



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

November 10, 2025

Licensee

Well Care Health Services LLC

8109 Ewing Avenue North

Brooklyn Park, MN 55443

RE: Project Number(s) SL41342015

Dear Licensee:

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

The Minnesota Department of Health completed an initial survey on October 2, 2025, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

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

STATE CORRECTION ORDERS

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

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

DOCUMENTATION OF ACTION TO COMPLY

Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the

correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

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

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

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

If you have any questions, please contact me.

Sincerely,



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

CLN

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41342	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/02/2025
NAME OF PROVIDER OR SUPPLIER WELL CARE HEALTH SERVICES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 8109 EWING AVENUE NORTH BROOKLYN PARK, MN 55443			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL#41342015 On September 29, 2024, through October 2, 2025, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 2 residents; 2 receiving services under the Provisional Assisted Living Facility with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480			

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 480	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A,	0 480			

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0 480	Continued From page 2 existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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, Food and Beverage Establishment Inspection Report (FBEIR) dated September 30, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee	0 480			

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0 480	Continued From page 3 within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			
0 510 SS=D	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 complies with accepted health care, medical and nursing standards for infection control when one of one employee (clinical nurse supervisor (CNS)-B) failed to perform hand hygiene. 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	0 510			

Minnesota Department of Health

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0 510	Continued From page 4 situation has occurred only occasionally). The findings include: On September 29, 2025, at approximately 12:00 p.m., CNS-B failed to perform hand hygiene prior to R1's medication administration. On September 29, 2025, at approximately 12:20 p.m., CNS-B acknowledged not washing hands prior to R1's medication administration and did not answer why when asked by the surveyor. The licensee's Standard Precautions for All Health Care Workers policy, undated, indicated staff would perform hand hygiene prior to caring for residents. 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 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	0 550			

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0 550	Continued From page 5 has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post the required information related to the grievance procedure and contact information for the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. This had the potential to affect all the licensee's current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During a facility tour on September 29, 2025, at approximately 12:35 p.m., the common areas shared by residents, staff, and visitors, lacked a posting of the grievance procedure to include the name, telephone number, and e-mail contact information for the individuals who were responsible for handling resident grievances. On September 29, 2025, at approximately 12:40 p.m., clinical nurse supervisor (CNS)-B	0 550			

Minnesota Department of Health

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0 550	Continued From page 6 acknowledged the required content was not posted in the common areas. CNS-B stated they were unaware of this requirement and the licensee would update the grievance procedure posting with the required information. The licensee's Complaint and investigation Process Posting policy, undated, indicated the licensee would inform residents about the process to follow when making a complaint to the licensee. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550			
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to implement and maintain a quality management program (QMP) appropriate	0 580			

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0 580	Continued From page 7 to the size of the facility and relevant to the type of services provided. This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On September 29, 2025, at approximately 11:20 a.m., during the entrance conference, clinical nurse supervisor (CNS)-B stated ongoing QMP areas were identified, but no meeting minutes, tracking, or specific improvement projects would be documented. CNS-B also stated the licensee was unaware of this requirement. The licensee's Quality Management Program policy, undated, indicated a QMP would be implemented, and documentation would be provided upon request. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 580			
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each	0 630			

Minnesota Department of Health

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0 630	Continued From page 8 vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop an individual abuse prevention plan (IAPP) with the required content for two of two residents (R1, 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 September 29, 2025, at approximately 2:30 p.m., clinical nurse supervisor (CNS)-B stated R1 and R2's IAPPs were included in the assessments. R1 R1 was admitted on February 18, 2025. R1's Assessment dated July 10, 2025, indicated	0 630			

