



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

September 22, 2026

Licensee
Comfort Care Homes
2018 Upton Avenue North
Minneapolis, MN 55411

RE: Project Number(s) SL34809016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 11, 2026, 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.

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

St - 0 - 0810 - 144g.45 Subd. 2 (b-F) - Fire Protection And Physical Environment - \$500.00

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.

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,

A handwritten signature in black ink, appearing to read "Casey DeVries". The signature is fluid and cursive, with the first name "Casey" and last name "DeVries" clearly distinguishable.

Casey DeVries, Supervisor

State Evaluation Team

Email: Casey.DeVries@state.mn.us

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

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34809	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/11/2026
NAME OF PROVIDER OR SUPPLIER COMFORT CARE HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 2018 UPTON AVENUE NORTH MINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL34809016-0 On August 10, 2026, through August 11, 2026, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were two residents; two receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34809	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/11/2026
NAME OF PROVIDER OR SUPPLIER COMFORT CARE HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 2018 UPTON AVENUE NORTH MINNEAPOLIS, MN 55411			
(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
0 470	Continued From page 1 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 update their staffing plan twice annually for determining its staffing level needs. 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	0 470			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34809	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/11/2026
NAME OF PROVIDER OR SUPPLIER COMFORT CARE HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 2018 UPTON AVENUE NORTH MINNEAPOLIS, MN 55411			
(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
0 470	Continued From page 2 problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee Staffing Plan indicated it was last updated on, "08/01/2021, 2/4/22, 8/12/22, 02/23." An additional document titled "Facility Staffing Plan" was provided with no date. On August 11, 2026, at 12:31 p.m., clinical nurse supervisor (CNS)-A stated the staffing plan was not up to date and stated she thought it should be updated every six months. The licensee's Staffing policy dated December 27, 2024, indicated, "The staffing plan shall be evaluated as part of the Quality Management program at least twice per year. The results of the evaluation are documented in the meeting minutes." 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	0 480			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34809	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/11/2026
NAME OF PROVIDER OR SUPPLIER COMFORT CARE HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 2018 UPTON AVENUE NORTH MINNEAPOLIS, MN 55411		
(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
0 480	Continued From page 3 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, 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	0 480			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34809	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/11/2026
NAME OF PROVIDER OR SUPPLIER COMFORT CARE HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 2018 UPTON AVENUE NORTH MINNEAPOLIS, MN 55411			
(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
0 480	Continued From page 4 (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 the 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 August 10, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that	0 510			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34809	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/11/2026
NAME OF PROVIDER OR SUPPLIER COMFORT CARE HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 2018 UPTON AVENUE NORTH MINNEAPOLIS, MN 55411			
(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
0 510	Continued From page 5 complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program that complied with accepted health care or medical and nursing standards for infection control related to hand hygiene. The deficient practice had the potential to affect all residents, employees, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The facility was a two-story home with a main floor bathroom. On August 10, 2026, at 10:00 a.m., during the facility tour with clinical nurse supervisor (CNS)-A,	0 510			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34809	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/11/2026
NAME OF PROVIDER OR SUPPLIER COMFORT CARE HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 2018 UPTON AVENUE NORTH MINNEAPOLIS, MN 55411		
(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
0 510	Continued From page 6 the surveyor observed the bathroom on the main level which lacked paper towels for hand drying. There was one resident living on the main floor, R1. On August 11, 2026, at 11:46 a.m., the surveyor observed the main floor bathroom which lacked paper towels for hand drying. On August 11, 2025, at 12:31 P.M., CNS-A stated all bathrooms should have paper towels for hand washing. CNS-A stated it was not hygienic and they should have had paper towels available. The Center for Disease Control (CDC) Clinical Safety: Hand Hygiene for Healthcare Workers webpage, last updated on February 27, 2024, indicated: "Know how to wash hands with soap and water 1. Wet hands with water. 2. Apply the manufacturer recommended amount of product to your hands. 3. Rub hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. 4. Rinse hands with water and use disposable towels to dry. Use a towel to turn off the faucet. 5. Avoid using hot water to prevent drying of the skin." A facility policy titled "Hand Hygiene Policy" dated December 27, 2024, indicated: "Hands should be washed at the following times. After changing beds Before assisting with medications Before and after treatments After all pet care After housekeeping After emptying bedpans After assisting the resident to the toilet	0 510			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34809	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/11/2026
