - Fire Protection And Physical Environment - \$1,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$2,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

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

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

To submit a hearing request, please visit:

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

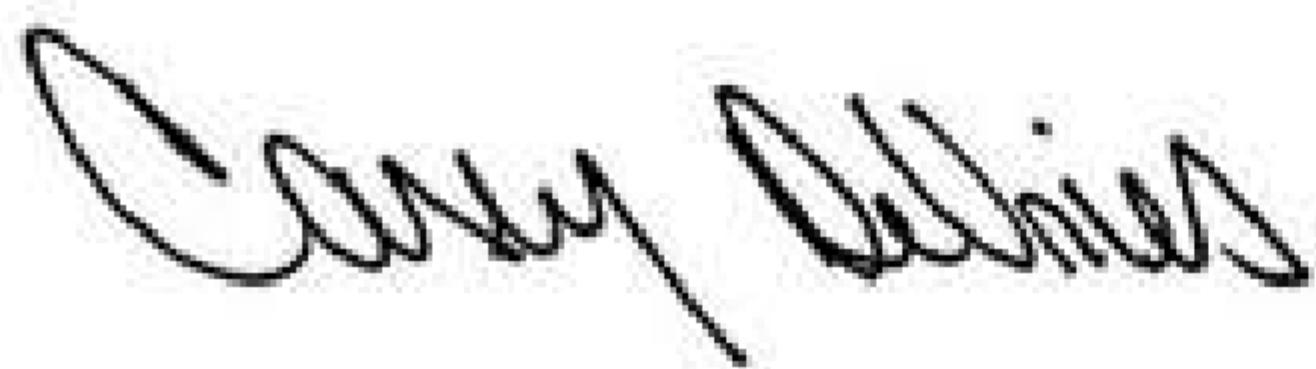
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms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

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

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

If you have any questions, please contact me.

Sincerely,



Casey DeVries, Supervisor

State Evaluation Team

Email: Casey.DeVries@state.mn.us

Telephone: 651-201-5917 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37041	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/11/2025
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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: SL37041016-0 On December 8, 2025, through December 11, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were three residents; three 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.		
0 330 SS=F	144G.30 Subd. 4 Information provided by facility (a) The assisted living facility shall provide	0 330			

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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0 330	Continued From page 1 accurate and truthful information to the department during a survey, investigation, or other licensing activities. (b) Upon request of a surveyor, assisted living facilities shall within a reasonable period of time provide a list of current and past residents and their legal representatives and designated representatives that includes addresses and telephone numbers and any other information requested about the services to residents. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide the Minnesota Department of Health (MDH) with accurate and truthful information during a survey. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 was admitted to the licensee on December 1, 2021, and discharged on October 23, 2024. R1's primary diagnoses included major depressive disorder, alcohol dependence, cocaine abuse, hypertension, left foot drop, right foot drop, multifocal neuropathy, other abnormalities of gait and mobility, paranoid schizophrenia, rhabdomyolysis, traumatic compartment syndrome of right lower extremity,	0 330			

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0 330	Continued From page 2 and vitamin D deficiency. On December 10, 2025, at 12:17 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-B stated the licensee did not dispose of R1's medications and the medications were just sent with R1 upon discharge. LALD/CNS-B stated they only documented that medications were sent with R1, and they did not document a total count. On December 10, 2025, at 12:40 p.m., LALD/CNS-B provided discharge information for R1, which the surveyor previously requested via email on December 8, 2025, at 2:27 p.m., and again on December 9, 2025, at 1:42 p.m. R1's record contained a form titled medication disposition. The document contained no medications and had a signature line titled "receiving signature" which appeared to contain R1's signature with a signing date of February 13, 2025. The document had a print date of December 8, 2025, listed in the lower right-hand corner. Upon closer inspection, the surveyor observed pen indentions made on the signature line of the document which indicated the document was an original and not a photocopy. On December 10, 2025, at 1:09 p.m., LALD/CNS-B stated the provided document was an original copy taken directly from R1's discharge records. On December 10, 2025, at 1:11 p.m., licensed practical nurse (LPN)-A stated the signature on the provided medication disposition form belonged to R1. On December 10, 2025, at 1:25 p.m., during a	0 330			

Minnesota Department of Health

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0 330	Continued From page 3 phone interview, R1 stated they were independent with all of their medications when they lived at the assisted living facility, and did not recall signing a disposition form when they discharged. Additionally, R1 stated they had just received a phone call from the assisted living facility on Monday, December 8, 2025, and that the licensee had asked them questions about when they had discharged. R1 stated that during their discharge from the facility, they primarily worked through their case manager and did not communicate with the facility at all. R1 also stated they had not been back to the facility since their time of discharge and wanted nothing to do with the facility. On December 10, 2025, at 2:43 p.m., LPN-A stated the form in question was created by LALD/CNS-B. On December 11, 2025, at 11:47 a.m., LALD/CNS-B stated they had printed out the form provided to the surveyor but had initially thought that it was an original. The surveyor pointed out that the form was an original document, as the pen indentions on the signature line were visible on the document and were able to be photographed. LALD/CNS-B asserted that the document had been printed from the computer and was not an original. Additionally, LALD/CNS-B stated the surveyor could call R1 to verify the signature on the document. The surveyor informed LALD/CNS-B that they had contacted R1 on the previous day, and R1 had denied signing any discharge documents and that they had been independent with their medications so there should not have been a medication disposition form to sign. LALD/CNS-B verified that the resident was in fact independent with their medications while living at the facility but	0 330			

