



Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF CONDITIONAL LICENSE

Electronically Delivered

July 14, 2026

Licensee

Living Well Home Care LLC
7040 Edgewood Avenue North
Brooklyn Park, MN 55428

RE: Conditional License Number 417121
Health Facility Identification Number (HFID) 40108
Project Number(s) SL40108016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on May 1, 2026, for the purpose of assessing compliance with state licensing statutes. Based on the survey results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, pursuant to Minn. Stat. § 144G.20, Subd. 1 (a), MDH is issuing a 90-day conditional license, pending appeal.

STATE CORRECTION ORDERS

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

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.

MDH may assess fines based on the level and scope of the orders outlined below. The total amount of **potential** fines that may be assessed related to these correction orders is \$6,500.00. **MDH is not imposing these fines against your license at this time.**

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

0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - \$3,000.00

0810 - 144g.45 Subd. 2 (b-F) - Fire Protection And Physical Environment - \$3,000.00

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

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders and immediately correct any reissued orders outlined on the state form; however, plans of correction are not required to be submitted for approval. **If corrections are not made, MDH may impose fines as described above and in accordance with Minnesota Statutes 144G.**

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>

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.

CONDITIONAL LICENSE ISSUED:

MDH will issue Living Well Home Care LLC a conditional assisted living facility license for 90 calendar days, pending appeal. At an unannounced point in time, within the 90 calendar days, MDH will conduct a follow-up survey, as defined in Minn. Stat. § 144G.30, Subd. 6. Based on the results of the follow-up survey, MDH will determine if Living Well Home Care LLC is in substantial compliance.

The following conditions apply on the conditional assisted living facility license:

- a. **No new substantiated maltreatment allegations:** If any new investigations begin in the conditional license period, and the allegations are substantiated, MDH may pursue additional enforcement actions up to and including immediate temporary suspension and revocation of the license.
- b. **No new admissions:** Living Well Home Care LLC will not admit any new residents under its conditional assisted living facility license until MDH removes the “no new admissions” condition. Living Well Home Care LLC must provide the Department:
 - i. A list of the names and birthdates of any individuals Living Well Home Care LLC is currently in the process of admitting. These individuals will be able to continue the admittance process.
 - ii. A list of all current residents:
 - 1. Name and birthdate of each resident
 - 2. Current payment source for services
 - 3. If Elderly Waiver, the name and contact information of the care coordinator/case manager
 - 4. If the resident is not able to make informed decisions, the name of their representative and how to contact the representative
- c. **Consultant:** Living Well Home Care LLC will contract with an RN to provide consultation concerning all resident(s) to whom Living Well Home Care LLC provides licensed assisted living services under the conditional license. The consultant must have access to all resident(s) receiving services from Living Well Home Care LLC. The consultant will conduct initial and ongoing evaluations of the provider. Direct resident observation may be required based on the consultant’s judgement or at the discretion of MDH. The RN must not have any affiliation with Living Well Home Care LLC and MDH must review the RN’s credentials and approve the selection. Living Well Home Care LLC is responsible for the expense of the contract with the RN. The main purpose of the consultant is to provide guidance to Living Well Home Care LLC in an effort to help Living Well Home Care LLC align their practices with the requirements of Minn. Stat. §§ 144G.01 – 144G.9999 and to provide oral and written reports to MDH noting progress toward substantial compliance and/or concerns about observations. Living Well Home Care LLC will develop and implement policies, procedures, and processes specific to the offered services in accordance with the guidance provided by the consultant to ensure ongoing monitoring and substantial compliance with statutory requirements.
- d. **Reports:** The RN consultant will provide MDH with regular reports at intervals specified by MDH. Reports will begin on a weekly basis until MDH notifies Living Well Home Care LLC and the RN consultant about a change. Each report will be electronically submitted to: HRDConsultantReports.MDH@state.mn.us. The content of the reports will include information such as:
 - i. Progress towards correction of orders;

- ii. Observations of staff delivering assisted living services and the level of competency observed;
 - iii. Conversations with residents and family members about satisfaction with assisted living services;
 - iv. Conversations with staff about their level of knowledge about the tasks they perform, the people they serve and the health professionals who delegate to them;
 - v. Overall impressions about the quality of the assisted living services delivered;
 - vi. Overall impressions about the dignity with which the residents and their family members are treated;
 - vii. Concerns; and
 - viii. Any other information requested by the Department or considered important by the RN consultant(s).
- e. **Monitoring visits:** MDH may make unannounced monitoring visits to assess the progress of Living Well Home Care LLC to correct the violations cited during the survey as well as to determine the overall practice of Living Well Home Care LLC in meeting the needs of the people it serves. In addition, the Office of Ombudsman for Long-Term Care (OOLTC) may also make unannounced monitoring visits to determine the level of satisfaction of those people who receive licensed assisted living services. The OOLTC will share their findings with MDH.
- f. **Follow-up survey:** At the time of the follow-up survey, MDH may pursue additional enforcement actions, up to and including immediate temporary suspension or revocation of the license if MDH identifies any level 3, 4 or 5 violations or widespread care related violations.
- g. **Health Facility Construction Permit:** Living Well Home Care LLC, will contact The Minnesota Department of Labor and Industry (MNDLI) or City with delegated authority to review and inspect State Licensed Facilities in accordance with Minn. Stat. § 326B.103, Subd. 13 and obtain a construction permit for a health facility. Within 21-days from the date of this notice, Living Well Home Care LLC, will provide MDH with a copy of the permit obtained from MNDLI or City with delegated authority.
- h. **Construction Plan Submittal Form for Assisted Living Providers:** Living Well Home Care LLC will submit a Construction Plan Submittal Form, along with A PDF copy of clear, legible, and dimensioned final construction plans detailing the alteration work to MDH (health.assistedliving@state.mn.us) via email within 21-days of the date of this notice.
- i. **General Contractor:** Living Well Home Care LLC must provide the following to Stephanie Jones de Palma (stephanie.jones.de.palma@state.mn.us) via email within 21-days of the date of this notice:
 - i. Name
 - ii. License Number
 - iii. Contact Information

- j. **Egress Window Requirements:** Living Well Home Care LLC will replace at least one window in the recreation room, occupied as a permanent sleeping room, meeting the minimum size requirements.
 - i. Must have a minimum openable width of no less than 20 inches
 - ii. Must have a minimum openable height of no less than 20 inches
 - iii. Must have a total openable area of no less than 648 square inches (4.5 square feet)
 - iv. Must have a windowsill height of no more than 48 inches from the floor to the clear opening
 - v. All measurements must be achieved under normal operation of opening window without the use of a key, tool or special knowledge
- k. **Accessible Egress Door:** Living Well Home Care LLC will comply with the Minnesota State Fire Code, Chapter 7511. An egress door shall be readily operable from the egress side without use of a key or special knowledge. To comply, the marked egress doors at the front door and rear door of the facility must meet the standards of the Minnesota State Fire Code **Section 1010 Doors, Gates and Turnstiles.**
- l. **Corrective Action Plan:** Living Well Home Care LLC will develop and work within a corrective action plan (CAP). The CAP is a working document that includes at least the following information:
 - i. A statement of the concern
 - ii. A description of what will happen to correct the concern
 - iii. A target date for when each correction will be complete
 - iv. Who is responsible to make sure it happens
 - v. Current status of correction work
 - i. vi. Description of a plan to monitor and ensure ongoing substantial compliance for each corrected order

RESULTS OF FOLLOW-UP EVALUATION DURING THE CONDITIONAL LICENSE PERIOD:

MDH will determine if Living Well Home Care LLC is in substantial compliance based on the results of the follow up survey. MDH will make this determination within the 90-day conditional license period. If MDH determines Living Well Home Care LLC is in substantial compliance on the follow up survey, MDH will remove the conditions from Living Well Home Care LLC's assisted living facility license, and Living Well Home Care LLC will correct any outstanding violations identified during the survey. If Living Well Home Care LLC is not in substantial compliance on the follow-up survey, MDH may take additional enforcement action, up to and including immediate temporary suspension and revocation, as authorized by Minn. Stat. § 144G.20.

REQUESTING A HEARING:

Pursuant to Minn. Stat. §144G.20, Subd. 18, the licensee may appeal an action against the license under this section. The licensee must request a hearing no later than 15 business days after licensee receives notice of the action.

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

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.

Living Well Home Care LLC

July 14, 2026

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If you have any questions, please contact Jess Schoenecker directly at: 651-201-3789 or email at: jess.schoenecker@state.mn.us.

Sincerely,

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

Rick Michals, J.D.