NAME OF PROVIDER OR SUPPLIER COMFORT CARE HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 2018 UPTON AVENUE NORTH MINNEAPOLIS, MN 55411			
(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
0 510	Continued From page 7 After removing items from the floor Before preparing food Before feeding residents After using the bathroom After coughing or sneezing After smoking After handling plants After removing gloves." 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 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 in a	0 550			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34809	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/11/2026
NAME OF PROVIDER OR SUPPLIER COMFORT CARE HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 2018 UPTON AVENUE NORTH MINNEAPOLIS, MN 55411			
(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
0 550	Continued From page 8 conspicuous place the information about the facilities' grievance procedure with the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On August 10, 2026, at 10:00 a.m., during the facility tour with clinical nurse supervisor (CNS)-A, the surveyor observed the licensee lacked a posting with information for the grievance procedure. CNS-A was on the phone with licensed assisted living director (LALD)-D, who was on speaker, and both CNS-A and LALD-D stated the required grievance information was not posted in the facility. A facility policy titled Grievance, dated December 27, 2024, indicated "Information about the grievance process will be posted in a conspicuous location with the following information: a. Name, phone number and email of person responsible for handling grievances." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34809	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/11/2026
NAME OF PROVIDER OR SUPPLIER COMFORT CARE HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 2018 UPTON AVENUE NORTH MINNEAPOLIS, MN 55411			
(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
0 660 SS=D	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 observation, interview, and record review, the licensee failed to ensure tuberculosis (TB) training was completed at the time of hire for one of three staff (unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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:	0 660			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34809	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/11/2026
NAME OF PROVIDER OR SUPPLIER COMFORT CARE HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 2018 UPTON AVENUE NORTH MINNEAPOLIS, MN 55411			
(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
0 660	Continued From page 10 The licensee's most recent TB risk assessment was dated December 29, 2025. ULP-B was hired on February 11, 2026, to provide direct care for residents. ULP-B's record included an Educare (online training platform) transcript which included a training module, "OSHA and Infection Control (w/TB)," and indicated it was assigned to ULP-B on May 22, 2026, but was not completed. On August 10, 2026, at 10:36 a.m., the surveyor observed ULP-B administer medications for R2. On August 11, 2026, at 10:22 a.m., the surveyor showed clinical nurse supervisor (CNS)-A the Educare transcript for ULP-B and explained the training module for TB was assigned but was not completed. CNS-A stated they did not realize ULP-B did not complete the training module. On August 11, 2026, at 12:31 p.m., CNS-A stated they understood TB training was required to be completed at the time of hire and annually. CNS-A stated ULP-B was completing the missed TB training, "right now." The licensee's Tuberculosis Screening/Prevention policy dated December 27, 2024, indicated: "All health care personnel will receive TB education annually, regardless of facility risk level classification. TB education includes: Information on TB exposure risk factors Signs and symptoms of TB disease Infection control policies and procedures The importance of evaluation of symptoms or signs of TB disease for early detection and treatment of TB disease	0 660			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34809	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/11/2026
NAME OF PROVIDER OR SUPPLIER COMFORT CARE HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 2018 UPTON AVENUE NORTH MINNEAPOLIS, MN 55411			
(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
0 660	Continued From page 11 The role of the caregiver in educating clients regarding the importance of reporting symptoms or signs of TB disease The importance of reporting any adverse effects to treatment for LTBI or TB disease." The Minnesota Department of Health (MDH) frequently asked questions (FAQ) website dated June 5, 2026, indicated, "All Minnesota health care personnel should receive TB education annually, regardless of facility risk level classification. TB education should include information on TB exposure risk factors (both occupational and nonoccupational), the signs and symptoms of TB disease, and TB infection control policies and procedures." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding	0 680			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34809	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/11/2026
NAME OF PROVIDER OR SUPPLIER COMFORT CARE HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 2018 UPTON AVENUE NORTH MINNEAPOLIS, MN 55411			
(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
0 680	Continued From page 12 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 develop a written emergency preparedness plan (EPP) with all the required content for staff, residents, and visitors to view. 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 August 11, 2026, at 11:26 a.m., the surveyor reviewed the licensee's Assisted Living Emergency Preparedness Manual, undated. The EPP was a hard copy in a three ringed binder, it was a template which was left blank without having been tailored to the licensee and facility needs. Clinical nurse supervisor (CNS)-A stated they had an electronic version they would send	0 680			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34809	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/11/2026