Minnesota Department of Health

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0 330	Continued From page 4 may not remember signing this document as they had a TBI or a stroke. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 330			
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a	0 480			

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NAME OF PROVIDER OR SUPPLIER UNITY TRUST HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 7333 DUPONT AVENUE NORTH BROOKLYN PARK, MN 55444		
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0 480	Continued From page 5 manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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	0 480			

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0 480	Continued From page 6 portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated December 9, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program that complied with accepted health care, medical and nursing standards for infection control. The deficient practice had the potential to affect all residents, employees, and visitors.	0 510			

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0 510	Continued From page 7 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 10, 2025, at 1:48 p.m., the Environmental Engineering surveyor reported to the surveyor that during their inspection of the facility, a visitor in the room of R3 pointed out mouse droppings in and around the closet of R3's bedroom. On December 8, 2025, at 11:11 a.m., to December 10, 2025, at 3:45 p.m., while the surveyor was on site, the surveyor observed the licensee had failed to provide hand soap or paper towels for hand washing purposes within one of the facility's bathrooms which was utilized by staff, residents, and visitors. On December 10, 2025, at 3:27 p.m., licensed practical nurse (LPN)-A stated they were not aware the bathroom was not stocked with soap or paper towels. On December 11, 2025, at 11:41 a.m. licensed assisted living director/clinical nurse supervisor (LALD/CNS)-B stated they were not aware of there was an active mouse infestation within the facility. The Centers for Disease Control (CDC),	0 510			

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0 510	Continued From page 8 Controlling Wild Rodent Infestation document dated April 8, 2024, indicated the following: "Rodents, such as rats, mice, and chipmunks, are known to carry many diseases. These diseases can spread to people directly, through: - Handling of rodents - Contact with rodent droppings (poop), urine, or saliva - Rodent bites Rodent droppings, urine, and saliva can spread by breathing in air or eating food that is contaminated with rodent waste." The CDC's "About Handwashing" document dated February 16, 2024, indicated the following: "Washing hands can keep you healthy and prevent the spread of respiratory and diarrheal infections." "You can help yourself and your loved ones stay healthy by washing your hands often, especially during these key times when you are likely to get and spread germs: - Before, during, and after preparing food - Before and after eating food - Before and after caring for someone at home who is sick with vomiting or diarrhea - Before and after treating a cut or wound - After using the toilet - After changing diapers or cleaning up a child who has used the toilet - After blowing your nose, coughing, or sneezing - After touching an animal, animal feed, or animal waste - After handling pet food or pet treats - After touching garbage" The CDC's Clinical Safety: Hand Hygiene for Healthcare Workers dated February 27, 2024, indicated the following instructions on completing	0 510			

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0 510	Continued From page 9 hand hygiene: "1. Wet hands with water. 2. Apply the manufacturer recommended amount of product to your hands. 3. Rub hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. 4. Rinse hands with water and use disposable towels to dry. Use a towel to turn off the faucet. 5. Avoid using hot water to prevent drying of the skin." The licensee's 8.01 Infection Control Policy dated August 23, 2023, indicated the licensee's infection control program would be consistent with current guidelines from CDC for prevention control in long-term care facilities, where applicable in assisted living facilities. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510			
0 570 SS=C	144G.42 Subdivision 1 Display of license The original current license must be displayed at the main entrance of each assisted living facility. The facility must provide a copy of the license to any person who requests it. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to display the original current license at the main entrance of the assisted living facility as required. This had the potential to affect all residents, staff, and visitors.	0 570			

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0 570	Continued From page 10 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: The licensee held an assisted living license effective December 1, 2025, with an expiration date of November 30, 2026. On December 8, 2025, at 11:11 a.m., during a tour of the facility, the surveyor observed the licensee's previous assisted living license for the time period of December 1, 2024, to November 31, 2025. On December 8, 2025, at 11:15 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-B stated they were still waiting on their license for the current year and was unaware licenses were available to be printed. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 570			
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	0 660			

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0 660	Continued From page 11 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 interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) for one of three staff (unlicensed personnel (ULP)-D). This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's facility TB risk assessment dated May 27, 2025, indicated the facility was at low risk for TB transmission. ULP-D was hired November 4, 2023, to provide	0 660			

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0 660	Continued From page 12 assisted living services. ULP-D's employee record contained a TB symptom screening dated June 30, 2022, and a QuantiFERON - TB Gold Plus test dated June 30, 2022. The screenings and testing occurred greater than 90-days prior to the start of employment. The results of the TB test under the column titled "value" indicated "positive", and under the column titled "Ref Range" indicated "Negative". The result titled "Negative" was circled. Additionally, the TB test indicated the following under the comment section: "Interferon gamma response to M. Tuberculosis antigens was detected, suggesting infection with M. Tuberculosis. Positive results in patients at low risk for infection should be interpreted with caution and repeat testing on a new sample should be considered as recommended by the 2017 ATS/IDSA/CDC Clinical Practice Guidelines for Diagnosis of Tuberculosis in Adults and Children." ULP-D's record lacked documentation of remedial action in response to positive results. On December 10, 2025, at 3:26 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-B stated ULP-D was removed from the schedule and was instructed to complete all steps for TB screening. LALD/CNS stated they were unaware it had not been previously completed. The licensee's 8.16 Tuberculosis Screening policy dated August 23, 2023, indicated the licensee will establish and maintain a comprehensive tuberculosis infection control program according to the most current	0 660			