Executive Regional Operations Manager

**Minnesota Department of Health
Health Regulation Division**

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40108	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/01/2026
NAME OF PROVIDER OR SUPPLIER LIVING WELL HOME CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 7040 EDGEWOOD AVENUE NORTH BROOKLYN PARK, MN 55428		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL40108016-0 On April 27, 2026, through May 1, 2026, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there 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.		
0 130 SS=F	144G.12, Subd. 1 Application for Licensure Each application for an assisted living facility	0 130			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 130	Continued From page 1 license, including provisional and renewal applications, must include information sufficient to show that the applicant meets the requirements of licensure, including: (1) the business name and legal entity name of the licensee, and the street address and mailing address of the facility; (2) the names, e-mail addresses, telephone numbers, and mailing addresses of all owners, controlling individuals, managerial officials, and the assisted living director; (3) the name and e-mail address of the managing agent and manager, if applicable; (4) the licensed resident capacity and the license category; (5) the license fee in the amount specified in section 144.122; (6) documentation of compliance with the background study requirements in section 144G.13 for the owner, controlling individuals, and managerial officials. Each application for a new license must include documentation for the applicant and for each individual with five percent or more direct or indirect ownership in the applicant; (7) evidence of workers' compensation coverage as required by sections 176.181 and 176.182; (8) documentation that the facility has liability coverage; (9) a copy of the executed lease agreement between the landlord and the licensee, if applicable; (10) a copy of the management agreement, if applicable; (11) a copy of the operations transfer agreement or similar agreement, if applicable; (12) an organizational chart that identifies all organizations and individuals with an ownership interest in the licensee of five percent or greater	0 130			

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0 130	Continued From page 2 and that specifies their relationship with the licensee and with each other; (13) whether the applicant, owner, controlling individual, managerial official, or assisted living director of the facility has ever been convicted of: (i) a crime or found civilly liable for a federal or state felony level offense that was detrimental to the best interests of the facility and its resident within the last ten years preceding submission of the license application. Offenses include: felony crimes against persons and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions; financial crimes such as extortion, embezzlement, income tax evasion, insurance fraud, and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions; any felonies involving malpractice that resulted in a conviction of criminal neglect or misconduct; and any felonies that would result in a mandatory exclusion under section 1128(a) of the Social Security Act; (ii) any misdemeanor conviction, under federal or state law, related to: the delivery of an item or service under Medicaid or a state health care program, or the abuse or neglect of a patient in connection with the delivery of a health care item or service; (iii) any misdemeanor conviction, under federal or state law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service; (iv) any felony or misdemeanor conviction, under federal or state law, relating to the interference with or obstruction of any investigation into any criminal offense described in Code of Federal Regulations, title 42, section 1001.101 or	0 130			

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0 130	Continued From page 3 1001.201; (v) any felony or misdemeanor conviction, under federal or state law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance; (vi) any felony or gross misdemeanor that relates to the operation of a nursing home or assisted living facility or directly affects resident safety or care during that period; (vii) any revocation or suspension of a license to provide health care by any state licensing authority. This includes the surrender of such a license while a formal disciplinary proceeding was pending before a state licensing authority; (viii) any revocation or suspension of accreditation; or (ix) any suspension or exclusion from participation in, or any sanction imposed by, a federal or state health care program, or any debarment from participation in any federal executive branch procurement or nonprocurement program; (14) whether, in the preceding three years, the applicant or any owner, controlling individual, managerial official, or assisted living director of the facility has a record of defaulting in the payment of money collected for others, including the discharge of debts through bankruptcy proceedings; (15) the signature of the owner of the licensee, or an authorized agent of the licensee; (16) identification of all states where the applicant or individual having a five percent or more ownership, currently or previously has been licensed as an owner or operator of a long-term care, community-based, or health care facility or agency where its license or federal certification has been denied, suspended, restricted, conditioned, refused, not renewed, or revoked	0 130			

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0 130	Continued From page 4 under a private or state-controlled receivership, or where these same actions are pending under the laws of any state or federal authority; (17) statistical information required by the commissioner; and (18) any other information required by the commissioner. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to meet the requirements of licensure for the assisted living facility license they possessed when the licensee had a non-resident individual (unlicensed personnel (ULP)-F) reside at the 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 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: The licensee's assisted living licensure effective date was June 27, 2025, with an expiration date of June 26, 2026. On April 27, 2026, at 12:19 p.m., during the facility tour with licensed assisted living director (LALD)-C, the surveyor observed an unnumbered room on the lower level of the facility with a closed door. The surveyor requested to see the inside of the unnumbered room. LALD-C attempted to open the door, but the door was	0 130			

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0 130	Continued From page 5 locked. The surveyor observed LALD-C ask staff for the key to the room. Upon entry, the surveyor observed a bed with full linens and pillows, dresser, television, mini fridge, food, closet full of clothes that were hung up, several over the counter medications, and mail throughout the room. The surveyor observed mail in the room was addressed to ULP-F and had the facility address. On April 27, 2026, at 12:22 p.m., LALD-C stated all staff would utilize the room. The surveyor asked LALD-C if ULP-F lived at the facility as their mail had the facility's address. LALD-C stated ULP-F was at the facility a lot but had their own place of residence in another city. On April 27, 2026, at 12:24 p.m., ULP-F stated they lived at the facility. ULP-F stated at times they may go see their children, but they always slept at the facility. ULP-F showed the surveyor their driver license, which had the facility's address listed as their home address. On April 27, 2026, at 12:25 p.m., LALD-C stated they did not have a contract or an individualized abuse prevention plan for ULP-F since they were staff and not a resident. LALD-C stated ULP-F had been sleeping at the facility since last year. Minnesota Assisted Living Statutes 144G.08 definitions indicated: - Subd. 5. Assisted living contract - means the legal agreement between a resident and an assisted living facility for housing, and if applicable, assisted living services; - Subd. 7. Assisted living facility - means a facility that provides sleeping accommodations and assisted living services to one or more adults; and	0 130			

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0 130	Continued From page 6 - Subd. 59. Resident - means an adult living in an assisted living facility who has executed an assisted living contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 130			
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 related to hand hygiene and use of personal protective equipment (PPE) for two of two unlicensed personnel ((ULP)-E, ULP-H). 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	0 510			

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0 510	Continued From page 7 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: ULP-H ULP-H was hired by the licensee on July 10, 2020, as a house manager. On April 28, 2026, at 7:04 a.m., during continuous observation, the surveyor observed ULP-H wash their hands at the kitchen sink with soap and water; then donned (put on) gloves. ULP-H went into the office (another room off the kitchen area) where they touched the medication cabinet, desk, computer and resident (R2) medications. ULP-H then went into the dining room area where R2 was sitting at the table and placed R2's medications that were set up by ULP-H on the table. R2 immediately stated to ULP-H, they had forgotten their nasal spray. ULP-H went back into the office while wearing the same gloves, gathered R2's nasal spray from the medication cabinet and then returned to the dining room area. ULP-H checked R2's vital signs that included blood pressure, temperature, and oxygen saturation using equipment shared with all residents. ULP-H was wearing the same gloves. After checking R2's vital signs, ULP-H went into the common kitchen cupboard to get a clean glass, filled the glass with purified water from a common water dispenser in the kitchen, and then gave the glass of water to R2 while wearing the same gloves. ULP-H then placed all the vital sign equipment used on R2 back into a common basket used to store vital sign	0 510			

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0 510	Continued From page 8 equipment without cleaning the equipment. ULP-H then went back into the office where they touched the computer, medication cabinet, put new needles on two insulin pens and dialed the insulin dose for both pens while wearing the same gloves. ULP-H went back to dining room where R2 was sitting, observed R2 taking their oral medications, administered inhaler, and nasal spray. ULP-H provided R2 with an alcohol wipe and insulin pens for R2 to self-administer the insulin. R2 took the insulin needles off the insulin pens and placed them in small disposable plastic medication cup. ULP-H grabbed the used needles in the cup and went to the office where they dropped the needles in the sharp container, put R2's inhaler, nasal spray, and insulin back in the medication cabinet; then documented medications administered on the computer while wearing the same gloves. ULP-H doffed (removed) gloves and donned a glove on one hand. ULP-H went into a supply closet to get Clorox wipes, donned the other glove without washing hands. ULP-H cleaned the vital sign equipment that was already placed in the common basket for vital sign equipment with the Clorox wipes. ULP-H doffed gloves and washed hands at the kitchen sink with soap. ULP-H's Personal Protective Equipment (PPE) Competency Validation dated October 1, 2022, indicated ULP-H was determined to be competent by a registered nurse in hand hygiene and the use of gloves. ULP-E ULP-E was hired by the licensee on September 7, 2023, to provide direct care and services to the licensee's residents. On April 28, 2026, at 11:43 a.m., during	0 510			