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0 630	Continued From page 9 R1 was at risk to be abused and did not include: - the resident's susceptibility to abuse by another individual, including other vulnerable adults; -the resident's risk of abusing other vulnerable adults; and - statements of specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. R2 R2 was admitted on March 13, 2025. R2's Assessment dated July 10, 2025, indicated R2 was at risk to be abused and did not include: - the resident's susceptibility to abuse by another individual, including other vulnerable adults; -the resident's risk of abusing other vulnerable adults; and - statements of specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. On September 29, 2024, at 3:00 p.m., CNS-B confirmed R1 and R2's IAPPs did not address the above noted areas of risk or include statements of specific measures to be taken to minimize risks. CNS-B stated the licensee was not aware of the required contents of the IAPP and the IAPP was completed based on the questions shown in the electronic health record. The licensee's Abuse Prevention Plans policy, undated, indicated the licensee developed individualized vulnerable adult abuse prevention plans that include the resident's susceptibility to be abused by another individual, including other vulnerable adults, the resident's risk of abusing other vulnerable adults, and specific measures to minimize the risk of abuse to that person and	0 630			

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0 630	Continued From page 10 other vulnerable adults. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630			
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post required content to include the 911 emergency number in common areas. 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	0 640			

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0 640	Continued From page 11 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On September 29, 2025, at 12:45 p.m., during the facility tour, the surveyor observed the main areas of the facility with clinical nurse supervisor (CNS)-B. The surveyor did not observe the 911 emergency number posted near two (2) cordless telephones. One cordless telephone was located on the fireplace's raised hearth in the living room area and one cordless telephone was located on top of the medication storage cabinet in the dining room area. On September 29, 2025, at 12:50 p.m., CNS-B stated the cordless telephones could be used by staff, residents, or visitors. On September 29, 2025, at 12:55 p.m., CNS-B stated the licensee was unaware of the requirement for the 911 emergency number to be posted near the cordless telephones in the common areas. The licensee's Reporting Maltreatment of Vulnerable Adult policy, undated, indicated the licensee would post the 911 emergency number in common areas and near telephones provided by the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640			
0 650 SS=D	144G.42 Subd. 8 (a) Staff records	0 650			

Minnesota Department of Health

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 650	Continued From page 12 (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 required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records included all required content for one of one employee (clinical nurse supervisor (CNS)-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 an isolated scope (when one or a	0 650			

Minnesota Department of Health

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0 650	Continued From page 13 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: CNS-B was hired on May 4, 2023. On September 29, 2025, at approximately 11:15 a.m., during the entrance conference, CNS-B stated CNS-B was responsible for all orientation requirements for the licensee. CNS-B's employee record lacked documentation of a completed orientation to assisted living regulations with the required content related to: -Overview of Assisted Living statutes; -Review of provider's policies and procedures; -Handling emergencies and using emergency services; -Reporting maltreatment of vulnerable adults or minors; -Handing of resident complaints, reporting of complaints, where to report; -Consumer advocacy services; -Review of types of Assisted Living services the employee will provide and provider's scope of license; and -Orientation to each specific resident and services provided. On October 1, 2025, at 9:30 a.m., per phone conversation, CNS-B stated CNS-B completed the initial orientation and the missing employee record content was an oversight by the licensee. The licensee's Personnel Records policy, undated, indicated each employee record would include records of orientation to the facility, the	0 650			

Minnesota Department of Health

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0 650	Continued From page 14 licensee, and employee roles and responsibilities. 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. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention and control program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) when the licensee failed to complete a facility TB risk assessment. This practice resulted in a level two violation (a	0 660			

Minnesota Department of Health

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0 660	Continued From page 15 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 September 29, 2025, at approximately 11:15 a.m. during the entrance conference, clinical nurse supervisor (CNS)-B stated the licensee had not completed a facility TB risk assessment. CNS-B also stated the licensee was aware of the TB risk assessment requirement but forgot to complete the TB risk assessment. The licensee could not provide any documents that indicated a completed facility TB risk assessment was performed by the licensee. The licensee's Tuberculosis Prevention and Control policy, undated, indicated the licensee would complete a facility TB risk assessment. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and the CDC guidelines, indicated a TB infection control program should include a facility TB risk assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 660			