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0 660	Continued From page 13 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 (MMWR). The CDC's Morbidity and Mortality Weekly Report, Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Settings, 2005, dated December 30, 2005, indicated that all HCW's (health care workers) should receive baseline TB screening upon hire, using two-step tuberculin skin tests (TST) or a single Blood Assay for Mycobacterium tuberculosis (BAMT) to test for infection with M. tuberculosis. HCWs with a baseline positive or newly positive test result for M. tuberculosis infection (i.e., TST or BAMT) or documentation of treatment for latent TB infection or TB disease should receive one chest radiograph result to exclude TB disease (or an interpretable copy within a reasonable time frame, such as 6 months). Repeat radiographs are not needed unless symptoms or signs of TB disease develop or unless recommended by a clinician. 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	0 680			

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0 680	Continued From page 14 temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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:	0 680			

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0 680	Continued From page 15 On December 9, 2025, at 8:01 a.m., the surveyor observed licensed assisted living director/clinical nurse supervisor (LALD/CNS)-B retrieve the licensee's EPP from the licensee's file cabinet situated in the secured nursing office located in the back of the facility. The licensee's written EPP dated October 1, 2023, lacked evidence of the following required content: - annual review of EPP; - documentation of the all-hazards risk assessment; - subsistence needs for staff and patients; * The licensee's EPP contained a document titled 2.03 Provision of Subsistence, dated October 1, 2023, which directed the licensee to utilize the spreadsheet incorporated into the document to record and track the licensee's current emergency supplies. The document indicated the assessment was to be completed on an annual basis. - annual review of the communication plan. On December 11, 2025, at 11:39 a.m., LALD/CNS-B stated they were responsible for the development and implementation of the licensee's EPP. LALD/CNS-B stated they had worked on it with a consultant, and they were aware it had not been completed by the time of survey. The licensee's 9.01 Emergency Preparedness Plan - Appendix Z Compliance policy dated August 23, 2023, indicated the licensee would have in place an effective and compliant Emergency Preparedness Plan and that the intent of the plan will be aligned with the Centers for Medicare and Medicaid Services State	0 680			

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0 680	Continued From page 16 Operation Manual Appendix Z: "State Operations Manual Appendix Z - Emergency Preparedness for All Provides and Certified Supplier Types: Interpretive Guidance." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
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, 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	0 775			

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0 775	Continued From page 17 12-10-25, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775			
0 780 SS=D	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated;	0 780			

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0 780	Continued From page 18 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 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 12-10-25, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780			
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.	0 800			

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NAME OF PROVIDER OR SUPPLIER UNITY TRUST HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 7333 DUPONT AVENUE NORTH 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
0 800	Continued From page 19 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 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 12-10-25, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800			
0 810 SS=I	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:	0 810			

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0 810	Continued From page 20 (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record 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 three violation (a	0 810			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 810	Continued From page 21 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 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: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated 12-10-25, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty one (21) days	0 810			
0 830 SS=F	144G.45 Subd. 3 Local laws apply Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements, except a facility with a licensed resident capacity of six or fewer is exempt from rental licensing regulations imposed by any town, municipality, or county. 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	0 830			

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0 830	Continued From page 22 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 12-10-25, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 830			
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 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.	0 910			

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0 910	Continued From page 23 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 two of two residents (R2, R3). 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 potential to affect a large portion or all the residents). The findings include: R2 R2 was admitted December 19, 2024, to receive assisted living services. R2's service plan dated December 19, 2024, indicated R2 received assisted living services to include assistance with dressing, oral hygiene, hair care, grooming, toileting, bathing, standby assistance, treatments and exercise, preparation of modified diets, medication administration, eating assistance, personal laundry, housekeeping and linen changes, safety checks, and abuse prevention. R2's record contained an assisted living contract which was signed on December 20, 2024. R3 R3 was admitted January 4, 2024, to receive assisted living services. R3's service plan dated January 5, 2024,	0 910			

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0 910	Continued From page 24 indicated R3 received assisted living services to include assistance with dressing, assistance with self-feeding, oral hygiene, hair care, grooming, toileting, bathing, standby assistance, medication reminders, treatments and exercise, eating assistance, personal laundry, housekeeping and linen changes, safety checks, delegated nursing tasks, delegated wound care monitoring, and medication management. R3's record contained an assisted living contract which was signed on January 5, 2024. R2 and R3's assisted living contracts lacked documentation of the licensee's Health Facility Identification (HFID) number. On December 11, 2025, at 11:36 a.m. licensed assisted living director/clinical nurse supervisor (LALD/CNS)-B stated they were aware of the requirement and thought the HFID number was listed on their contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 910			
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law.	0 970			