NAME OF PROVIDER OR SUPPLIER COMFORT CARE HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 2018 UPTON AVENUE NORTH MINNEAPOLIS, MN 55411			
(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
0 680	Continued From page 13 via email which was more complete. The EPP hard copy failed to address the following: - establish and maintain a comprehensive EP, reviewed/updated annually; - how they would coordinate with other health care facilities and community during an emergency or disaster (natural, man-made, facility, etc.), reviewed/updated annually; - documented date of reviews and updates; - risk assessment with documentation; - consider duration of interruptions; - arrangements/contracts to re-establish utility services; - take an all-hazards approach; - categorize the various probable risks/hazards by likelihood of occurrence; - develop strategies for addressing community-based risks (evacuation plans, staffing/shortage, back-up plans); - missing resident plan reviewed quarterly; - an assessment of at-risk population's needs including maintaining independence, communication, transportation, supervision, and medical care; - must identify which staff would assume specific roles in another's absence through succession planning and delegation of authority; - a qualified person who is authorized, in writing, to act in the absence of the administrator; - a process for cooperation and collaboration with local, tribal, regional, State and Federal EP to maintain integrated response; - develop and implement EP policies/procedures and review/update annually; - develop/implement EP policies and procedures to address evacuation and shelter in place for staff and residents which must include: - alternate sources of energy to maintain temperature, safety and sanitary storage of provisions;	0 680			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34809	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/11/2026
NAME OF PROVIDER OR SUPPLIER COMFORT CARE HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 2018 UPTON AVENUE NORTH MINNEAPOLIS, MN 55411		
(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
0 680	Continued From page 14 - alternate sources of energy to fire detection, extinguishing, alarms systems; - sewage and waste disposal; - a tracking system used to document locations of residents, staff, and relocation of staff; - develop policies and procedures to address safe evacuation from the facility including: - needs of evacuees; - staff responsibilities; - transportation; - evacuation location; - alternate communication means; - develop policy and procedures for shelter in place for residents, staff and volunteers who remain at the facility; - develop policy and procedures to address: - systems of medical documentation that preserve resident information; - protects confidentiality; - secures/maintains availability of records; - develop policy and procedures must address use of volunteers including process and role for integration; - develop policy and procedures which address development and arrangements with other facilities or providers to receive residents in the event continuity of services cannot be provided; - develop policies and procedures which address role of the [licensee] under a waiver declared by the secretary in accordance with section 1135; - develop a written communication plan and review/update annually; - communication plan must include all the following names/contact information: - staff; - entities providing services under agreement; - residents' physicians; - other facilities; - volunteers; - communication plan must include contact	0 680			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34809	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/11/2026
NAME OF PROVIDER OR SUPPLIER COMFORT CARE HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 2018 UPTON AVENUE NORTH MINNEAPOLIS, MN 55411			
(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
0 680	Continued From page 15 information for: - Federal, State, tribal, regional, and local EP staff; - State Licensing and Certification Agency; - MN Office of Ombudsman for LTC; - other sources of assistance; - communication plan must include; - method for sharing information and medical documentation for residence; - means, in event of evacuation, to release resident information; - means of providing information about general condition and location of residents under [licensee's] care; - communication plan must include: - means to provide information about facility occupancy; - needs; - and ability to provide assistance; - authority having jurisdiction; - incident Command Center; - or designee; - communication plan must include A method for sharing information from emergency plan; - must develop and maintain EP training and testing program, review/update annually; - training program must include initial EP training to policies and procedures to all new and existing staff and volunteers; - provide EP training at least annually; - maintain documentation of EP training; - demonstrate staff knowledge of EP; - must conduct exercises to test the EP plan at least twice per year including unannounced staff drills using the EP; - must implement emergency and standby power systems based on their EP; and - if part of a healthcare system consisting of separately certified healthcare facilities and elects to have a unified and integrated EP, they may	0 680			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34809	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/11/2026
NAME OF PROVIDER OR SUPPLIER COMFORT CARE HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 2018 UPTON AVENUE NORTH MINNEAPOLIS, MN 55411			
(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
0 680	Continued From page 16 choose to participate. On August 11, 2026, at 11:31 a.m., CNS-A emailed fire drills and education documentation, however, CNS-A's email contained no further information. On August 11, 2026, at 12:31 p.m., CNS-A stated the required information was missing from the binder and they would need to update it. The licensee's 9.01 Emergency Preparedness Plan policy dated March 1, 2026, indicated, "It is the intent that [licensee] has in place an effective and compliant Emergency Preparedness Plan. The intent is the plan will be aligned with the Centers for Medicare and Medicaid Services State Operation Manual Appendix Z: "State Operations Manual Appendix Z - Emergency Preparedness for All Provides and Certified Supplier Types: Interpretive Guidance." Minnesota Administrative Rule 4659.0100 Emergency Disaster and Preparedness Plan dated August 11, 2021, indicated assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.73, or successor requirements. The code references documents, specifications, methods, and standards in the State Operations Manual Appendix Z - Emergency Preparedness for All Provider and Certified Supplier Types. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34809	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/11/2026