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0 510	Continued From page 9 continuous observation, the surveyor observed ULP-E wash their hands at the kitchen sink with soap, then ULP-E donned gloves. ULP-E went into the office where they touched multiple surfaces that included the medication cabinet to retrieve medications and the computer. ULP-E placed all medications to be administered into a small plastic disposable medication cup and placed a new needle on R2's insulin pen. ULP-E placed R2's medications that were not to be administered back into the medication cabinet. ULP-E then went to the dining room area where R2 was sitting and provided R2 with their medications, alcohol wipe, and insulin pen. ULP-E observed medication administration. R2 placed the used insulin needle in the small disposable medication cup. ULP-E went into the office where they disposed of the used insulin needle into the sharps container and documented the medications administered on the computer while wearing the same gloves. ULP-E doffed the gloves but did not perform hand hygiene after removing the gloves. ULP-E donned gloves again and went into the kitchen cupboard to retrieve a clean glass, then got ice from the freezer and a soda from the refrigerator. ULP-E poured the soda into the glass and gave the glass to a resident. ULP-E doffed the gloves and donned gloves again without hand hygiene. ULP-E went into the cupboard to get a cup, poured water into the coffee maker, then assisted a resident in a wheelchair to go outside on the deck while wearing the same gloves. ULP-E came back inside, doffed the gloves but did not perform hand hygiene after the removal of the gloves. ULP-E's Home Health Aide Competency Evaluation dated October 7, 2023, indicated ULP-E was determined to be competent by a registered nurse for hand hygiene.	0 510			

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0 510	Continued From page 10 On April 29, 2026, at 11:50 a.m., clinical nurse supervisor (CNS)-D stated the staff needed to perform hand hygiene prior to resident contact and use gloves when handling residents, food, or medications. CNS-D stated they expected staff to perform hand hygiene after the removal of gloves. On April 29, 2025, at 3:29 p.m., licensed assisted living director (LALD)-C stated ULP-E's personnel record did not have documentation of a competency evaluation by the registered nurse for PPE (use of gloves). On April 29, 2026, at 4:57 p.m., CNS-D stated ULP-E and ULP-H were both trained on hand hygiene and use of gloves. The licensee's Infection Control policy dated October 17, 2022, indicated hands would be washed immediately after gloves were removed and between resident contacts. The policy indicated gloves were to be worn when touching blood, body fluids, secretions, excretions, non-intact skin, mucous membranes, or contaminated items. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510			
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who	0 550			

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0 550	Continued From page 11 are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post the grievance procedure along with the required contact information. This had the potential to affect all the licensee's current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On April 27, 2026, at 11:38 a.m., during a facility tour, the surveyor observed a wooden box with a sign posted above that indicated grievance and suggestion box with an arrow that pointed to the wooden box. The surveyor did not observe the licensee's grievance procedure along with the	0 550			

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0 550	Continued From page 12 required contact information posted in the facility. On April 27, 2025, at 12:05 p.m., licensed assisted living director (LALD)-C stated they had this posted at their other locations, so they felt this was an oversight not to have the grievance procedure with the contact information posted at the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550			
0 650 SS=D	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as	0 650			

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0 650	Continued From page 13 required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records included all required content for one of two unlicensed personnel ((ULP)-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: ULP-A was hired by the licensee on July 4, 2024, to provide direct care and services to the licensee's residents. ULP-A's record lacked documentation of competency evaluations related to medication administration for all routes. On April 27, 2026, at 10:15 a.m., licensed assisted living director (LALD)-C stated they were aware of the required contents of the personnel records. On April 28, 2026, at 11:08 a.m., clinical nurse supervisor (CNS)-D stated they only trained and completed competency evaluations on medications that included the administration of insulin. CNS-D stated they did train and observed ULP-A perform medication administration.	0 650			

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0 650	Continued From page 14 On April 29, 2026, at 3:18 p.m., LALD-C confirmed ULP-A did not have the training competencies in the personnel record. LALD-C stated they did not know if the training had been completed as they had checked everywhere for the documentation. LALD-C stated they planned to talk to ULP-A. The licensee's Personnel Records policy dated October 17, 2022, indicated each employee record would include documentation of competency evaluations. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650			
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision.	0 660			

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0 660	Continued From page 15 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) infection control program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included a facility TB risk assessment, TB training, and TB testing results for two or two unlicensed personnel ((ULP)-A, ULP-B). 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: The licensee's Facility Tuberculosis (TB) Risk Assessment dated December 28, 2025, indicated the assessment was completed for a different facility and address. ULP-A ULP-A was hired by the licensee on July 4, 2024, to provide direct care and services to the licensee's residents. ULP-A's personnel record lacked documentation of TB testing and TB training upon hire and annually. ULP-B ULP-B was hired by the licensee on November	0 660			

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0 660	Continued From page 16 13, 2024, to provide direct care and services to the licensee's residents. ULP-B's record included negative test results of QuantiFERON-TB Gold Plus (TB blood test) on November 24, 2025, which was 376 days after ULP-B's hire date. ULP-B's record lacked other TB testing. ULP-B's personnel record lacked documentation of TB training upon hire and annually. On April 29, 2026, at 3:13 p.m., licensed assisted living director (LALD)-C stated past surveyors had accepted an x-ray for TB testing so they were confused and did not know they also needed a TST or blood test in the personnel record. LALD-C acknowledged the licensee's Facility Tuberculosis (TB) Risk Assessment had a different address indicated; and stated this was an oversight. On April 29, 2026, at 4:00 p.m., LALD-C confirmed the licensee did not provide TB training. LALD-C stated they knew the licensee needed to provide training on infection control that included TB but was not sure how often it needed to be completed. LALD-C stated they thought it was every six months. LALD-C stated they did not think the training was provided. The licensee's Tuberculosis Screening/Prevention policy dated October 17, 2022, indicated the director was responsible for conducting the facility's TB risk assessment annually. The policy indicated all personnel would receive TB education annually regardless of the facility's risk. The policy did not indicate TB training was required upon hire. The policy indicated baseline TB testing would include	0 660			

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0 660	Continued From page 17 two-step tuberculin skin tests (TST) or blood assay for M. tuberculosis (BAMT), and TB testing would be completed upon hire for all direct care providers and anyone who visited residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule.	0 680			

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0 680	Continued From page 18 This MN Requirement is not met as evidenced by: Based on observation, 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; and failed to post the EPP prominently. 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 the potential to affect a large portion or all of the residents). The findings include: On April 27, 2026, at 11:38 a.m., during a facility tour, the surveyor did not observe the EPP posted prominently. On April 27, 2026, at 1:47 p.m., the surveyor asked unlicensed personnel (ULP)-E where the licensee's EPP was located. The surveyor observed ULP-E ask ULP-H where the EPP was located. The surveyor then observed ULP-H call licensed assisted living director (LALD)-C to ask where the EPP was located. LALD-C told ULP-H the EPP binder was with the other items they had brought from the office for survey. The surveyor confirmed with ULP-E and ULP-H the licensee's EPP had been located offsite at the licensee's office location. The licensee's undated EPP lacked evidence of the following required content:	0 680			

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0 680	Continued From page 19 - a facility risk assessment that considered hazards like care related emergencies, emerging infectious diseases, equipment/utility failures, interruptions in communications/cyber-attacks, loss of all or portion of a facility, interruption to normal supply of essential resources and medical supplies; - develop and maintain the EPP; - maintain and annual EPP updates; - EPP program patient population; - development of EPP policies and procedures; - subsistence needs for staff and patients; - procedures for tracking of staff and patients; - policies and procedures for medical documents; - policies and procedures for volunteers; - development of communication plan; - names and contact information; - emergency officials contact information; - emergency officials contact information; - primary/alternate means for communication; - methods for sharing information; - sharing information on occupancy/needs; - LTC (long term care) family notifications; - emergency prep training and testing; and - emergency prep testing requirements. On April 28, 2026, at 2:29 p.m., LALD-C confirmed the licensee did not have a facility risk assessment. LALD-C stated the licensee had arrangements with another facility in which the written arrangement was located offsite at the licensee's office. LALD-C stated the licensee did not have a written agreement for transportation needs in the event the licensee needed to evacuate residents who depended on a wheelchair for mobility. LALD-C stated the licensee would utilize a taxi, private transportation, or ambulance in an emergency. LALD-C stated the licensee reviewed the EPP every six months but did not document the	0 680			