Minnesota Department of Health

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0 680	Continued From page 16	0 680			
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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have a written emergency preparedness plan (EPP) with all the required content and failed to post an emergency preparedness plan prominently. This had the potential to impact all residents, staff, and visitors to the facility.	0 680			

Minnesota Department of Health

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0 680	Continued From page 17 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 September 29, 2025, at approximately 11:45 a.m. during a tour of the facility, the surveyor did not observe any signage or information regarding the licensee's emergency preparedness plan posted in a prominent location. On September 29, 2025, at approximately 4:00 p.m., the surveyor requested the licensee's EPP. Clinical nurse supervisor (CNS)-B stated the licensee was working on a EPP but was not completed and does not have EPP documents for the surveyor to review. The licensee's Emergency Management policy, undated, indicated the licensee would have an identified EPP in place to ensure the safety and well-being of residents and employees during periods of an emergency or a disaster that disrupts facility services. The licensee's Hazard Vulnerability Analysis (HVA) policy, undated, indicated the licensee would complete a HVA using an all-hazards approach to identify possibly emergency events the facility could experience that could interfere with the delivery of care and services.	0 680			

Minnesota Department of Health

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0 680	Continued From page 18 No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 800			

Minnesota Department of Health

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0 800	Continued From page 19 The findings include: On September 29, 2025, the surveyor toured the facility with clinical nurse supervisor (CNS)-B. The following was observed. GENERAL MAINTENANCE: The sliding patio door was shattered and broken. On September 29, 2025, CNS-B acknowledged the deficiency while accompanying on the facility tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800			
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in	0 810			

Minnesota Department of Health

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0 810	Continued From page 20 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 develop the fire safety and evacuation plan with the required content. This had the potential to directly 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) 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 September 29, 2025, clinical nurse supervisor (CNS)-B provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility.	0 810			

Minnesota Department of Health

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0 810	Continued From page 21 FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP failed to include the following: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The provided FSEP was from a third-party provider and had not been updated to the specific facility. The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. On September 29, 2025, CNS-B stated they understood the areas of their policy that were incomplete and would work on bringing them into compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810			
01530 SS=D	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			

Minnesota Department of Health

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01530	Continued From page 22 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 employees received eight hours of initial dementia care training and two hours of mental illness and de-escalation	01530			

Minnesota Department of Health

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01530	Continued From page 23 training within the first 120 working hours of employment for supervisors of direct care staff as required for one of one clinical nurse supervisor ((CNS)-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 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: On September 29, 2025, at 11:10 a.m., during the entrance conference, CNS-B stated he worked at the facility every day with hours that varied. CNS-B was hired on May 4, 2023, to provide direct care to residents and supervise employees. The licensee's Provisional Assisted Living License was issued on December 10, 2024. CNS-B's employee record included the following initial dementia training: -Dementia - Problem Solving - Anger and Aggression (0.50 hours) completed on February 16, 2025; -Dementia - Person-centered Care (0.75 hours) completed on January 30, 2025; and -Aging Process (0.75 hours) completed on December 21, 2024. CNS-B had a total of two hours completed within	01530			

Minnesota Department of Health

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01530	Continued From page 24 120 hours of working for the licensee. CNS-B's employee record lacked the required eight hours of dementia care training and the required two hours of mental illness and de-escalation training within 120 hours of working for the licensee. On October 1, 2025, at 9:30 a.m., per phone conversation, CNS-B verified the initial dementia care training was not completed for CNS-B. CNS-B stated it was an oversight by the licensee and was unaware of all the dementia care training requirements for supervisors. CNS-B further stated the licensee would ensure any new employee would be provided 8 hours of the initial dementia training and two hours of mental illness and de-escalation training during orientation. The licensee's Dementia Care Training policy, undated, indicated supervisors of direct care staff would complete at least eight hours of initial dementia training within 120 working hours of employment start date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530			
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	01640			