NAME OF PROVIDER OR SUPPLIER COMFORT CARE HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 2018 UPTON AVENUE NORTH MINNEAPOLIS, MN 55411			
(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
0 730	Continued From page 17	0 730			
0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received	0 730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34809	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/11/2026
NAME OF PROVIDER OR SUPPLIER COMFORT CARE HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 2018 UPTON AVENUE NORTH MINNEAPOLIS, MN 55411		
(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	
0 730	Continued From page 18 and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure resident records included a discharge summary which met rule and regulation requirements for one of two discharged residents (R1). Further, the licensee failed to accurately document the administration of services for two of two residents (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: DISCHARGE SUMMARY R1 R1 was admitted to the licensee on March 15, 2024, and discharged from the licensee on February 16, 2026. R1's Discharge/Transfer Summary, undated, lacked the following required discharge	0 730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34809	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/11/2026
NAME OF PROVIDER OR SUPPLIER COMFORT CARE HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 2018 UPTON AVENUE NORTH MINNEAPOLIS, MN 55411		
(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
0 730	Continued From page 19 information: -a summary of the resident's stay that includes diagnoses, courses of illnesses, allergies, treatments, and therapies, and pertinent lab, radiology, and consultation results; -a final summary of the resident's status from the latest assessment or review under Minnesota Statutes, section 144G.70, if applicable, which includes the resident status, including baseline and current mental, behavioral, and functional status; -a reconciliation of all predischarge medications with the resident's post discharge prescribed and over-the-counter medications; and -a post discharge care plan that is developed with the resident and, with the resident's consent, the resident's representatives, which will help the resident adjust to a new living environment. The post discharge care plan must indicate where the resident plans to reside, any arrangements that have been made for the resident's follow-up care, and any post discharge medical and nonmedical services the resident will need. On August 11, 2026, at 12:31 p.m., clinical nurse supervisor (CNS)-A stated they realized their discharge assessment did not meet requirements. CNS-A stated they had used the incorrect discharge template in Residex (charting software). SERVICE DOCUMENTATION R2 R2 was admitted to the licensee on December 10, 2023. R2's Service Plan dated August 11, 2026, unsigned, indicated R2 received services for appointment reminders/assistance, bathing assistance, bedmaking, housekeeping, laundry,	0 730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34809	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/11/2026
NAME OF PROVIDER OR SUPPLIER COMFORT CARE HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 2018 UPTON AVENUE NORTH MINNEAPOLIS, MN 55411			
(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
0 730	Continued From page 20 manage behaviors, meal assistance, medication administration, medication setup, record vital signs and shopping assistance. On August 10, 2026, at 10:36 a.m., the surveyor observed unlicensed personnel (ULP)-B administer medications for R2. R2's Service Recap Summary for August 2026 indicated the licensee lacked documentation for the following services and dates: -laundry; August 5; -manage behavior agitation; August 1-9; -manage behavior anxiety; August 1-9; -manage behavior physical aggression; August 1-9; -manage behavior property destruction; August 1-9; -manage behavior verbal aggression; August 1-9; -manage behavior paranoia; August 1-9; -meal assistance; August 1-9; -medication administration; August 1 and 5; -medication setup; August 3; -record blood pressure; August 1-9; -record oxygen saturation; August 1-9; -record pulse; August 1-9; -record respiration; August 1-9; -record temperature; August 1-9; and -record weight; August 1-9. R3 R3 was admitted to the licensee on November 16, 2025. R3's Service Plan dated August 11, 2026, indicated R3 received services for medication administration. R3's Resident Notes dated August 3, 2026, indicated R3 was still at the facility. R3's Resident	0 730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34809	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/11/2026
NAME OF PROVIDER OR SUPPLIER COMFORT CARE HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 2018 UPTON AVENUE NORTH MINNEAPOLIS, MN 55411			
(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