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0 680	Continued From page 20 review. LALD-C stated the licensee had not reviewed the missing person policy and procedure as the licensee had not had a situation of a missing person before. LALD-C confirmed the licensee did not have policy and procedures for substance needs for minimum food, water, and pharmaceutical supplies. LALD-C confirmed the licensee only had flashlights for their emergency supplies. LALD-C confirmed the licensee did not have a process to track residents or staff during an emergency. LALD-C stated the licensee had a fire drill in November, but the licensee did not have an analysis of the drill documented. The licensee's Emergency Preparedness policy dated October 17, 2022, indicated the licensee would have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupted services. The policy referenced CMS (Centers for Medicare and Medicaid Services) State Operations Manual (SOM) Appendix Z and MN Rules 4659.0100. Minnesota Administrative Rule 4659.0100 dated August 11, 2021, indicated assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.72, or successor requirements. This part referenced documents, specifications, methods, and standards in "State Operations Manual Appendix Z - Emergency Preparedness for All Provider and Certified Supplier Types: Interpretive Guidance." No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 680			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40108	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/01/2026
NAME OF PROVIDER OR SUPPLIER LIVING WELL HOME CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 7040 EDGEWOOD AVENUE NORTH BROOKLYN PARK, MN 55428		
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0 680	Continued From page 21 (21) days	0 680			
0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been	0 730			

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0 730	Continued From page 22 provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and maintain resident records with all required content related to a discharge summary for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's Discharged or Deceased Resident Roster dated April 27, 2026, indicated R1 had an admission date of August 23, 2023; and a discharge date of April 14, 2026. R1's record lacked evidence of a discharge summary. On April 27, 2026, at 11:22 a.m., licensed	0 730			

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0 730	Continued From page 23 assisted living director (LALD)-C asked the surveyor if a resident was considered discharged if they had moved out of the facility to another facility owned by the same owner. On April 27, 2026, at 1:27 p.m., licensed assisted living director (LALD)-C stated the licensee did not complete a discharge summary for R1 since R1 moved from one facility to another facility owned by the same licensee. The licensee's Clinical Records policy dated October 17, 2022, indicated the clinical record would contain a discharge summary. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730			
0 750 SS=F	144G.43 Subd. 5 Record retention Following the resident's discharge or termination of services, an assisted living facility must retain a resident's record for at least five years or as otherwise required by state or federal regulations. Arrangements must be made for secure storage and retrieval of resident records if the facility ceases to operate. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain resident records for at least five years for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 750			

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0 750	Continued From page 24 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: On April 28, 2026, at 8:26 a.m., the surveyor requested medication orders for R2. Clinical nurse supervisor (CNS)-D asked the surveyor if the orders being requested would be from a resident's "After Visit Summary (AVS)". CNS-D stated the licensee usually did not keep the residents AVS. CNS-D stated they would get doctor orders from the AVS, enter the orders in the system, and then shred the document because otherwise it would be a lot of papers to keep. On April 29, 2026, at 3:49 p.m., licensed assisted living director (LALD)-C confirmed the clinical records did not have resident's AVSs following medical appointments. The licensee's Clinical Records policy dated October 17, 2022, indicated the clinical record would contain pertinent health information and information that was needed to provide assisted living services. Also, the policy indicated the licensee would retain the clinical record for at least five years following the resident's discharge. No further information was provided. TIME PERIOD OF CORRECTION: Twenty-one (21) days	0 750			

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0 775	Continued From page 25	0 775			
0 775 SS=L	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with Minnesota State Fire Code in Minnesota Rules chapter 7511. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level four violation (a violation harmed a resident's health or safety, not including serious injury or death, or a violation that was likely to lead to serious injury 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 March 28, 2026, the surveyor toured the facility with unlicensed personnel (ULP)-E. During the tour, the surveyor observed several serious fire code violations including no egress window in the room identified on the site map as "recreation room" that was occupied by unlicensed personnel (ULP)-F, double keyed deadbolt locks on the front and back doors to the facility, and cigarette butts that have been discarded into dried leaves on a wooden deck. In the recreation room occupied by ULP-F as a permanent bedroom, the window measured 44 inches clear width, 15 ½ inches clear height, and	0 775			

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0 775	Continued From page 26 682 square inches total open area. The windowsill was 64 inches above the finished floor. The window in the recreation room did not meet the minimum requirements for opening height and did not meet the requirement for sill height. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. The windowsill shall not be higher than 48 inches above the finished floor. The front door to the facility, and the rear signed exit door by the ramp were equipped with double keyed deadbolt locks. Egress doors shall be readily openable from the egress side without the use of a key or special knowledge or effort. ULP-E identified the rear wooden deck as the designated smoking area for the facility. There were two metal cigarette ashtrays in the general area where ULP-E identified as the smoking area. There was a large amount of cigarettes that were discarded on the wooden deck, and in the leaves sitting on the wooden deck. Lighted matches, cigarettes, cigars or other burning objects shall not be discarded in such a manner that could cause ignition of other combustible material. TIME PERIOD FOR CORRECTION: Immediate	0 775			

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0 780	Continued From page 27	0 780			
0 780 SS=C	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; 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.	0 780			

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0 780	Continued From page 28 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 the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated April 28, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780			
0 800 SS=C	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota	0 800			

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0 800	Continued From page 29 Statute 144G. 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 the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated April 28, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800			
0 810 SS=L	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive	0 810			

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0 810	Continued From page 30 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 four violation (a violation harmed a resident's health or safety, not including serious injury or death, or a violation that was likely to lead to serious injury 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: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated April	0 810			

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0 810	Continued From page 31 28, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Two (2) days.	0 810			
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: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language that waived the licensee's liability for the 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 residents and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On April 27, 2026, at 2:16 p.m., licensed assisted	0 970			

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0 970	Continued From page 32 living director (LALD)-C provided the licensee's blank assisted living contract and stated the contract was used for all residents who lived at the facility. The licensee's Assisted Living Contract, undated, under section Indemnification, read "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..." Also under section Liability, the contract read, "Provider is not liable to Resident... for any injury, death or property damage occurring in the Apartment Unit or on Provider's premises unless such injury, death or property damage occurs as the result of an equipment malfunction or hazardous conditions within the building not caused by Resident... Unless caused by one of the aforementioned excepted reasons, Resident agrees to hold Provider harmless from any and all claims for injuries, property damage or any other loss resulting from an accident or other occurrence in the Apartment Unit or on Provider's premises." On April 29, 2026, at 4:44 p.m., LALD-C acknowledged the contract had a waiver of liability. LALD-C stated the licensee would need to update the contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970			

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01290	Continued From page 33	01290			
01290 SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study (BGS) was associated with the licensee's current assisted living facility's health facility identification number (HFID) for four of eleven unlicensed personnel ((ULP)-B, ULP-E, ULP-F, ULP-I). 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).	01290			

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01290	Continued From page 34 The findings include: ULP-B was hired by the licensee on November 13, 2024, to provide direct care and services to the licensee's residents. ULP-E was hired by the licensee on September 7, 2023, to provide direct care and services to the licensee's residents. ULP-F was hired by the licensee on June 25, 2021, to provide direct care and services to the licensee's residents. ULP-I was hired by the licensee on April 23, 2026, to provide direct care and services to the licensee's residents. The licensee's NS2 Employee Roster dated April 28, 2026, at 4:19 p.m., indicated the report criteria included all active employees for the licensee's current HFID 40108. The report lacked a BGS for ULP-B, ULP-E, ULP-F, and ULP-I. The licensee's NS2 Employee Roster dated April 29, 2026, at 11:30 a.m., indicated the report criteria included all active employees for the licensee's HFID 37939, HFID 41736, and HFID 40108. The report indicated the following BGS were affiliated with a different HFID owned by the same licensee: - ULP-B was affiliated with HFID 37939 on November 30, 2022, with a determination as eligible; - ULP-E was affiliated with HFID 37939 on September 6, 2023, with a determination as eligible; - ULP-F was affiliated with HFID 37939 on April 11, 2025, with a determination as eligible; and - ULP-I was affiliated with HFID 41736 on April	01290			

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NAME OF PROVIDER OR SUPPLIER LIVING WELL HOME CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 7040 EDGEWOOD AVENUE NORTH BROOKLYN PARK, MN 55428		
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01290	Continued From page 35 20, 2026, with a determination as eligible. On April 29, 2026, at 4:10 p.m., licensed assisted living director (LALD)-C confirmed the licensee did not have all staff affiliated to the licensee's HFID 40108. LALD-C stated they were aware of the need to have staff affiliated with each facility where the staff had access to residents; however, it was an oversight to not have everyone affiliated as they thought all staff were affiliated with the appropriate HFIDs. The licensee's Recruitment and Hiring policy dated October 17, 2022, indicated the director would initiate criminal background checks for new employees. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290			
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise	01470			

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01470	Continued From page 36 and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions.	01470			