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0 970	Continued From page 25 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property of a resident. This had the potential to affect all residents. 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: R2 R2 was admitted December 19, 2024, to receive assisted living services. R2's service plan dated December 19, 2024, indicated R2 received assisted living services to include assistance with dressing, oral hygiene, hair care, grooming, toileting, bathing, standby assistance, treatments and exercise, preparation of modified diets, medication administration, eating assistance, personal laundry, housekeeping and linen changes, safety checks and abuse prevention. R2's record contained an assisted living contract which was signed on December 20, 2024. R3 R3 was admitted January 4, 2024, to receive assisted living services.	0 970			

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0 970	Continued From page 26 R3's service plan dated January 5, 2024, indicated R3 received assisted living services to include assistance with dressing, assistance with self-feeding, oral hygiene, hair care, grooming, toileting, bathing, standby assistance, medication reminders, treatments and exercise, eating assistance, personal laundry, housekeeping and linen changes, safety checks, delegated nursing tasks, delegated wound care monitoring, and medication management. R3's record contained an assisted living contract which was signed on January 5, 2024. R2 and R3's assisted living contracts contained the following language: Page 20, section VI. General Terms, item 2. "Resident will indemnify and hold harmless Provider, its employees and agents from and against any and all claims, actions, damages, and liability and expense in connection with loss of life, personal injury or damage to property, arising from or out of the use by Resident of the rented premises or any other part of Provider's property, or caused wholly or in part by an act or omission of Resident or Resident's guests or agents." On December 10, 2025, at 3:24 p.m., license assisted living director/clinical nurse supervisor (LALD/CNS)-B stated they were unaware the licensee's contract contained a liability waiver. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970			

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01460	Continued From page 27	01460			
01460 SS=D	144G.63 Subdivision 1 Orientation of staff and supervisors (a) All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility, except as provided in paragraph (b). (b) A staff person is not required to repeat the orientation required under subdivision 2 if the staff person transfers from one licensed assisted living facility to another facility operated by the same licensee or by a licensee affiliated with the same corporate organization as the licensee of the first facility, or to another facility managed by the same entity managing the first facility. The facility to which the staff person transfers must document that the staff person completed the orientation at the prior facility. The facility to which the staff person transfers must nonetheless provide the transferred staff person with supplemental orientation specific to the facility and document that the supplemental orientation was provided. The supplemental orientation must include the types of assisted living services the staff person will be providing, the facility's category of licensure, and the facility's emergency procedures. A staff person cannot transfer to an assisted living facility with dementia care without satisfying the additional training requirements under section 144G.83. This MN Requirement is not met as evidenced by:	01460			

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01460	Continued From page 28 Based on observation, interview, and record review, the licensee failed to ensure employees received orientation to 144G licensing requirements for one of two employees (licensed practical nurse (LPN)-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: During the entrance conference on December 8, 2025, at 10:31 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-B stated they were aware of the required content for employee records. LPN-A was hired April 28, 2021, to provide clinical oversite and assisted living services. On December 9, 2025, at 7:46 a.m., the surveyor observed LPN-A administer medications to R2. LPN-A's record contained a record of orientation completed on April 6, 2021, under the licensee's prior comprehensive home care licensure. LPN-A's record lacked any additional documentation of orientation. On December 11, 2025, at 11:32 a.m., LALD/CNS-B stated LPN-A would need to be retrained under current 144G regulations.	01460			

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01460	Continued From page 29 The licensee's 4.18 Employee General Orientation policy dated August 23, 2023, indicated prior to performing any functions of their position each employee and volunteer will be oriented in accordance with State and Federal regulations, as well as company policy and procedure. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01460			
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging	01500			

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01500	Continued From page 30 behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employees received at least eight (8) hours of annual training for each 12 months of employment for one of three employees (licensed practical nurse (LPN)-A).	01500			

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01500	Continued From page 31 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: LPN-A was hired April 28, 2021, to provide clinical oversight and assisted living services. On December 9, 2025, at 7:46 a.m., the surveyor observed LPN-A administer medications to R2. LPN-A's record lacked documentation of annual trainings. On December 11, 2025, at 11:33 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-B stated they were unaware LPN-A had not completed annual trainings and assumed they had been keeping up on it. Additionally, LALD/CNS-B stated that they were responsible for ensuring employee records were kept up to date. LPN-A was unavailable for interview. The licensee's 5.06 Annual Required Staff Training policy dated August 23, 2023, indicated all staff that perform direct care services will complete at least eight hours of annual training for each 12 months of employment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	01500			

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01500	Continued From page 32 (21) days	01500			
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	01530			

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NAME OF PROVIDER OR SUPPLIER UNITY TRUST HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 7333 DUPONT AVENUE NORTH BROOKLYN PARK, MN 55444			
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01530	Continued From page 33 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; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide two hours of initial training on mental illness and de-escalation for employees hired prior to July 1, 2025, for three of three employees (licensed practical nurse (LPN)-A, unlicensed personnel (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: LPN-A LPN-A was hired April 28, 2021, to provide clinical oversite and assisted living services. On December 9, 2025, at 7:46 a.m., the surveyor observed LPN-A administer medications to R2. ULP-C ULP-C was hired October 4, 2025, to provide assisted living services.	01530			