Minnesota Department of Health

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01640	Continued From page 25 on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the current service plan included a signature or other authentication by resident or resident representative to document agreement on the services to be provided for two of two residents (R1, 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: R1 R1 was admitted on February 18, 2025.	01640			

Minnesota Department of Health

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01640	Continued From page 26 On September 29, 2025, at 2:00 p.m., R1's Service Plan dated February 15, 2025, was provided by clinical nurse supervisor (CNS)-B and indicated as R1's current service plan with services R1 was receiving. R1's Service Plan was signed by CNS-B but was not signed or authenticated by R1. R2 R2 was admitted on March 13, 2025. On September 29, 2025, at 2:30 p.m., R2's Service Plan dated March 15, 2025, was provided by CNS-B and indicated as R2's current service plan with services R2 was receiving. R2's Service Plan was signed by CNS-B but was not signed or authenticated by R2. On September 29, 2025, at approximately 2:45 p.m., CNS-B stated they were unaware all service plans were to be signed by CNS-B and then the resident or the resident's designated representative. The licensee's Service Plan policy, undated, indicated the initial service plan, and any revisions to the resident's service plan would be signed by the resident or the resident's representative and the licensee's representative. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41342	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/02/2025
NAME OF PROVIDER OR SUPPLIER WELL CARE HEALTH SERVICES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 8109 EWING AVENUE NORTH BROOKLYN PARK, MN 55443			
(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 27	01880			
01880 SS=D	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 ensure refrigerated medications were stored securely and maintained at manufacturer recommended temperatures by failing to monitor and document medication refrigerator temperatures 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 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: On September 29, 2025, at approximately 11:40 a.m., during a tour of the facility, the surveyor observed an unlocked refrigerator in the upper-level kitchen area that lacked a thermometer and temperature log. Six (6) prefilled pens of the medication Lantus (insulin glargine) U-100 Insulin 100 unit/milliliter (ml) and 6 prefilled pens of the medication NovoLog (insulin aspart) U-100 Insulin 100 unit/ml was	01880			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41342	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/02/2025
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01880	Continued From page 28 observed stored in the refrigerator. R1 was admitted on February 18, 2025. R1's Service Plan dated February 15, 2025, indicated services R1 was receiving that included medication administration. R1's Assessment dated July 10, 2025, indicated R1 needed full medication management that included help with injectable medications, monitoring medical supplies, and secured storage of medications. R1's admission orders dated February 13, 2025, indicated active prescribed medications that included insulin glargine U-100 Insulin 100 unit/ml (inject 20 Units subcutaneously in the morning for type 2 diabetes mellitus) and medication insulin aspart U-100 Insulin 100 unit/ml (inject 5 Units subcutaneously three times a day for type 2 diabetes mellitus). R1's record contained a Scheduled Medications list dated February 27, 2025, that indicated medication insulin glargine U-100 Insulin 100 unit/ml (inject 20 Units subcutaneously every morning with meal for type 2 diabetes mellitus) and medication insulin aspart U-100 Insulin 100 unit/ml (inject 5 Units subcutaneously with meals for type 2 diabetes mellitus). Manufacturer storage directions for Lantus (insulin glargine) U-100 Insulin 100 units/ml dated August 2022, indicated protect from light, store in the refrigerator at 36°F [degrees Fahrenheit] to 46°F, and do not freeze. Manufacturer storage directions for NovoLog	01880			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41342	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/02/2025
NAME OF PROVIDER OR SUPPLIER WELL CARE HEALTH SERVICES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 8109 EWING AVENUE NORTH BROOKLYN PARK, MN 55443			
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01880	Continued From page 29 (insulin aspart) U-100 Insulin 100 units/ml dated February 2023, indicated protect from light, store in the refrigerator at 36°F [degrees Fahrenheit] to 46°F, and do not freeze. On September 29, 2025, at 11:50 a.m., clinical nurse supervisor (CNS)-B acknowledged R1's insulin medications were not stored in a secured refrigerator and lacked temperature tracking. CNS-B stated it was an oversight by the licensee for R1's insulin medications that were stored unsecured. CNS-B also stated the licensee was not aware of the temperature tracking requirement. The licensee's Individualized Medication Management Plan and Record policy, undated, indicated medication stored would be consistent with manufacturer's recommendations. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880			
02310 SS=D	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care,	02310			