0 730	Continued From page 21 Notes dated August 6, 2026, indicated R3, "has not been at the house for the last several days." R3's Service Recap Summary for August 2026, indicated the licensee lacked documentation for the following services and dates: -medication administration AM; August 3; and -medication administration bedtime; August 1. It further indicated staff continued to document service administration when R3 was not at the facility for the confirmed following dates: -medication administration AM; August 6-10; and -medication administration bedtime; August 10. On August 10, 2026, at 11:21 a.m., clinical nurse supervisor CNS-A stated they did not know where R3 was; they had not seen R3 in approximately seven days. CNS-A stated they filed a police report and provided the case number. On August 11, 2026, at 12:31 p.m., CNS-A stated they did not realize staff were missing documentation. CNS-A stated staff should always document something even if the service was not provided and give an explanation why it wasn't provided; service documentation should never be left blank. CNS-A stated they were performing audits of documentation and charting. The licensee's Clinical Records policy dated December 27, 2024, indicated, "All entries into the clinical record will be legible, permanently recorded in ink, dated and authenticated with the name and title of the person making the entry," and "Documentation will be entered into the clinical record no later than two weeks after the end of the day service was provided." Further, it indicated, "Documentation of services provided as identified in the service plan."	0 730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34809	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/11/2026
NAME OF PROVIDER OR SUPPLIER COMFORT CARE HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 2018 UPTON AVENUE NORTH MINNEAPOLIS, MN 55411			
(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
0 730	Continued From page 22 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730			
0 775 SS=D	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, record review, and interview, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated August 10, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Two (2)	0 775			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34809	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/11/2026
NAME OF PROVIDER OR SUPPLIER COMFORT CARE HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 2018 UPTON AVENUE NORTH MINNEAPOLIS, MN 55411			
(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
0 775	Continued From page 23 days	0 775			
0 780 SS=D	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to ensure the physical environment of the facility was	0 780			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34809	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/11/2026
NAME OF PROVIDER OR SUPPLIER COMFORT CARE HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 2018 UPTON AVENUE NORTH MINNEAPOLIS, MN 55411			
(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
0 780	Continued From page 24 maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated August 10, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Two (2) days	0 780			
0 790 SS=E	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and	0 790			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34809	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/11/2026
NAME OF PROVIDER OR SUPPLIER COMFORT CARE HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 2018 UPTON AVENUE NORTH MINNEAPOLIS, MN 55411			
(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
0 790	Continued From page 25 This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a 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: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated August 10, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790			
0 800 SS=E	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	0 800			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34809	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/11/2026
NAME OF PROVIDER OR SUPPLIER COMFORT CARE HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 2018 UPTON AVENUE NORTH MINNEAPOLIS, MN 55411			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 800	Continued From page 26 residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a 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: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated August 10, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800			
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34809	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/11/2026
NAME OF PROVIDER OR SUPPLIER COMFORT CARE HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 2018 UPTON AVENUE NORTH MINNEAPOLIS, MN 55411			
(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 27 (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 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, record review, and interview, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34809	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/11/2026
NAME OF PROVIDER OR SUPPLIER COMFORT CARE HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 2018 UPTON AVENUE NORTH MINNEAPOLIS, MN 55411			
(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 28 of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated August 10, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
0 950 SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including	0 950			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34809	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/11/2026
NAME OF PROVIDER OR SUPPLIER COMFORT CARE HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 2018 UPTON AVENUE NORTH MINNEAPOLIS, MN 55411		
(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
0 950	Continued From page 29 some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide residents with the required verbatim notice on a document separate from the contract to elect or decline a designated representative for two of two residents (R2, R3). This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R2 R2 was admitted to the licensee on December 12, 2023. R2's Service Plan dated August 11, 2026,	0 950			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34809	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/11/2026
NAME OF PROVIDER OR SUPPLIER COMFORT CARE HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 2018 UPTON AVENUE NORTH MINNEAPOLIS, MN 55411			
(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