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01530	Continued From page 34 ULP-D ULP-D was hired November 4, 2023, to provide assisted living services. LPN-A, ULP-C, and ULP-D's employee record lacked documentation of mental illness and de-escalation training. On December 11, 2025, at 11:33 a.m., licensed assisted living director /clinical nurse supervisor (LALD/CNS)-B stated they were not aware of the new mental health training requirements. The licensee's policies did not address the new statutory requirement to provide mental illness and de-escalation training. 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 distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be	01620			

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01620	Continued From page 35 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: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident assessment	01620			

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01620	Continued From page 36 and reassessment, not to exceed 90 calendar days from the last date of the assessment for two of two residents (R2, R3). 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: R2 R2 was admitted December 19, 2024, to receive assisted living services. R2's diagnoses included autistic disorder, anxiety, expressive language disorder, intermittent explosive disorder, moderate intellectual disabilities and type 2 diabetes mellitus without complications. R2's service plan dated December 19, 2024, indicated R2 received assisted living services to include assistance with dressing, oral hygiene, hair care, grooming, toileting, bathing, standby assistance, treatments and exercise, preparation of modified diets, medication administration, eating assistance, personal laundry, housekeeping and linen changes, safety checks, and abuse prevention. R2 records contained a 90-day assessment dated May 21, 2025, with the next assessment occurring on August 22, 2025, which indicated 93 days had lapsed between assessments. R2's	01620			

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01620	Continued From page 37 next assessment on record was after the start of survey on December 8, 2025, indicating 108 days had lapsed since their last assessment. R3 R3 was admitted January 4, 2024, to receive assisted living services. R3's diagnoses included cellulitis of right lower limb, acute kidney failure, aphasia, cellulitis of left lower limb, cerebral palsy, chronic kidney disease stage 2, chronic venous hypertension idiopathic with inflammation of bilateral lower extremities, dysphagia, dysphasia, muscle weakness, underweight and unspecified intellectual disabilities. R3's service plan dated January 5, 2024, indicated R3 received assisted living services to include assistance with dressing, assistance with self-feeding, oral hygiene, hair care, grooming, toileting, bathing, standby assistance, medication reminders, treatments and exercise, eating assistance, personal laundry, housekeeping and linen changes, safety checks, delegated nursing tasks, delegated wound care monitoring, and medication management. R3's records contained a 90-day assessment dated May 20, 2025, with the next assessment occurring on August 22, 2025, which indicated 94 days had lapsed between assessments. R2's next assessment on record was after the start of survey on December 8, 2025, indicating 108 days had lapsed since their last assessment. On December 1, 2025, at 3:22 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-B stated they were aware assessments were required to be completed on	01620			

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01620	Continued From page 38 or before the 90th day and the assessments were done late due to an oversight. The licensee's undated Nursing Assessment and Reassessment of Residents policy indicated on-going reassessment, and monitoring will be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620			
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	01640			

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01640	Continued From page 39 the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a written service plan which included a signature or other authentication by the resident or resident's designated representative to document agreement on the services to be provided for one of two 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: R2 was admitted December 19, 2024, to receive assisted living services. R2's diagnoses included autistic disorder, anxiety, expressive language disorder, intermittent explosive disorder, moderate intellectual disabilities and type 2 diabetes mellitus without complications. R2's service plan dated December 19, 2024, indicated R2 received assisted living services to include assistance with dressing, oral hygiene, hair care, grooming, toileting, bathing, standby assistance, treatments and exercise, preparation of modified diets, medication administration, eating assistance, personal laundry,	01640			

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01640	Continued From page 40 housekeeping and linen changes, safety checks, and abuse prevention. R2's unsigned Service Plan - Modification dated December 8, 2025, indicated the following services were no longer being offered: - assistance with oral hygiene; - assistance with hair care, and; - standby assistance. R2's unsigned Service Plan - Modification dated December 8, 2025, indicated the following services not found on the initial signed service plan: - appointment reminder / assistance; - equipment care - other; - escort / mobility assistance; - finance management; - incontinence care; - manage behavior - agitation; - manage symptom - depression; - manage symptom - other mental health need; - vital signs; - shopping assistance; - skin care; - socialization, and - transportation assistance. On December 8, 2025, at 10:48 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-B stated they were responsible for updating service plans and that service plans were kept within the licensee's computer charting system. LALD/CNS-B stated service plans were only printed out if someone needed a copy and signatures were only obtained at the time of admission. The licensee's undated Service Plan policy indicated the service plan, and any revisions must	01640			

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01640	Continued From page 41 include a signature or other authentication by the assisted living provider and by the resident or resident's representative documenting agreement on the services to be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640			
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to reconcile, clarify, or accurately transcribe medication orders to ensure medications were administered per prescriber's order for one of three residents (R4). 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	01760			

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01760	Continued From page 42 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: R4 was admitted April 4, 2024, to receive assisted living services. R4's diagnoses included schizoaffective disorder, cognitive impairment, chronic leg pain, and generalized weakness. R4's unsigned Service Plan - Modification document dated December 10, 2025, indicated R4 received assisted living services to include appointment reminders, bathing assistance, bed making and linen changes, dressing assistance, equipment care, escort assistance, finance management, grooming, housekeeping, incontinence care, laundry, behavior management, medication administration, vital signs, safety checks, toileting and assistance with transfers. R4's signed provider orders dated April 17, 2025, indicated the following: - Atorvastatin 80mg tab, take 1 tablet by mouth daily at 8:00 a.m. R4's medication administration record (MAR) indicated R4 was to receive their prescribed Atorvastatin 80mg at 8:00 a.m. R4's pre-setup comingled medication cards set up by the pharmacy had R4's Atorvastatin 80mg set up to be administered at 8:00 p.m.	01760			

