Electronically Delivered

January 16, 2026

Licensee
United Providers LLC
6601 75th 1/2 Avenue North
Brooklyn Park, MN 55428

RE: Project Number(s) SL36751016

Dear Licensee:

On December 30, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on October 28, 2025. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

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

HHH

Electronically Delivered

November 17, 2025

Licensee
United Providers LLC
6601 75th 1/2 Avenue North
Brooklyn Park, MN 55428

RE: Project Number(s) SL36751016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on October 28, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement;
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;
Level 3: a fine of $1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 4: a fine of $3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 5: a fine of $5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

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

pursuant to this survey:

St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - $1,000.00

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

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

The correction order documentation should include the following:

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

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

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

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

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

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in

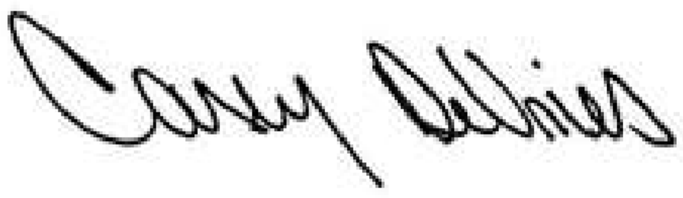
a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

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

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

If you have any questions, please contact me.

Sincerely,



Casey DeVries, Supervisor
State Evaluation Team
Email: Casey.DeVries@state.mn.us
Telephone: 651-201-5917 Fax: 1-866-890-9290

CLN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36751	A. BUILDING: _____ B. WING _____	10/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED PROVIDERS LLC	6601 75TH 1/2 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 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: SL36751016-0 On October 27, 2025, through October 28, 2025, the Minnesota Department of Health conducted a change of ownership (CHOW) survey at the above provider. At the time of the survey, there was one resident; one receiving services under the Assisted Living Facility license. An immediate correction order was identified on October 27, 2025, issued for SL36751016-0, tag identification 1290. During the survey, the licensee took action to mitigate the immediate risk. However, noncompliance remained, and the scope and level remain unchanged.	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.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements	0 470		

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0 470	Continued From page 1 (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to develop and implement a written staffing plan that included an evaluation completed by the clinical nurse supervisor (CNS) (as indicated in Minnesota Administrative Rule 4659.0180) at least twice a year. This had the potential to affect all residents, staff, and visitors.	0 470		

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0 470	Continued From page 2 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 October 27, 2025, at 10:20 a.m., licensed assisted living director (LALD)-D stated one unlicensed personnel (ULP) worked each shift and the shift schedule was 8:00 a.m. until 4:00 p.m., 4:00 p.m. until 11:00 p.m., and 11:00 p.m. until 8:00 a.m., and the CNS was at the facility as needed. On October 27, 2025, at 11:49 a.m., CNS-C provided an undated document titled Facility Staffing Plan. At the end of the document included, "Home Care Consultants, LLC 2021." The document lacked any additional dates. On October 28, 2025, at 10:03 a.m., CNS-C stated they were responsible for creating the staffing plan, and they were aware the staffing plan had to be evaluated every six months. CNS-C stated they did not date the staffing plan to show it was evaluated by a registered nurse (RN). The licensee's Staffing policy dated May 16, 2025, indicated the CNS would prepare and implement a 24-hour daily staffing plan that ensures the adequate staffing to meet the	0 470		

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0 470	Continued From page 3 resident's needs at all times including reasonably foreseeable needs. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a	0 480		

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0 480	Continued From page 4 manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic	0 480		

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0 480	Continued From page 5 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 October 27, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 660 SS=E	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a tuberculosis (TB)	0 660		

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0 660	Continued From page 6 prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included a two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test for two of three employees (clinical nurse supervisor (CNS)-C, registered nurse (RN)-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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: CNS-C CNS-C was hired on February 12, 2025, to provide supervision and direct care services. CNS-C's employee record included a TB screening form completed on February 2, 2025, and a chest x-ray dated May 30, 2025. CNS-C's record lacked a correlating TB test result from either a TST or blood test. RN-B RN-B was hired on April 1, 2025, to provide supervision and direct care services. RN-B employee record included a TB screening form completed on April 16, 2025, and a chest x-ray dated November 3, 2022. RN-B's record lacked a correlating TB test result from either a	0 660		