0 950	Continued From page 30 unsigned, indicated R2 received medication management, appointment reminder/assistance, bathing assistance, housekeeping, laundry, behavior management (agitation, anxiety, physical aggression, property destruction, verbal aggression, paranoia), meal assistance, vital signs, and shopping assistance. R2's record included an Assisted Living Resident Contract dated December 10, 2023, which lacked the following: -the contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. R3 R3 was admitted to the licensee on November 16, 2025. R3's Service Plan dated August 11, 2026, unsigned, indicated R3 received services for medication management. R3's medical record contained a blank and unsigned document titled "Exhibit 1: Designation of Representative." On August 11, 2026, at 11:11 a.m., clinical nurse supervisor (CNS)-A reviewed R2 and R3's medical records. CNS-A stated she thought the form was completed for R3 adding that she now realized it was not. CNS-A stated R2's contract did not have the requirements for the designation of representative. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 950			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34809	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/11/2026
NAME OF PROVIDER OR SUPPLIER COMFORT CARE HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 2018 UPTON AVENUE NORTH MINNEAPOLIS, MN 55411			
(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
0 950	Continued From page 31 (21) days	0 950			
01330 SS=D	144G.60 Subd. 4 (b) Unlicensed personnel (b) Unlicensed personnel performing delegated nursing tasks in an assisted living facility must: (1) have successfully completed training and demonstrated competency by successfully completing a written or oral test of the topics in section 144G.61, subdivision 2, paragraphs (a) and (b), and a practical skills test on tasks listed in section 144G.61, subdivision 2, paragraphs (a), clauses (5) and (7), and (b), clauses (3), (5), (6), and (7), and all the delegated tasks they will perform; (2) satisfy the current requirements of Medicare for training or competency of home health aides or nursing assistants, as provided by Code of Federal Regulations, title 42, section 483 or 484.36; or (3) have, before April 19, 1993, completed a training course for nursing assistants that was approved by the commissioner. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency evaluations were completed for all required skill areas, prior to providing services, for one of three employees (unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a	01330			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34809	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/11/2026
NAME OF PROVIDER OR SUPPLIER COMFORT CARE HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 2018 UPTON AVENUE NORTH MINNEAPOLIS, MN 55411			
(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
01330	Continued From page 32 limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-B ULP-B was hired on February 11, 2026, to provide direct care for residents. On August 10, 2026, at 10:36 a.m., the surveyor observed ULP-B administer medications for R2. ULP-B's record included an Educare (online training platform) transcript which lacked documentation of the following required competency training and evaluation: -basic infection control, including blood-borne pathogens; -standby assistance techniques and how to perform them; -medication, exercise, and treatment reminders; -understanding appropriate boundaries between staff and residents and the resident's family; -awareness of commonly used health technology equipment and assistive devices; -basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; -reading and recording temperature, pulse, and respirations of the resident; -safe transfer techniques and ambulation; and -range of motioning. On August 11, 2026, at 10:22 a.m., the surveyor showed clinical nurse supervisor (CNS)-A the Educare transcript for ULP-B and explained the training module for the above-mentioned competencies were assigned but were not	01330			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34809	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/11/2026
NAME OF PROVIDER OR SUPPLIER COMFORT CARE HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 2018 UPTON AVENUE NORTH MINNEAPOLIS, MN 55411			
(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
01330	Continued From page 33 completed. CNS-A stated they did not realize ULP-B did not complete the training modules. On August 11, 2026, at 12:31 p.m., CNS-A stated they understood the competency training requirements and ULP-B was completing the missed TB training, "right now." The licensee's Staff Competency policy dated December 27, 2024, indicated: "Observation, reporting and documenting of resident status Basic knowledge of body functioning and changes in body function, injuries or other reportable changes Recognizing physical, emotional, cognitive and development needs of the resident Basic infection control, including blood-borne pathogens Maintenance of a clean and safe environment Falls prevention Safe transfer techniques and ambulation Range of motion and positioning Administering medications or treatments as required Basic nutrition, meal preparation, food safety and assistance with eating Preparation of modified diets Communication skills and barriers Cultural diversity Confidentiality/privacy Professional boundaries Handling of emergencies Commonly used health technology equipment and assistive devices." Additionally, it indicated: "Training and competency evaluations for all unlicensed personnel include the following. Refer to the Competency Manual for criteria. Unlicensed personnel may not work for Comfort	01330			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34809	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/11/2026
NAME OF PROVIDER OR SUPPLIER COMFORT CARE HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 2018 UPTON AVENUE NORTH MINNEAPOLIS, MN 55411			
(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
01330	Continued From page 34 Care Homes until they have successfully passed the written (at 80%) and demonstration competency evaluation. Documentation requirements for all services provided Reports of changes in the resident's condition to the supervisor designated by the assisted living provider Basic infection control, including blood-borne pathogens Maintenance of a clean and safe environment Appropriate and safe techniques in personal hygiene and grooming, including hair care and bathing; care of teeth, gums and oral prosthetic devices; care and use of hearing aids; and dressing and assisting with toileting. Training on the prevention of falls for providers working with the elderly or those at risk of falls Standby assistance techniques and how to perform them Medication, exercise and treatment reminders Basic nutrition, meal preparation and preparation of modified diets as ordered by a licensed health professional, food safety and assistance with eating Communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background and family Awareness of confidentiality and privacy Understanding appropriate boundaries between staff, residents and the resident's family Procedures to utilize in handling various emergency situations Awareness of commonly used health technology equipment and assistive devices." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	01330			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34809	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/11/2026