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01760	Continued From page 43 On December 9, 2025, the surveyor observed licensed practical nurse (LPN)-A administer medications to R4. The surveyor observed LPN-A open R4's comingled medication packet which had been set up by the pharmacy. LPN-A then dumped the medication into a cup and crushed the medications in a mortar and pestle. The medications prepared included the following: - Tamsulosin 0.4mg capsule; - Cerovite tablet; - Aspirin 81mg tablet; - vitamin B1 100mg - Folic acid 1mg; - Metformin 500 mg ER, and; - Sennexon 8.6-50 mg. On December 11, 2025, at 11:26 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-B stated R4's Atorvastatin 80mg was transcribed incorrectly and should be administered at 8:00 p.m. The licensee's 7.20 Medication & Treatment Orders policy dated August 23, 2023, indicated a resident's MAR will be audited regularly by licensed nurse or designee for documentation compliance. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			
01830 SS=D	144G.71 Subd. 14 Renewal of prescriptions Prescriptions must be renewed at least every 12 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions for	01830			

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01830	Continued From page 44 controlled substances must comply with chapter 152. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure prescriptions were renewed at least every 12 months for one of two residents (R3). 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: R3 was admitted January 4, 2024, to receive assisted living services. R3's diagnoses included cellulitis of right lower limb, acute kidney failure, aphasia, cellulitis of left lower limb, cerebral palsy, chronic kidney disease stage 2, chronic venous hypertension idiopathic with inflammation of bilateral lower extremities, dysphagia, dysphasia, muscle weakness, underweight, and unspecified intellectual disabilities. R3's service plan dated January 5, 2024, indicated R3 received assisted living services to include assistance with dressing, assistance with self-feeding, oral hygiene, hair care, grooming, toileting, bathing, standby assistance, medication reminders, treatments and exercise, eating	01830			

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01830	Continued From page 45 assistance, personal laundry, housekeeping and linen changes, safety checks, delegated nursing tasks, delegated wound care monitoring, and medication management. R3's record contained signed provider orders dated August 20, 2024. R3's record lacked additional signed orders. The signed order contained the following medications: - Baclofen 10 mg, give 10 mg by mouth two times a day for muscle spasm; - calcium carbonate-vitamin D3 600 -400, take 1 tablet by mouth twice daily; - Compleat Liquid, Drink 1 can by mouth twice daily for decreased appetite and wound healing; - Eucerine Cream, apply to skin: Apply to both lower legs daily: do not apply between toes; - medications, ok to crush meds. Verify with pharmacy that all meds are safe to be crushed every for other dysphagia; - Nystatin cream 100 ,000 units/g, apply to skin 1 application 3 times daily: Apply cream to the glans of the penis as well as foreskin around it; and - Tab-A-Vite Tablet, take 1 tablet by mouth daily. R3's medications administration record (MAR) for the month of December 2025, indicated R3 was receiving the following medications: - Baclofen 10 mg, give 10 mg by mouth two times a day for muscle spasm; - calcium carbonate-vitamin D3 600 -400, take 1 tablet by mouth twice daily; - Compleat Liquid, Drink 1 can by mouth twice daily for decreased appetite and wound healing; - Eucerine Cream, apply to skin: Apply to both lower legs daily: do not apply between toes; - medications, ok to crush meds. Verify with pharmacy that all meds are safe to be crushed every for other dysphagia;	01830			