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01470	Continued From page 37 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide orientation to assisted living licensing requirements and regulations prior to providing services for two of two unlicensed personnel ((ULP)-A, ULP-B). 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: ULP-A ULP-A was hired by the licensee on July 4, 2024, to provide direct care and services to the licensee's residents. ULP-A's personnel record lacked evidence of orientation training of an overview of Assisted Living Statutes; handling of resident complaints, reporting of complaints, where to report; consumer advocacy services; and review of the types of assisted living services the employee would provide and the provider's scope of license. ULP-B ULP-B was hired by the licensee on November 13, 2024, to provide direct care and services to	01470			

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01470	Continued From page 38 the licensee's residents. ULP-B's personnel record lacked evidence of orientation training of an overview of Assisted Living Statutes; handling of resident complaints, reporting of complaints, where to report; consumer advocacy services; and review of the types of assisted living services the employee would provide and the provider's scope of license. The licensee's undated Annual Training Requirements for Dual Caregiver Employees provided through Educare (common online education) indicated the following training topics: - Assisted Living Bill of Rights; - infection control techniques; - vulnerable adult; - person-centered care principles; - dementia - communication; - dementia - problem-solving; - dementia - activities - a balanced approach; - emergency preparedness and disaster planning; and - mental illness - response strategies. On April 27, 2026, at 2:16 p.m., licensed assisted living director (LALD)-C provided the surveyor with the licensee's Annual Training Requirements for Dual Caregiver Employees provided through Educare; and stated they utilized the list of training topics to determine which topics to assign to staff. On April 28, 2026, at 8:02 a.m., LALD-C stated the licensee's Annual Training Requirements for Dual Caregiver Employees represented the orientation courses the licensee would assign to new employees. LALD-C stated the topics on the Annual Training Requirements for Dual Caregiver Employees covered the required training needed	01470			

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01470	Continued From page 39 for orientation, except the licensee would complete resident orientation with new staff. On April 29, 2026, at 3:58 p.m., LALD-C stated it was an oversight with just assigning the training topics from the Annual Training Requirements for Dual Caregiver Employees as they thought it covered all the required training topics needed for orientation as well as the annual training requirements. The licensee's Staff Orientation and Education policy dated October 17, 2022, indicated orientation topics would include the following: - an overview of Assisted Living Statutes; - handling of resident complaints, reporting of complaints, where to report; consumer advocacy services; and - review of the types of assisted living services the employee would provide and the provider's scope of license. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470			
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	01530			

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01530	Continued From page 40 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure all employees received eight (8) hours of initial dementia care training within the first 160 working hours of employment for two of two unlicensed personnel ((ULP)-A, ULP-B);	01530			

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01530	Continued From page 41 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: ULP-A ULP-A was hired by the licensee on July 4, 2024, to provide direct care and services to the licensee's residents. ULP-A's personnel record included two and a half hours of dementia training as follows: - dementia - communication (one hour); - dementia - problem-solving (0.75 hours); and - dementia - activities - a balanced approach (0.75 hours). ULP-A's personnel record lacked evidence of required initial dementia training topics to include: - an explanation of Alzheimer's Disease and other dementias; - assistance with activities of daily living (ADL's); - person-centered planning and service delivery. ULP-B ULP-B was hired by the licensee on November 13, 2024, to provide direct care and services to the licensee's residents. ULP-B's personnel record included two and a half hours of dementia training as follows: - dementia - communication (one hour);	01530			

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01530	Continued From page 42 - dementia - problem-solving (0.75 hours); and - dementia - activities - a balanced approach (0.75 hours). ULP-B's personnel record lacked evidence of required initial dementia training topics to include: - an explanation of Alzheimer's Disease and other dementias; - assistance with activities of daily living (ADL's); - person-centered planning and service delivery. The licensee's undated Annual Training Requirements for Dual Caregiver Employees provided through Educare (common online education) indicated the following dementia training topics: - dementia - communication (one hour); - dementia - problem-solving (0.75 hours); and - dementia - activities - a balanced approach (0.75 hours). On April 27, 2026, at 2:16 p.m., licensed assisted living director (LALD)-C provided the surveyor with the licensee's Annual Training Requirements for Dual Caregiver Employees provided through Educare; and stated they utilized the list of training topics to determine which topics to assign to staff. On April 28, 2026, at 8:02 a.m., LALD-C stated the licensee would assign the dementia training topics indicated on the Annual Training Requirements for Dual Caregiver Employees provided through Educare for a total of two and a half hours of dementia training for new staff. On April 29, 2026, at 9:16 a.m., LALD-C confirmed they only provided dementia training as indicated on the licensee's Annual Training Requirements for Dual Caregiver Employees	01530			

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01530	Continued From page 43 provided through Educare for the list of dementia training needed. LALD-C stated if more dementia training was needed for eight hours, then they would need to get an updated list from Educare so they could assign the required training to staff. On April 29, 2026, at 3:23 p.m., LALD-C stated they could not identify when both ULP-A and ULP-B reached 160 working hours from their hire dates. LALD-C stated ULP-A and ULP-B should have had all their dementia training completed within at least three months of their hire dates. LALD-C stated they now understood the Statute required eight hours of dementia training within 160 hours of working. LALD-C stated they plan to assign all the required dementia courses to all staff. The licensee's Dementia Education policy dated October 17, 2022, indicated direct care employees would complete at least eight (8) hours of initial dementia education within 160 working hours of the employment start date in the following topics: - an explanation of Alzheimer's Disease and other dementias; - assistance with activities of daily living (ADL's); - problem solving with challenging behaviors; - communication skills; and - person-centered planning and service delivery. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530			
01610 SS=F	144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring	01610			

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01610	Continued From page 44 (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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed an initial assessment prior to the date on which a prospective resident executed a contract with a facility or on the day the resident moved in for one of three residents (R2) receiving services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	01610			

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01610	Continued From page 45 On April 28, 2026, at 11:43 a.m., the surveyor observed unlicensed personnel (ULP)-E assist R2 with medication administration. R2 was admitted to licensee on May 15, 2024, with diagnoses of depression, bipolar disorder, and post-traumatic stress disorder. R2's Assisted Living Contract was signed on May 24, 2024. R2's Service Plan - Waiver dated April 28, 2026, indicated R2 received assistance with medications. R2's record lacked evidence of a service plan prior to the initiation of survey. R2's Service Recap Summary - Month dated May 2024, indicated R2 had started to receive assisted living services on May 15, 2024, for mobility assistance, housekeeping, and delegated tasks; and on May 16, 2024, for appointment reminder/assistance, bathing, bedmaking, dressing, grooming, temperature recording, mobility assistance, grooming, housekeeping, meal assistance, delegated tasks. R2's Assessment dated May 30, 2024, indicated the assessment was an admission assessment. The assessment was completed fifteen days after R2 moved into the facility. R2's record lacked an initial assessment that was completed prior to the date on which a prospective resident executed a contract with the facility or on the day the resident moved into the facility. On April 28, 2026, at 10:24 a.m., clinical nurse supervisor (CNS)-D stated all current residents were admitted prior to CNS-D's employment with the licensee so they only performed weekly	01610			

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01610	Continued From page 46 assessments and the comprehensive assessment every 90 days unless there was a change in condition. CNS-D stated they would complete an initial assessment within three days of a resident's admission. On April 29, 2026, at 3:20 p.m., licensed assisted living director (LALD)-C stated R2 had moved into the facility on May 15, 2024; and the licensee did not have another contract signed by R2 prior to May 24, 2024. The licensee's Assessment and Reassessment policy dated October 17, 2022, indicated the initial assessment should be completed prior to the date on which the prospective resident executes a contract or on the date of which the prospective resident moved in, whichever was earlier. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01610			
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	01640			

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01640	Continued From page 47 Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a current service plan was completed within fourteen days of starting services; and failed to obtain a signature or other authentication by the licensee to document agreement of services to be provided for two of two residents (R2, R4) that were receiving services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2 On April 28, 2026, at 11:43 a.m., the surveyor observed unlicensed personnel (ULP)-E assist R2 with medication administration. R2 was admitted to licensee on May 15, 2024.	01640			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40108	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/01/2026
NAME OF PROVIDER OR SUPPLIER LIVING WELL HOME CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 7040 EDGEWOOD AVENUE NORTH BROOKLYN PARK, MN 55428			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01640	Continued From page 48 R2's Assisted Living Contract was signed on May 24, 2024. R2's Service Plan - Waiver dated April 28, 2026, indicated R2 received assistance with medication administration. R2's record lacked evidence of a service plan prior to the initiation of survey. R2's service plan lacked a signature or other authentication by the licensee. R4 R4 was admitted to licensee on January 21, 2025. R4's Service Plan - Waiver dated April 28, 2026, indicated R4 received assistance with medication administration. R4's record lacked evidence of a service plan prior to the initiation of survey. R4's service plan lacked a signature or other authentication by the licensee. On April 29, 2026, at 3:08 p.m., licensed assisted living director (LALD)-C stated the licensee did not have signed service plans prior to the initiation of survey as the licensee did not realize the residents had to sign the service plans. The licensee's Service Plan policy dated October 17, 2022, indicated an individualized service plan would be implemented for all residents; and the service plan would be finalized no later than fourteen days after the date services were first provided. Also, the service plan would be signed by a representative from the licensee. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640			