NAME OF PROVIDER OR SUPPLIER COMFORT CARE HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 2018 UPTON AVENUE NORTH MINNEAPOLIS, MN 55411			
(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
01330	Continued From page 35 (21) days	01330			
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a registered nurse (RN) conducted direct supervision of staff performing a delegated task within 30 days of providing services for one of three employees (unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a	01440			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34809	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/11/2026
NAME OF PROVIDER OR SUPPLIER COMFORT CARE HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 2018 UPTON AVENUE NORTH MINNEAPOLIS, MN 55411		
(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
01440	Continued From page 36 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-B was hired on February 11, 2026, to provide direct care for residents. On August 10, 2026, at 10:36 a.m., the surveyor observed ULP-B administer medications for R2. ULP-B's record included a 30 Day Performance Report dated March 11, 2026. It was a performance review and did not identify competencies were observed. On August 11, 2026, at 10:15 a.m., clinical nurse supervisor (CNS)-A stated they used the wrong form for ULP-B's RN 30-day supervision which lacked the RN 30-day requirements. CNS-A stated they switched forms for ULP-B's supervision but would be going back to the old form which was used for their other ULP RN 30-day supervisions. The licensee's Supervision: Unlicensed Staff policy dated December 27, 2024, indicated: "Direct supervision of home health aides performing delegated tasks will be provided within 30 days after the individual begins working for the assisted living provider and thereafter as needed based on performance. For home health aides who have not performed delegated tasks for one year or longer, the RN	01440			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34809	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/11/2026
NAME OF PROVIDER OR SUPPLIER COMFORT CARE HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 2018 UPTON AVENUE NORTH MINNEAPOLIS, MN 55411			
(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
01440	Continued From page 37 will provide direct supervision within 30 days." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440			
01630 SS=D	144G.70 Subd. 3 Temporary service plan When a facility initiates services and the individualized assessment required in subdivision 2 has not been completed, the facility must complete a temporary plan and agreement with the resident for services. A temporary service plan shall not be effective for more than 72 hours. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to complete a temporary service plan as required at the time of admission for one of two residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R3 was admitted to the licensee on November 16, 2025. R3's Service Plan dated August 11, 2026,	01630			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34809	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/11/2026
NAME OF PROVIDER OR SUPPLIER COMFORT CARE HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 2018 UPTON AVENUE NORTH MINNEAPOLIS, MN 55411		
(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
01630	Continued From page 38 indicated R3 received services for medication administration. On August 10, 2026, at 9:36 a.m., during the entrance conference, clinical nurse supervisor (CNS)-A stated they were still in the process of transitioning to, and learning, how to use Residex (charting software). On August 11, 2026, at 11:11 a.m., CNS-A stated they did not have a temporary service plan for R3 until today (August 11, 2026). CNS-A requested help from the surveyor on how they could view R3's service plan in Residex (charting software). CNS-A found R3's service plan in Residex with the help of the surveyor but the service plan lacked identification of services the licensee would provide to R3. CNS-A stated they were aware of the temporary service plan requirement. On August 11, 2026, at 11:21 a.m., CNS-A provided the surveyor with the unsigned above-mentioned Service Plan for R3, dated August 11, 2026. The licensee's Service Plan policy dated December 27, 2024, indicated, "A temporary service plan and agreement with the resident will be developed if services are initiated and the individualized assessment*** has not been completed. The temporary service plan shall not be effective for more than 72 hours." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01630			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34809	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/11/2026
NAME OF PROVIDER OR SUPPLIER COMFORT CARE HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 2018 UPTON AVENUE NORTH MINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01640	Continued From page 39	01640			
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop current service plans with signatures for two of two residents (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic	01640			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34809	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/11/2026