Minnesota Department of Health

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
02310	Continued From page 30 medical or nursing standards for one of one resident (R2) who utilized hospital side rails. 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: On September 29, 2025, at approximately 11:45 a.m., during a facility tour, the surveyor observed a hospital style bed with raised bilateral (both sides of the bed) upper ½ side rails on R2's hospital bed. R2 was admitted to the licensee on March 13, 2025. R2's clinical nurse supervisor (CNS)-B Bed Safety Assessment dated July 10, 2025, indicated there were bed rails in use for R2, bed rails were consumer portable bed rails, and the hospital bed safety zone assessment was not applicable. R2's Bed Safety assessment lacked documentation of the actual hospital bed rails in use for R2 to include the safety zone measurements per the Food and Drug Administration (FDA) guidelines for zones of entrapment and if the side rail was FDA compliant. On September 29, 2025, at 3:30 p.m., CNS-B stated the licensee charted on consumer bedrails	02310			

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER WELL CARE HEALTH SERVICES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 8109 EWING AVENUE NORTH BROOKLYN PARK, MN 55443			
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02310	Continued From page 31 instead of hospital style bedrails for R2 by mistake. CNS-B also stated there were no actual measurements for R2's side rails performed and was unaware of this requirement for hospital style bedrails. The licensee's Use of Side Rails policy, undated, indicated the licensee would assess if side rails used by residents meet FDA safety guidelines. The Food and Drug Administration's (FDA), A Guide to Bed Safety, revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients." The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." On page 21, Table 3 Summary of FDA Hospital Bed Dimensional Limit Recommendations indicated specific measurement limits for each entrapment zone. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	02310			
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security	03090			

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER WELL CARE HEALTH SERVICES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 8109 EWING AVENUE NORTH BROOKLYN PARK, MN 55443		
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03090	Continued From page 32 cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the required notice was posted at the main entry way of the establishment to display statutory language to disclose electronic monitoring activity, potentially affecting all current residents in the assisted living facility, staff, and any visitors to the facility. This practice resulted in a level one violation (a violation that has not potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: On September 29, 2025, at 10:00 a.m., the surveyor observed a doorbell with a camera system installed at the main entrance accessible by visitors to the facility that lacked the required notice for electronic monitoring. On September 29, 2025, at 12:30 p.m., clinical nurse supervisor (CNS)-B stated the licensee was not aware of the required verbatim notice to be posted at the entrance accessible by visitors. CNS-B also stated the required electronic monitoring posting would need to be placed at	03090			

Minnesota Department of Health

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03090	Continued From page 33 the entrance. The licensee's Electronic Monitoring policy, undated, indicated the licensee would comply with the Minnesota Electronic monitoring law. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090			



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

WELL CARE HEALTH SERVICES LLC
8109 EWING AVENUE NORTH
Brooklyn Park, MN 55443
Hennepin County
Parcel:

Phone:

License Info

License: HFID 41342

Risk:
License:
Expires on:
CFPM: SARAH BROWN
CFPM #: FOOD MANAGER; Exp:

Inspection Info

Report Number: F1023251141
Inspection Type: Full - Single
Date: 9/30/2025 Time: 12:39:08 PM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 1
Total Priority 2 Orders: 1
Total Priority 3 Orders: 1
Delivery:

New Order: 2-100 Supervision

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

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

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

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

Comply By: 9/30/2025 Originally Issued On: 9/30/2025

! New Order: 3-300B Protection from Contamination: cross-contamination, eggs

3-302.11A(1) Priority Level: Priority 1 CFP#: 15

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

COMMENT: OBSERVED RAW SHELL EGGS STORED OVER SALAD LETTUCE. STORE RAW MEAT/EGGS IN SAFE LOCATION.