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01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, a registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any	01730			

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01730	Continued From page 50 changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an individualized medication management plan with the required content for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or 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 April 28, 2026, at 11:43 a.m., the surveyor observed unlicensed personnel (ULP)-E assist R2 with medication administration. R2 was admitted to licensee on May 15, 2024. R2's Service Plan - Waiver dated April 28, 2026, indicated R2 received assistance with medication administration. R2's record lacked evidence of a service plan prior to the initiation of survey. R2's Assessment dated February 22, 2026, indicated R2 required assistance with medication management and administration of medications.	01730			

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01730	Continued From page 51 R2's record lacked evidence of the following required content: - documentation of specific resident instructions relating to the administration of medications; - identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; - identification of medication management tasks that may be delegated to unlicensed personnel; - procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and - any resident-specific requirements related to documentation medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. On April 29, 2026, at 5:41 p.m., clinical nurse supervisor (CNS)-D stated they were not aware of the required content for an individualized medication management plan; and the need to have the medication management plan individualized to the residents' needs. CNS-D stated they followed what the licensee had in Residex (electronic record system). The surveyor provided CNS-D the Statute related to individualized medication management plan and the required content. The licensee's Service Plan for Medication Management policy dated October 17, 2022, indicated the registered nurse was responsible for preparing and documenting the medication management plan; and the written Medication Management Plan would include required content as follows:	01730			

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01730	Continued From page 52 - a statement describing the medication management services that will be provided; - a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; - identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; - identification of medication management tasks that may be delegated to unlicensed personnel; - procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and - any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. The policy excluded the required content needed to also include documentation of specific resident instructions related to the administration of medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730			
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to	01790			

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01790	Continued From page 53 exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that	01790			

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01790	Continued From page 54 medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) developed written procedures for the unlicensed personnel (ULP) providing medications for residents having unplanned time away when the licensed nurse was not available. This had the potential to affect all residents who would need medications for an unplanned time away. 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 April 28, 2026, at 12:00 p.m., ULP-E stated they were not trained on the procedure to follow	01790			

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01790	Continued From page 55 for residents having unplanned time away when the licensed nurse was not available; and they had just figured it out by exploring the licensee's Residex (electronic record system) when they had discovered a form they could use to give to residents. On April 28, 2026, at 2:23 p.m., the surveyor requested the licensee's written procedure developed by the RN for the ULPs who provided medications to residents having unplanned time away when the licensed nurse was not available. On April 29, 2026, at 4:08 p.m., licensed assisted living director (LALD)-C stated they had not been able to look for the nurse's written procedure for ULPs to use when they provided medications to residents having unplanned time away when the licensed nurse was not available. The licensee failed to provide the surveyor with the requested written procedure developed by the RN. On April 29, 2026, at 4:44 p.m., clinical nurse supervisor (CNS)-D stated they did not develop a written procedure for ULPs to follow as the licensee just used a form provided in Rtask (electric record system). The licensee's Medication Management Plan for Residents Away from Home policy dated October 1, 2022, indicated the RN could delegate to ULP if the RN had developed written procedures/protocols that included the following: - special instructions regarding controlled substances; - type of container to be used for the medications appropriate to the facility's medication system; - how the containers should be labeled; - written information about the medications to be provided;	01790			

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01790	Continued From page 56 - Documentation requirements; - how the RN should be notified that the medications were provided to the resident and whether the RN should be notified before the medications are given; and - medications may be set up for the length of the anticipated absence, not to exceed seven days. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790			
01820 SS=F	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure written or electronically recorded prescriptions were maintained for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or 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:	01820			

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01820	Continued From page 57 On April 28, 2026, at 11:43 a.m., the surveyor observed unlicensed personnel (ULP)-E assist R2 with medication administration. R2 was admitted to licensee on May 15, 2024. R2's Service Plan - Waiver dated April 28, 2026, indicated R2 received assistance with medication administration. R2's record lacked evidence of a service plan prior to the initiation of survey. R2's Assessment dated February 22, 2026, indicated R2 required assistance with medication management and administration of medications. R2's Med Admin Summary - Month (MAR) dated April 2026, indicated the licensee assisted with the following medications to be administered: - metformin 500 milligrams (mg) take one tablet by mouth two times daily with meals; - sucralfate 1 gram (g) by mouth four times daily before each meal and at bedtime; - bupropion hydrochloride 150 mg take one tablet by mouth once daily in the morning; - cephalexin 500 mg take one capsule by mouth twice daily for seven days with meal; - dextlansoprazole 30 mg take one capsule by mouth daily; - insulin aspart 100 units (u)/milliliter (ml) give 28 u for breakfast, 28 u for lunch, 24 u for dinner; and check blood sugar 15 minutes before each meal, add sliding scale (ss) insulin when blood sugar is above 150 per ss as followed: 151 - 180 = 1 u, 181 - 210 = 2 u; 211 - 240 = 3 u, 241 - 270 = 4 u, 271 - 300 = 5 u, 301 - 330 = 6 u, 331 - 360 = 7 u, 361 - 390 = 8 u, 391 - 420 = 9 u, 421 - 450 = 10 u, 451+ = 11 u; - Toujeo U300 (insulin glargine) 300 u/ml inject 42 u subcutaneous (sq) in AM (morning) and 40	01820			

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01820	Continued From page 58 units sq in PM (evening); - ipratropium bromide 0.06 percent (%) use two sprays in each nostril three times per day; - lisinopril 5 mg take one tablet by mouth twice daily; and - prednisone 10 mg take three tablets once daily with a meal for two days, then take two tablets once daily with a meal for two days, then one tablet once daily with a meal for two days. R2's record lacked signed provider orders for the following medications: - metformin 500 mg take one tablet by mouth two times daily with meals; - sucralfate 1 g by mouth four times daily before each meal and at bedtime; - bupropion hydrochloride 150 mg take one tablet by mouth once daily in the morning; - cephalexin 500 mg take one capsule by mouth twice daily for seven days with meal; - dextlansoprazole 30 mg take one capsule by mouth daily; - insulin aspart 100 u/ml give 28 u for breakfast, 28 u for lunch, 24 u for dinner; and check blood sugar 15 minutes before each meal, add ss insulin when blood sugar is above 150 per ss as followed: 151 - 180 = 1 u, 181 - 210 = 2 u; 211 - 240 = 3 u, 241 - 270 = 4 u, 271 - 300 = 5 u, 301 - 330 = 6 u, 331 - 360 = 7 u, 361 - 390 = 8 u, 391 - 420 = 9 u, 421 - 450 = 10 u, 451+ = 11 u; - Toujeo U300 (insulin glargine) 300 u/ml inject 42 u sq in AM and 40 units sq in PM; - ipratropium bromide 0.06 % use two sprays in each nostril three times per day; - lisinopril 5 mg take one tablet by mouth twice daily; and - prednisone 10 mg take three tablets once daily with a meal for two days, then take two tablets once daily with a meal for two days, then one tablet once daily with a meal for two days.	01820			

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01820	Continued From page 59 On April 28, 2026, at 8:26 a.m., clinical nurse supervisor (CNS)-D stated they usually would get provider orders from an After Visit Summary (AVS) but the licensee did not keep the AVS, for the record. CNS-D acknowledged they did not know if AVS had the providers' signature included for any of the orders. CNS-D stated R2's provider would send any orders to R2 directly; and then R2 would text the nurse the order to be entered into the electronic record. On April 29, 2026, at 3:49 p.m., licensed assisted living director (LALD)-C stated the orders they have for R2 were the annual orders last signed by R2's provider on November 4, 2025 (the annual orders did not include the above medications). LALD-C stated the licensee did not have any other orders signed by the provider. LALD-C stated the nurse gets the orders from the residents After Visit Summary (AVS) when they see their provider, but the AVS are not in the records. The licensee's Medication Orders policy dated October 17, 2022, indicated the licensee would maintain a current written or electronically recorded prescription for all prescribed medications managed for the resident. Also, the policy indicated verbal prescription orders from an authorized prescriber would be received by a nurse or pharmacist. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820			