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NAME OF PROVIDER OR SUPPLIER UNITY TRUST HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 7333 DUPONT AVENUE NORTH 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
01830	Continued From page 46 - Nystatin cream 100 ,000 units/g, apply to skin 1 application 3 times daily: Apply cream to the glans of the penis as well as foreskin around it; - Tab-A-Vite Tablet, take 1 tablet by mouth daily; On December 11, 2025, at 11:24 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-B stated R3 was stable and did not take many medications, so they have not been back to the provider. LALD/CNS-B stated there were no additional orders on file for R3. The licensee's 7.18 Medication & Treatment Orders - Renewal policy dated August 23, 2023, indicated medication and treatment orders must be renewed at least every 12 months or more frequently as required. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01830			
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were maintained bearing the original prescription label with legible information. This had the	01890			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37041	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/11/2025
NAME OF PROVIDER OR SUPPLIER UNITY TRUST HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 7333 DUPONT AVENUE NORTH 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
01890	Continued From page 47 potential to affect all 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 9, 2025, at 9:06 a.m., the surveyor observed an unidentified white, small round directly in front of the licensee's medication cabinet. The surveyor also observed an additional unidentified white, small round tablet directly to the left of the licensee's medication cabinet between the countertop and refrigerator. On December 9, 2025, at 9:06 a.m., the surveyor pointed the loose medications out to licensed assisted living director/clinical nurse supervisor (LALD/CNS)-B who stated staff were trained to notify the registered nurse of any dropped medications and then to discard them with a witness. The licensee 7.11 Medication Storage policy dated August 23, 2023, indicated when medications are managed and stored by the licensee, the medications will be kept securely locked and stored per manufacturer's directions. Only authorized staff will have access to stored medications. No further information was provided.	01890			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37041	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/11/2025
NAME OF PROVIDER OR SUPPLIER UNITY TRUST HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 7333 DUPONT AVENUE NORTH 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
01890	Continued From page 48	01890			
	TIME PERIOD FOR CORRECTION: Seven (7) days				
02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure staff followed appropriate medication administration procedures for one of three (R4) residents currently residing within facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: R4 was admitted April 4, 2024, to receive assisted living services. R4's diagnoses included schizoaffective disorder, cognitive impairment, chronic leg pain, and	02320			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37041	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/11/2025
NAME OF PROVIDER OR SUPPLIER UNITY TRUST HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 7333 DUPONT AVENUE NORTH 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
02320	Continued From page 49 generalized weakness. R4's unsigned Service Plan - Modification document dated December 10, 2025, indicated R4 received assisted living services to include appointment reminders, bathing assistance, bed making and linen changes, dressing assistance, equipment care, escort assistance, finance management, grooming, housekeeping, incontinence care, laundry, behavior management, medication administration, vital signs, safety checks, toileting and assistance with transfers. R4's Clinical Update Summary dated December 8, 2025, indicated R4 had no difficulty in taking medications and swallowed without difficulty. On December 9, 2025, at 8:55 a.m., the surveyor observed licensed practical nurse (LPN)-A administer medications to R4. The surveyor observed LPN-A open R4's comingled medication packet into a mortar and pestle to be crushed for administration. The medications prepared included the following: - Tamsulosin 0.4mg capsule; - Cerovite tablet; - Aspirin 81mg tablet; - Vitamin B1 100mg - Folic acid 1mg; - Metformin 500 mg ER, and; - Sennexon 8.6-50 mg. On December 9, 2025, at 8:55 a.m., LPN-A stated they crushed the medications as R4 had difficulty swallowing. On December 11, 2025, at 11:26 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-B stated there was no order on file	02320			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37041	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/11/2025
NAME OF PROVIDER OR SUPPLIER UNITY TRUST HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 7333 DUPONT AVENUE NORTH 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
02320	Continued From page 50 to crush R4's medications. The Food and Drug Administration's (FDA) drug information page, Glucophage XR (metformin hydrochloride) Extended-Release Tablets, dated April 2017, indicated the medication must be swallowed whole and never crushed or chewed. The licensee's 7.20 Medication & Treatment Orders policy dated August 23, 2023, indicated an order for medication or treatment must be dated, signed by the prescriber and must be current and consistent with the resident's nursing assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320			



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

Food & Beverage Inspection Report

Page: 1

Establishment Info

UNITY TRUST HOME CARE
7333 DUPONT AVENUE NORTH
Brooklyn Park, MN 55444
Hennepin County
Parcel:

Phone:

License Info

License: HFID 37041

Risk:
License:
Expires on:
CFPM:
CFPM #: ; Exp:

Inspection Info

Report Number: F1023251236
Inspection Type: Full - Single
Date: 12/9/2025 Time: 9:19:30 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 1
Total Priority 3 Orders: 1
Delivery:

New Order: 2-100 Supervision

2-102.12AMN Priority Level: Priority 3 CFP#: 2

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

COMMENT: TO GET A CFPM YOU MUST TAKE EIGHT HOUR MANAGER CLASS, PASS TEST, AND CERTIFY WITH MDH WITHIN 6 MONTHS OF PASSING. YOU CAN SIGN UP FOR FOOD MANAGER COURSES AND CERTIFY WITH MDH HERE:

<https://www.health.state.mn.us/communities/environment/food/cfpm/howto.html>

Comply By: 12/9/2025 Originally Issued On: 12/9/2025

New Order: 4-300 Equipment Numbers and Capacities

4-302.13B Priority Level: Priority 2 CFP#: 48

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

COMMENT: HOT WATER DISH MACHINE IN USE BUT NO WAY OF VERIFYING INTERNAL CHAMBER TEMPERATURE. ACQUIRE AND USE THIS DEVICE TO ENSURE PATHOGEN ELIMINATION.

Comply By: 12/9/2025 Originally Issued On: 12/9/2025

Food & Beverage General Comment

THIS INSPECTION WAS CONDUCTED IN CONJUNCTION WITH MDH HEALTH REGULATORY DIVISION (HRD) SURVEY. INSPECTION CONDUCTED IN PRESENCE OF THE PERSON IN CHARGE.

THIS FACILITY DOES NOT HAVE COMMERCIAL GRADE ANSI EQUIPMENT. ALL FOOD MUST BE SERVED THE SAME DAY IT IS PREPARED, AND LEFTOVERS CAN NEVER BE SAVED. FOOD IS PURCHASED, PREPARED, AND SERVED BY FACILITY STAFF.

FOOD SERVICE AREA FLOORS, WALLS, CEILINGS, COUNTERTOPS, AND FINISH MATERIALS MUST BE NON-ABSORBANT, SMOOTH, DURABLE, AND EASILY CLEANABLE. WOOD IS NOT AN APPROVED FOOD CONTACT SURFACE.