Comply By: 9/30/2025 Originally Issued On: 9/30/2025

New Order: 4-300 Equipment Numbers and Capacities

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

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

COMMENT: ACQUIRE AND USE THIS DEVICE TO ENSURE DISH WASHER IS EFFECTIVELY DESTROYING PATHOGENS.

Comply By: 9/30/2025 Originally Issued On: 9/30/2025

Food & Beverage General Comment

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

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

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

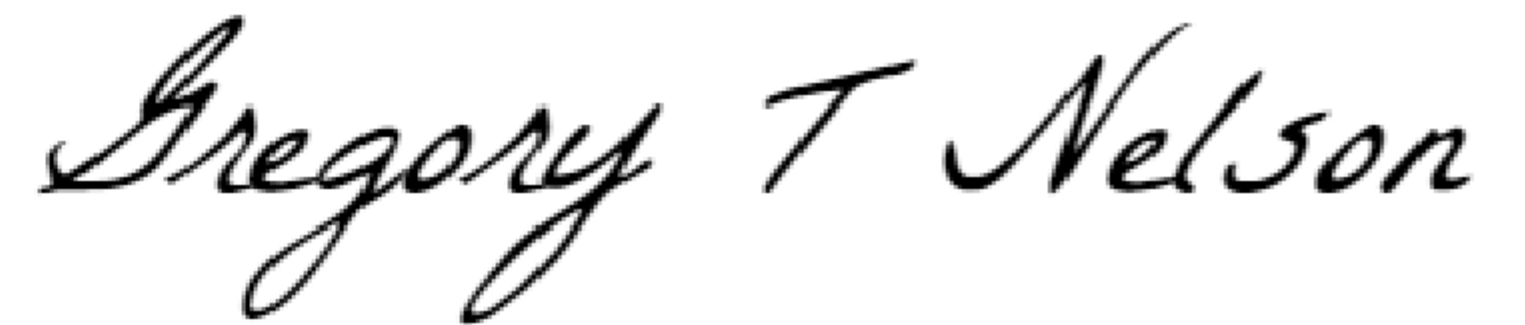
APPROVED FOOD CONTACT SURFACE.

THESE TOPICS WERE DISCUSSED WITH THE PERSON IN CHARGE:

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

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 F1023251141 from 9/30/2025



SOLOMON
PERSON IN CHARGE

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



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

Temperature Observations/Recordings

Page: 1

Establishment Info

WELL CARE HEALTH SERVICES LLC
Brooklyn Park
County/Group: Hennepin County

Inspection Info

Report Number: F1023251141
Inspection Type: Full
Date: 9/30/2025
Time: 12:39:08 PM

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

Location: Refrigerator at 41 Degrees F.

Comment:

Violation Issued?: No

Equipment Temperature: Product/Item/Unit: ; Temperature Process: Freezer

Location: Freezer at frozen Degrees F.

Comment: basement

Violation Issued?: No



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

Sanitizer Observations/Recordings

Page: 1

Establishment Info

WELL CARE HEALTH SERVICES LLC
Brooklyn Park
County/Group: Hennepin County

Inspection Info

Report Number: F1023251141
Inspection Type: Full
Date: 9/30/2025
Time: 12:39:08 PM

Sanitizing Chemical: Product: Chlorine; **Sanitizing Process:** Wiping Cloth Bucket

Location: Kitchen **Equal To** PPM

Comment:

Violation Issued?: No

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

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

Comment:

Violation Issued?: No