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01880	Continued From page 60	01880			
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to monitor refrigeration temperatures to ensure temperatures were maintained according to the manufacturer's instructions for one of one resident (R2) with medications stored in the refrigerator. 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 April 27, 2026, at 11:54 a.m., during the facility tour, the surveyor observed the refrigerator used to store resident medications. Inside of the refrigerator, there were nine boxes of R2's Novolog Flexpen (insulin aspart) and three boxes of R2's Toujeo Max SoloStar (insulin glargine). The medication refrigerator did not have a thermometer to monitor the temperature inside of the refrigerator. Licensed assisted living director (LALD)-C stated they thought the nurse monitored the refrigerator temperature.	01880			

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01880	Continued From page 61 On April 28, 2026, at 9:10 a.m., the surveyor asked clinical nurse supervisor (CNS)-D if they had been monitoring the temperature of the refrigerator used to store medications. CNS-D stated they needed to ask unlicensed personnel (ULP)-H. On April 28, 2026, at 9:12 a.m., the surveyor asked ULP-H how the licensee monitored the temperature of the refrigerator used to store medications. ULP-H showed the surveyor a thermometer placed inside of the refrigerator. The surveyor confirmed with ULP-H the timing of when the thermometer was placed inside of refrigerator. ULP-H stated the thermometer was placed inside of the refrigerator the day prior. ULP-H stated it was an oversight as the licensee had not monitored the temperature of the medication refrigerator and did not have any records of the temperatures. On April 28, 2026, at 9:15 a.m., CNS-D stated they were aware that medications required specific temperature ranges for storage, however it was an oversight since the medication did not indicate it needed to be refrigerated when it was delivered. The licensee's Storage/Control of Medications policy dated October 17, 2022, indicated all prescription drugs are securely locked in substantially constructed compartments according to the manufacturer's directions when the licensee is providing storage of medication outside of the residents private living space. Also, the policy indicated medications that required refrigeration would be stored with a temperature maintained at 35° and 40°.	01880			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40108	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/01/2026
NAME OF PROVIDER OR SUPPLIER LIVING WELL HOME CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 7040 EDGEWOOD AVENUE NORTH BROOKLYN PARK, MN 55428		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01880	Continued From page 62 The manufacturer's instructions for Novolog flex pen (insulin aspart) revised February 2023, indicated to store unused pens in the refrigerator at 36° F to 46° F and not to use if the pen had been frozen. The manufacturer's instructions for Toujeo Max SoloStar (insulin glargine) revised May 2025, indicated to store new pens in the refrigerator between 36° F to 46° F and to throw away if the pen had been frozen. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880			
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 expired medications were disposed of and failed to label time-sensitive medications with an opened-on date for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	01890			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40108	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/01/2026
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01890	Continued From page 63 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: EXPIRED MEDICATIONS On April 27, 2026, at 11:38 a.m., during a tour of the facility, the surveyor reviewed the inside of the medication cabinet with licensed assisted living director (LALD)-C. The surveyor observed the following expired medications: - R2's meclizine 25 milligram (mg) with an expiration date of December 1, 2025; - R2's Budes/formot AER with an expiration date of December 9, 2025; and - R2's artificial tears with an expiration date of August 2024 (opened January 27, 2023). On April 29, 2026, at 5:15 p.m., clinical nurse supervisor (CNS)-D stated the licensee should be checking for expired medications every day. CNS-D stated they believed it was an oversight as the expired medications were as needed medications or had not been used in a long time. The licensee's Disposition and Disposal of Medications policy dated October 17, 2022, indicated any medication under the licensee's storage that was expired would be disposed of by a licensed nurse according to the instructions on the drug label or by means of the household trash mixed with undesirable substance or community drug take back program. OPENED-ON DATE On April 28, 2026, at 7:04 a.m., the surveyor observed unlicensed personnel (ULP)-H	01890			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40108	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/01/2026
NAME OF PROVIDER OR SUPPLIER LIVING WELL HOME CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 7040 EDGEWOOD AVENUE NORTH BROOKLYN PARK, MN 55428		
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01890	Continued From page 64 administer Novolog Flexpen (insulin aspart) and Toujeo Max SoloStar (insulin glargine) to R2. The surveyor did not observe open-on dates documented on either insulin pen. On April 28, 2026, at 11:43 a.m., the surveyor observed ULP-E administer Novolog Flexpen (insulin aspart) to R2. The surveyor did not observe an open-on date documented on the insulin pen. On April 29, 2026, at 5:13 p.m., CNS-D stated they put the open-on dates when they come to the facility but sometimes the medications were opened before they come so it might not be indicated right away. The manufacturer's instructions for Novolog flex pen (insulin aspart) revised February 2023, indicated to store insulin pens at room temperature for up to 28 days after the first use. The manufacturer's instructions for Toujeo Max SoloStar (insulin glargine) revised May 2025, indicated to store insulin pens at room temperature for up to 56 days after the first use. The licensee's Storage/Control of Medications policy dated October 17, 2022, indicated the licensed nurse was responsible for dating time-sensitive medications when opened. However, the licensee does not always have a licensed nurse at the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40108	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/01/2026
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01910	Continued From page 65	01910			
01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide documentation in the resident's record regarding the disposition of medication to include quantity and names of staff and other individuals involved in the disposition of medications for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic	01910			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40108	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/01/2026
NAME OF PROVIDER OR SUPPLIER LIVING WELL HOME CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 7040 EDGEWOOD AVENUE NORTH BROOKLYN PARK, MN 55428			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01910	Continued From page 66 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's Discharged or Deceased Resident Roster dated April 27, 2026, indicated R1 had an admission date of August 23, 2023; and a discharge date of April 14, 2026. R1's record lacked evidence of a medication disposition. On April 27, 2026, at 11:22 a.m., licensed assisted living director (LALD)-C asked the surveyor if a resident was considered discharged if they had moved out of the facility to another facility owned by the same owner. On April 27, 2026, at 1:27 p.m., licensed assisted living director (LALD)-C stated the licensee did not complete a medication disposition for R1 since R1 moved from one facility to another facility owned by the same licensee. The licensee's Disposition and Disposal of Medications policy dated October 17, 2022, indicated upon disposition, the licensee would document the following information in the clinical record: - name, strength and prescription number of medication, as applicable; - quantity; - method of disposition or to whom the medications were given; - date of disposition; - name(s)/signature(s) of staff or other individuals involved in disposition; and - if applicable, to whom the medications were given.	01910			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40108	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/01/2026
NAME OF PROVIDER OR SUPPLIER LIVING WELL HOME CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 7040 EDGEWOOD AVENUE NORTH BROOKLYN PARK, MN 55428		
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01910	Continued From page 67 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01910			
02320 SS=F	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure unlicensed personnel (ULP) followed appropriate medication administration procedures for two of two employees (ULP-E, ULP-H), observed during medication administration. 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 April 27, 2026, at 11:38 a.m., the surveyor	02320			

Minnesota Department of Health

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02320	Continued From page 68 observed the licensee had a procedure for instructions on how to prepare an insulin pen that included performance of a safety test (priming the insulin pen) prior to the administration of insulin posted in the office for all staff to see. ULP-E ULP-E was hired by the licensee on September 7, 2023, to provide direct care and services to the licensee's residents. On April 28, 2026, at 11:43 a.m., the surveyor observed ULP-E assist R2 with administration of insulin aspart. The surveyor observed ULP-E dial the dose to be administered on the insulin pen without performed safety test to ensure the pen and needle worked properly; and to ensure no air bubbles remained in the cartridge. ULP-E gave the insulin pen to R2 with the dose dialed to the amount to be administered. On April 28, 2026, at 12:09 p.m., ULP-E stated they had realized they did not prime the insulin pen when the surveyor observed them. ULP-E stated the nurse trained and observed them perform insulin administration that included priming of the insulin pen. ULP-H ULP-H was hired by the licensee on July 10, 2020, as a house manager and to provide direct care and services to the licensee's residents. On April 28, 2026, at 7:04 a.m., the surveyor observed ULP-H assist R2 with administration of insulin aspart and insulin glargine. The surveyor observed ULP-H dial the doses to be administered on the insulin pens without performed safety test to ensure the pen and needle worked properly; and to ensure no air	02320			