THESE TOPICS WERE DISCUSSED WITH THE PERSON IN CHARGE:

- EMPLOYEE ILLNESS EXCLUSION
- HAND WASHING PROCEDURE

-
- NO BARE HAND CONTACT WITH RTE FOOD
 - VOMIT CLEAN UP PROCEDURE
 - FULLY COOKING FOOD FOR HIGH RISK POPULATIONS
 - ANSI 184 DISH WASHER

TO GET A CFPM YOU MUST TAKE EIGHT HOUR MANAGER CLASS, PASS TEST, AND CERTIFY WITH MDH WITHIN 6 MONTHS OF PASSING. YOU CAN SIGN UP FOR FOOD MANAGER COURSES AND CERTIFY WITH MDH HERE:

<https://www.health.state.mn.us/communities/environment/food/cfpm/howto.html>

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 F1023251236 from 12/9/2025

Gregory T Nelson

CATHERINE ABBA
PERSON IN CHARGE

Greg Nelson,
Public Health Sanitarian 3
651-201-4259
greg.nelson@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

UNITY TRUST HOME CARE
Brooklyn Park
County/Group: Hennepin County

Inspection Info

Report Number: F1023251236
Inspection Type: Full
Date: 12/9/2025
Time: 9:19:30 AM

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

Location: Refrigerator at 41 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: **Product/Item/Unit:** CHICKEN; **Temperature Process:** Frozen

Location: Freezer at Degrees F.

Comment: frozen

Violation Issued?: No



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

Sanitizer Observations/Recordings

Page: 1

Establishment Info

UNITY TRUST HOME CARE
Brooklyn Park
County/Group: Hennepin County

Inspection Info

Report Number: F1023251236
Inspection Type: Full
Date: 12/9/2025
Time: 9:19:30 AM

Sanitizing Equipment: Product: Hot Water; **Sanitizing Process:** Dish Machine

Location: Kitchen **Greater Than** 150 Degrees F.

Comment:

Violation Issued?: No

Sanitizing Chemical: Product: Chlorine; **Sanitizing Process:**

Location: Equal To PPM

Comment:

Violation Issued?: No

Physical Environment Inspection Report

ASSISTED LIVING | ASSISTED LIVING WITH DEMENTIA CARE

Project No: SL37041016-0	Date: 12/10/2025
Facility Name: UNITY TRUST HOME CARE	
Facility Address: 7333 Dupont Ave N, Brooklyn Park, Minnesota, 55444	

☒ 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. In buildings that contain a fuel-burning appliance or fireplace, or attached private garage, carbon monoxide detection shall be installed in dwelling units within ten feet of bedrooms. Where a fuel burning appliance is located in a bedroom or its attached bathroom, carbon monoxide detection shall be installed within the bedroom. Carbon monoxide detection can be provided by carbon monoxide alarms installed in dwelling or sleeping units or a carbon monoxide detection system installed in the room or space that contains the fuel-burning appliance. [Minn. Stat. 144G.45 subd. 2; MSFC 915]

Comments: The carbon monoxide detector outside of sleeping rooms 4&5 was not working.

☒ TAG IDENTIFICATION: 0780

SCOPE/ SEVERITY: Level 2; Isolated

TIME PERIOD OF CORRECTION: Seven (7) days

1. Smoke alarms are provided in each room used for sleeping purposes. [Minn. Stat. 144G.45 subd.2]

Comments: The smoke alarm in unoccupied sleeping room #3 was missing.

☒ TAG IDENTIFICATION: 0800

SCOPE/ SEVERITY: Level 2; Isolated

TIME PERIOD OF CORRECTION: Seven (7) days

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: The outlet cover in unoccupied sleeping room #3 was missing.

☒ TAG IDENTIFICATION: 0810

SCOPE/ SEVERITY: Level 3; 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 the location and number of resident rooms. [Minn. Stat. 144G.45 subd.2]

Comments:

The floor diagrams show the garage as an exit. Evacuation through spaces of higher hazard are not permitted.

The exit diagrams show the deck as a designated exit. There was no EXIT sign present at the deck sliding door.

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: No resident fire policy was provided when requested. licensed assisted living director/clinical nurse supervisor (LALD/CNS)-B stated no resident policy was in place.

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: No policy was provided when requested. LALD/CNS-B stated no policy was in place.

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: LALD/CNS-B stated staff trainings were only provided at hire and not twice per year as required.

5. 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. [Minn. Stat. 144G.45 subd.2]

Comments: LALD/CNS-B stated no trainings were provided for residents.

6. 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 licensee's fire drill log calendar indicated fire drills for the overnight shift were scheduled 3-19-25, 5-22-25, 8-15-25, 11-13-25. No drill reports for these drills were provided indicating the drills had been completed for the overnight staff.

☒ **TAG IDENTIFICATION: 0830**

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Seven (7) days

1. Facility complies with all state and local governing laws, and codes for fire safety, building, and zoning requirements. [Minn. Stat. 144G.45 subd.3]

Comments: The licensee stated the furnace and water heater were both replaced in 2025. No proof of a permit or inspections was present on site.