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0 660	Continued From page 7 TST or blood test. On October 28, 2025, at 10:03 a.m., CNS-C stated the process was to complete a TB screening including a chest x-ray or the TST. CNS-C stated they did not know baseline testing was still required and had to correlate with the chest x-ray. The licensee's Tuberculosis Screening/Prevention policy dated May 16, 2025, indicated licensee would follow the Center for Disease Control recommendations. The Minnesota Department of Health (MDH) Resources and Frequently Asked Questions (FAQ) dated July 1, 2025, read, "A CXR [chest Xray] alone is not acceptable documentation. You either need - documentation of a positive two-step Tuberculin Skin Test (TST) or Interferon-Gamma Release Assay (IGRA) test, and - a CXR with provider evaluation after that date or - documentation of refusal of both the two-step TST and IGRA - followed by a new CXR and provider evaluation. The CDC's document titled Baseline Tuberculosis Screening and Testing for Health Care Personnel dated December 19, 2023, recommended all health care personnel should be screened for TB upon hire and the TB screening process included: - a baseline individual TB risk assessment; - TB symptom evaluation; and - a TB test which could include TB blood test or TB skin test.	0 660		

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0 660	Continued From page 8 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 775 SS=E	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 maintain facility in compliance with Minnesota State Fire Code under Minnesota Rules Chapter 7511. This had the potential to affect some 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On October 28, 2025, from approximately 11:15 a.m. to 12:30 p.m., the surveyor toured the facility with licensed assisted living director (LALD)-D. During the tour the surveyor observed the following:	0 775		

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0 775	Continued From page 9 The rear sliding door from the kitchen area was marked as an exit but was not readily openable. A wooden dowel was placed in the door to secure the door shut, requiring special knowledge or effort to open. The LALD-D removed the exit signage from the door as the door was improper for use as a primary egress route. LALD-D acknowledged that the rear door should not be used as a primary egress as it is configured and indicated that the front door to the property will be the only door so designated. TIME PERIOD FOR CORRECTION: Two (2) days	0 775		
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.	0 810		

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0 810	Continued From page 10 (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 develop the fire safety and evacuation plan with 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, 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 October 28, 2025, at approximately 12:10 p.m., licensed assisted living director (LALD)-D provided documents on the fire safety and	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36751	A. BUILDING: _____ B. WING _____	10/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED PROVIDERS LLC	6601 75TH 1/2 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
0 810	Continued From page 11 evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. The licensee FSEP failed to include the following: The FSEP failed to include appropriate employee actions to take during a fire or similar emergency. LALD-D stated verbal training is provided but no specific written policy has been created. The FSEP must include fire procedures for residents. During an interview on October 28, 2025, at approximately 12:20 p.m., the surveyor explained the requirements for site specific resident evacuation policies and FSEP documentation. LALD-D stated they understood the requirements. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01290 SS=G	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	01290		

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01290	Continued From page 12 liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a background study was submitted and received in affiliation with the assisted living license for one of eight staff (registered nurse (RN)-B). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident), and was issued at 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 finding include: RN-B was hired on April 1, 2025, to provide supervision and direct care services. On October 27, 2025, at 11:55 a.m., licensed assisted living director (LALD)-D provided a document titled Roster (Live/Employees/Search Roster) from the Department of Human Services (DHS) NETStudy 2.0 (a web-based system used for submitting background study requests to DHS. The document indicated staff members that were affiliated to the licensee's health facility identification number (HFID) 36751. RN-B was not listed on the roster. On October 27, 2025, at 12:00 p.m., the surveyor observed RN-B working at the facility. RN-B stated they worked at the facility one hour per	01290		