Minnesota Department of Health

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02320	Continued From page 69 bubbles remained in the cartridge. ULP-H gave the insulin pens to R2 with the doses dialed on the insulin pens to be administered. On April 29, 2026, at 4:58 p.m., clinical nurse supervisor (CNS)-D stated ULP-E and ULP-H were nervous with the surveyor observation. CNS-D stated they have seen staff prime insulin pens; and they are knowledgeable of this. The manufacturer's instruction for NovoLog (insulin aspart) injection FlexPen revised February 2023, indicated that before each injection small amounts of air may collect in the cartridge during normal use. To avoid injecting air and to ensure proper dosing: - turn the dose selector to select two units; - hold the pen with the needle pointing up and tap the cartridge gently to make any air bubbles collect at the top of the cartridge; and - keep the needle pointed upwards and press the push-button all the way in until the dose selector returns to zero where a drop of insulin should appear. The manufacturer's instructions for Toujeo Max SoloStar (insulin glargine) revised May 2025, indicated to always perform a safety test before each injection to make sure the pen is working properly, and the correct insulin dose is received by performing the following steps - turn the dose selector to select three units; and - press the injection button all the way in to see insulin at the tip of the needle. 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

Living Well Home Care LLC
7040 EDGEWOOD AVENUE NORTH
Brooklyn Park, MN 55428
Hennepin County
Parcel:

Phone:

License Info

License: HFID 40108

Risk:
License:
Expires on:
CFPM: SELIKE KAMARA
CFPM #: FOOD MANAGER; Exp:
11/04/2028

Inspection Info

Report Number: F8087261092
Inspection Type: Full - Single
Date: 4/28/2026 Time: 2:00:00 PM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

No orders were issued for this inspection report.

Food & Beverage General Comment

THIS WAS AN ANNOUNCED AND SCHEDULED FULL INSPECTION.

INSPECTION CONDUCTED IN THE PRESENCE OF HRD NURSE EVALUATOR.

THE FOLLOWING OBSERVATIONS WERE MADE:

CEILING: PAINTED, SMOOTH, APPEARS TO BE DURABLE - COMPLIANT

FLOORS: LAMINATE PLANKS - NON COMPLIANT

COUNTERTOPS: LAMINATE - NON COMPLIANT

CABINETS: WOOD - NON COMPLIANT

REFRIGERATOR/FREEZER: GE

DISHWASHER: WHIRLPOOL

STOVE/RANGE: WHIRLPOOL

HAND WASHING SINK: YES - RIGHT SIDE OF 2-BIN STAINLESS STEEL KITCHEN SINK

NON COMPLIANT COUNTERTOP, FLOOR, AND CABINETS ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT SUCH A TIME THEY ARE FOUND TO BE A CONCERN OR RISK OF CONTAMINATION, THEY WILL BE ORDERED TO BE REPLACED AND BROUGHT UP TO CODE.

DISHWASHER IS RESIDENTIAL BUT HAS SANITIZING RINSE CYCLE OPTION. TEMPERATURE STICKERS USED TO ENSURE UTENSIL SURFACE TEMPERATURES REACH 165.

HOT WATER TEMPERATURE AT THE KITCHEN SINK REACHED 120 DEGREES.

INSPECTION REPORT EMAILED TO FACILITY AND HRD NURSE SURVEYOR Rhawnie Quinehan

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 F8087261092 from 4/28/2026

John Boettcher

SELIKE KAMARA
FOOD MANAGER

John Boettcher,
Public Health Sanitarian 3
651-201-5076
john.boettcher@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

Living Well Home Care LLC
Brooklyn Park
County/Group: Hennepin County

Inspection Info

Report Number: F8087261092
Inspection Type: Full
Date: 4/28/2026
Time: 2:00:00 PM

Equipment Temperature: Product/Item/Unit: AMBIENT AIR; Temperature Process: Ambient Air

Location: Upright Freezer at 7 Degrees F.

Comment:

Violation Issued?: No

Equipment Temperature: Product/Item/Unit: AMBIENT AIR; Temperature Process: Ambient Air

Location: Upright Cooler at 38 Degrees F.

Comment:

Violation Issued?: No

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

Location: Upright Cooler at 37 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: Product/Item/Unit: SOUR CREAM; Temperature Process: Cold-Holding

Location: Upright Cooler at 37 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: Product/Item/Unit: COTTAGE CHEESE; Temperature Process: Cold-Holding

Location: Upright Cooler at 38 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: Product/Item/Unit: CUT MELON; Temperature Process: Cold-Holding

Location: Upright Cooler at 38 Degrees F.

Comment:

Violation Issued?: No

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

Location: Upright Cooler at 37 Degrees F.

Comment:

Violation Issued?: No

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL40108016-0	Date: April 28, 2026
Facility Name: Living Well Home Care LLC	
Facility Address: 7040 Edgewood Ave N, Brooklyn Park, MN 55428	

☒ **TAG IDENTIFICATION: 0780**

SCOPE/ SEVERITY: Level 1; Widespread

TIME PERIOD OF CORRECTION: Seven (7) days

1. Smoke alarms shall be interconnected so that actuation of one alarm causes all alarms in the individual dwelling or sleeping unit to operate where more than one smoke alarm is required within an individual dwelling or sleeping unit. [Minn. Stat. 144G.45 subd.2]

Comments: When the surveyor requested that unlicensed personnel (ULP)-E test the interconnected smoke alarms during the tour ULP-E initially refused to test the smoke alarms and stated that they did not know which smoke alarms were interconnected or how to operate them. ULP-E called someone on their cell phone who gave them instructions on how to test the smoke alarms. It was observed that there were two smoke alarms installed outside of resident rooms 1 and 2, outside of resident rooms 3 and 4, and inside of resident room 5. In all locations where two smoke alarms were installed only one of the smoke alarms sounded as interconnected. The other smoke alarms only sounded locally. There was also a single smoke alarm installed above the stairs to the basement that only sounded locally and was not interconnected.

☒ **TAG IDENTIFICATION: 0800**

SCOPE/ SEVERITY: Level 1; Widespread

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: In resident room 5 the light fixture was missing light bulbs and the protective globe that the fixture was designed to have.

There were ceiling tiles in the basement by the furnace room that had brown staining on them consistent with water damage.

There was a smoke alarm in the lower level common area that was chirping with a low battery alarm.

The screen door on the front of the facility would not close and latch. The door swung past the fully open position and banged into the outside wall of the facility multiple times during the survey. The gas plunger that is designed to close the door had been bent due to the door opening too far and would not allow the door to close properly.

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 4; Widespread

TIME PERIOD OF CORRECTION: Two (2) days

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

Comments: The FSEP lacked staff actions to take in the event of a fire or similar emergency.

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

Comments: The FSEP directed residents to follow exit routes and know alternative exit routes but did not include the identification of those routes in the policy. The FSEP also indicated that residents should use low positions (stooping and crawling) to avoid smoke. These actions were inappropriate due to the acuity and diagnosis of the residents. The residents of the facility would be unable to follow the steps in the FSEP.

In a phone interview on April 29, 2026, at 11:50 a.m., clinical nurse supervisor (CNS)-D stated R3 was wheelchair bound and cannot walk. R3 can't stand on their own without assistance due to safety and needs a one-person assist for all transfers. R3 was alert and oriented to self only, very forgetful, and had impaired memory. R3 needed reminders to even call the nurse. R3 had a baby monitor used to assist staff with acknowledging their needs/ when they wake up. R3 had a history of falling out of bed as they forget they cannot walk.

CNS-D also stated that R4 was paraplegic, had a stroke before they came to live at the facility and was wheelchair bound. To transfer, the facility staff used a gait belt, and at times when R3 is tired or weaker, like at night they had to use a Hoyer lift. R4 was alert and oriented x4 but their judgement is impaired as they had a history of alcohol abuse and used alcohol frequently, which was what impaired their judgement.

3. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) 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: Licensed assisted living director (LALD)-C provided what they stated were unique and unusual needs for resident relocation during a fire or similar emergency. The document titled "Individualized fire/emergency evacuation plan" dated November 2025, indicated a priority code for residents with a generalized description of the level, but lacked any specific, unique, or unusual needs for residents during a fire or similar emergency. All residents living at the facility were identified by CNS-D as needing assistance with movement and evacuation during a fire or similar emergency, but the licensee lacked documentation of resident needs and staff procedures.

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

Comments: During record review, LALD-C stated that staff receive training on the FSEP every six months. LALD-C stated that the records were not on site, and that the staff training records were kept at an offsite office. No training records for staff on the FSEP were provided for review during the survey.

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: During record review, LALD-C stated that residents receive training on the FSEP every three to six months. LALD-C stated that the records were not on site, and that the resident training records were kept at an offsite office. No training records for residents on the FSEP were provided for review during the survey.

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: During record review, LALD-C stated that evacuation drills were completed every six months. LALD-C stated that the drill records were not on site and that the drill records were kept at an offsite office. No documentation of completed evacuation drills was provided for review during the survey.