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01290	Continued From page 13 week. RN-B stated they would check on the resident and sometimes review R1's medications. The Minnesota Board of Nursing indicated RN-B was licensed on August 29, 1985. On October 27, 2025, at 12:07 p.m., LALD-D stated staff were required to have a NETStudy 2.0 cleared background study before they provide direct cares to residents. LALD-D stated they transferred the NETStudy 2.0 background studies for staff from a previous owner's license number 1100647 to the current HFID 36751 roster. LALD-D stated they were unsure why RN-B's background study did not transfer from the previous owner's roster to NETStudy 2.0 roster HFID 36751. LALD-D presented a DHS Background Study Notice dated October 27, 2020, that indicated RN-B had a cleared background study affiliated to license number1100647. LALD-D stated they could not access the NETStudy 2.0 roster for HFID1100647 and would have to call NETStudy 2.0 to find out what happened. On October 27, 2025, at 12:55 p.m., clinical nurse supervisor (CNS)-C stated the last three shifts RN-B worked were October 10, 2025, October 18, 2025, and October 25, 2025. CNS-C stated the licensee did not have a policy for background studies. On October 27, 2025, at 1:01 p.m., LALD-D provided another document titled Roster Live/Employees/Search Roster for HFID 36751. The roster listed RN-B as an employee but did not show RN-B having a cleared eligible background study. LALD-D stated staff without a cleared background study should not be providing direct care services or supervising.	01290		

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01290	Continued From page 14 On October 27, 2025, at approximately 1:40 p.m., NETStudy 2.0 indicated LALD-D separated RN-B from the licensee's NETStudy 2.0 on May 1, 2025. On October 27, 2025, at 1:50 p.m., LALD-D stated they were unsure why RN-B was separated from roster HFID 36751on May 1, 2025. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01290		
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 permit only authorized personnel to have access to 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 failure that has affected or has potential to affect a large portion or all of the residents).	01880		

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01880	Continued From page 15 The findings include: On October 28, 2025, at 7:15 a.m., the surveyor observed the main level of the licensee's two-story assisted living facility (ALF) consisted of a combined kitchen and dining area, common area, and a hallway that lead to resident rooms. The combined kitchen and dining area had a closet that contained medications for R1. The surveyor observed unlicensed personnel (ULP)-A unlock the closet and remove a plastic container that contained medication cards which had the following medications: pantoprazole 40 milligram (mg), Vitamin D3, senna 8.6 mg, cetirizine 10 mg, clonazepam 0.5 mg, clozapine 100 mg, Keppra 500 mg, nabumetone 750 mg, Effexor 150 mg, and Caltrate 1000 mg. ULP-A removed the medication card that contained pantoprazole 40 milligram (mg). ULP-A dispensed the medication into a medication cup and without securing the medications in the plastic container and with no other staff present, ULP-A walked the hallway to R1's room and administered the medications. On October 28, 2025, at 7:19 a.m., the surveyor observed ULP-A walk back to the common area, document the medication as administered and place the medication box back into the closet and lock the door. On October 28, 2025, at 7:57 a.m., the surveyor observed ULP-A remov the same plastic container containing medications for R1 from the same closet, place the plastic container onto the small desk in the common area and place the following medications into a medication cup: Vitamin D3, senna 8.6 mg, cetirizine 10 mg, clonazepam 0.5 mg, clozapine 100 mg, Keppra	01880		

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01880	Continued From page 16 500 mg, nabumetone 750 mg, Effexor 150 mg, and Caltrate 1000 mg. Without securing the medications and with no other staff present, ULP-A walked the hallway to R1's room and administered the medications. On October 28, 2025, at 8:04 a.m., the surveyor observed ULP-A return to the small desk where the medications were located, document the medications as administered, place the medication box back into the closet and lock the door. On October 28, 2025, at 9:58 a.m., ULP-A stated they were trained to keep the medications secured at all times. ULP-A stated the reason the medications were left unsecured was they were nervous because of the state surveyor observing them. On October 28, 2025, at 10:10 a.m., clinical nurse supervisor (CNS)-C stated staff were trained to secure the medications at all times and not leave them out during the medication pass. CNS-C stated if the medications were left out there was a risk of medication diversion. CNS-C stated that situation should not have occurred, and the medications should have been secured. The licensee's Storage/Control of Medication policy dated May 16, 2025, indicated all medications would be securely locked and only would allow authorized personnel to have access to the stored medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		

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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

Establishment Info

United Providers
6601 75th ½ Avenue North

Brooklyn Park
, MN 55428
Hennepin County
Parcel:

Phone:

License Info

License: HFID 36751

Risk:
License:
Expires on:
CFPM: AYAN MOHAMED OMAR
CFPM #: 108840; Exp: 9/27/2027

Inspection Info

Report Number: F1029251251
Inspection Type: Full - Single
Date: 10/27/2025 Time: 10:45:15 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 2
Total Priority 2 Orders: 2
Total Priority 3 Orders: 1
Delivery:

New Order: 2-100 Supervision
2-102.12DMN *Priority Level: Priority 3 CFP#: 2*
MN Rule 4626.0033D Post the certified food protection manager certificate.
COMMENT: PHOTOCOPY OF CFPM CERTIFICATE. POST OFFICIAL MN ISSUED CFPM CERTIFICATE.
Comply By: 10/31/2025 Originally Issued On: 10/27/2025

! **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: RAW UNPASTEURIZED SHELL EGGS ABOVE READY TO EAT FOODS IN REFRIGERATOR. MOVED BY STAFF TO LOWEST LEVEL. PROTECTION FROM CONTAMINATION REVIEWED. RAW ANIMAL PROTEINS MUST BE SEPARATED FROM READY TO EAT FOODS TO PREVENT POSSIBLE CONTAMINATION.
Comply By: 10/27/2025 Originally Issued On: 10/27/2025

New Order: 3-500C Microbial Control: date marking
3-501.17B *Priority Level: Priority 2 CFP#: 23*
MN Rule 4626.0400B Mark the refrigerated, ready-to-eat, TCS food prepared and packaged in a processing plant and opened and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded. The date must not exceed the manufacturer's use-by-date.
COMMENT: OPENED BAG OF SHREDDED LETTUCE WITHOUT DATE MARK AND BEYOND MANUFACTURER'S USE BY DATE. DATE MARKING REVIEWED WITH STAFF.
Comply By: 10/27/2025 Originally Issued On: 10/27/2025

! **New Order: 3-500D Microbial Control: disposition of food**
3-501.18A *Priority Level: Priority 1 CFP#: 23*
MN Rule 4626.0405A Discard all TCS food prepared in the establishment or opened commercially packaged food when the time exceeds 7 days from the preparation or opening date or if the container or package is not marked.
COMMENT: OPENED AND CLOSED BAGS OF SHREDDED LETTUCE WITH SIGNS OF SPOILAGE BEYOND MANUFACTURER'S USE BY DATE (10/18). LUNCHABLES BEYOND MANUFACTURER'S USE BY DATE. DISCARDED BY STAFF. DATE MARKING, PROTECTION FROM CONTAMINATION, AND LISTERIOSIS REVIEWED WITH STAFF.
Comply By: 10/27/2025 Originally Issued On: 10/27/2025

New Order: 4-300 Equipment Numbers and Capacities
4-302.12B *Priority Level: Priority 2 CFP#: 36*
MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.
COMMENT: SMALL DIAMETER PROBE THERMOMETER NOT PRESENT. STAFF INSTRUCTED TO OBTAIN AND MAINTAIN SMALL DIAMETER PROBE THERMOMETER AT FACILITY.
Comply By: 10/31/2025 Originally Issued On: 10/27/2025

Food & Beverage General Comment

Food and beverage inspection conducted as part of HRD survey of ALF. Identified correction orders reviewed with staff and nursing surveyor. Establishment is residential in nature and solely performs same day food and beverage services. Establishment uses GE high heat dishwasher to sanitize equipment and utensils. Thermal stickers are used to verify sanitizing temperatures in the dishwasher.

Food safety topics reviewed with staff: employee illness logging, exclusion, and notification requirements; employee hygiene and handwashing; temperature control; date marking and discarding after 7 days; common foodborne illness pathogens; protection from contamination.

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 F1029251251 from 10/27/2025

AYAN OMAR
FOOD MANAGER

Trevor McCliment

Trevor McCliment,
Public Health Sanitarian 3
651-201-3957
trevor.mccliment@state.mn.us

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

Temperature Observations/Recordings

Establishment Info

United Providers

Brooklyn Park

County/Group: Hennepin County

Inspection Info

Report Number: F1029251251
Inspection Type: Full
Date: 10/27/2025
Time: 10:45:15 AM

New Record: Product/Item/Unit: MILK**; Temperature Process:** Cold-Holding
Location: REFRIGERATOR at 37 Degrees F.
Comment:
Violation Issued?: No

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

Sanitizer Observations/Recordings

Establishment Info

United Providers
Brooklyn Park

County/Group: Hennepin County

Inspection Info

Report Number: F1029251251
Inspection Type: Full
Date: 10/27/2025
Time: 10:45:15 AM

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: **Equal To** 160 Degrees F.
Comment:
Violation Issued?: No