NAME OF PROVIDER OR SUPPLIER COMFORT CARE HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 2018 UPTON AVENUE NORTH MINNEAPOLIS, MN 55411			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01640	Continued From page 40 failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2 R2 was admitted to the licensee on December 10, 2023. R2's Service Plan signed and dated December 10, 2023, completed upon admission, indicated R2 received services for medication reminders, medication administration, laundry, housekeeping, linen change, "I'm Okay" checks and behavioral support. R2's Service Plan dated August 11, 2026, unsigned, indicated R2 received services for appointment reminders/assistance, bathing assistance, bedmaking, housekeeping, laundry, manage behaviors, meal assistance, medication administration, medication setup, record vital signs, and shopping assistance. The service plan did not match the signed service plan from December 10, 2023. On August 10, 2026, at 10:36 a.m., the surveyor observed ULP-B administer medications for R2. R3 R3 was admitted to the licensee on November 16, 2025. R3's Service dated August 11, 2026, indicated R3 received services for medication administration. On August 10, 2026, at 9:36 a.m., during the entrance conference, clinical nurse supervisor (CNS)-A stated they were still in the process of transitioning to, and learning, how to use Residex	01640			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34809	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/11/2026
NAME OF PROVIDER OR SUPPLIER COMFORT CARE HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 2018 UPTON AVENUE NORTH MINNEAPOLIS, MN 55411		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01640	Continued From page 41 (charting software). On August 11, 2026, at 11:11 a.m., CNS-A stated they did not have a current service plan for R2 or R3 until today (August 11, 2026). CNS-A requested help from the surveyor on how they could view R2 and R3's service plans in Residex. CNS-A found R2 and R3's service plan in Residex with the help of the surveyor. CNS-A stated R3's service plan had nothing added to it. CNS-A stated they did not have service plans signed updated annually as they were supposed to. The surveyor explained service plans only needed to be updated if there was a change to the residents services. On August 11, 2026, at 11:21 a.m., CNS-A provided the above-mentioned Service Plans for R2 and R3, dated August 11, 2026, both unsigned. The licensee's Service Plan policy dated December 27, 2024, indicated: "Beginning with the date assisted living services are first provided, a service plan is developed for the resident based on an agreement with the resident/responsible party and on the assessed needs identified in the comprehensive assessment. The service plan will be finalized no later than 14 days after the date home care services are first provided, if not already completed. The service plan must be revised, if needed, based on resident review or reassessment. The initial service plan and any revisions are signed by a representative from Comfort Care Homes and the resident or resident's representative, indicating agreement with the services to be provided."	01640			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34809	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/11/2026
NAME OF PROVIDER OR SUPPLIER COMFORT CARE HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 2018 UPTON AVENUE NORTH MINNEAPOLIS, MN 55411			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01640	Continued From page 42 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640			
01760 SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure staff accurately documented medication administration for two of two residents (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34809	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/11/2026
NAME OF PROVIDER OR SUPPLIER COMFORT CARE HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 2018 UPTON AVENUE NORTH MINNEAPOLIS, MN 55411			
(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
01760	Continued From page 43 The findings include: R2 R2 was admitted to the licensee on December 12, 2023. R2's Service Plan dated August 11, 2026, unsigned, indicated R2 received medication management, appointment reminder/assistance, bathing assistance, housekeeping, laundry, behavior management (agitation, anxiety, physical aggression, property destruction, verbal aggression, paranoia), meal assistance, vital signs, and shopping assistance. R2's August 2026, Med Admin Summary (medication administration record (MAR)) lacked documentation of medication administration for the following medications, dates and times: -clozapine 100 milligram (mg) orally disintegrating tablet (ODT), dissolve one tablet by mouth twice daily with 75mg tablets; August 1, 6, at PM; -clozapine 25 mg ODT, dissolve three tablets (75 mg) by mouth twice daily with 100mg for total daily dose of 175mg twice a day; August 1, 6, at bedtime; -senna 8.6mg, take one tablet by mouth twice a day; August 1, 6, at PM; and -lithium carbonate 300 mg, take two tablets by mouth every day at bedtime; August 1, 6, at PM. R2's August 2026 MAR indicated the following medications administered: -ferrous sulfate 325mg, take one tablet by mouth on Mon, Wed, Fri; August 7 at AM; -methimazole 5mg, take one tablet by mouth daily; August 1, 6, 7, 8, 9 at AM; and -senna 8.6mg, take one tablet by mouth twice a day; August 1, 6, 7, 8, 9 at AM and August 2, 3, 7,	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34809	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/11/2026
NAME OF PROVIDER OR SUPPLIER COMFORT CARE HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 2018 UPTON AVENUE NORTH MINNEAPOLIS, MN 55411		
(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
01760	Continued From page 44 8, 9 at bedtime. On August 10, 2026, at 10:36 a.m., the surveyor observed unlicensed personnel (ULP)-B administer the following medications to R2: -clozapine 100 milligram (mg) orally disintegrating tablet (ODT), dissolve one tablet by mouth twice daily with 75mg tablets; and -clozapine 25 mg ODT, dissolve three tablets (75 mg) by mouth twice daily with 100mg for total daily dose of 175mg twice a day. ULP-B stated R2 had not received ferrous sulfate, methimazole, or senna in 6 months and documented "med not in medication box". ULP-B stated the nurse was aware. R3 R3 was admitted to the licensee on November 16, 2025. R3's Service Plan dated August 11, 2026, unsigned, indicated R3 received services for medication management. R3's August 2026, MAR lacked documentation of medication administration for the following medications, dates and times: -benztropine 2mg, give 2mg tablet by mouth twice daily; August 3 in AM, August 1, 6, 7, 8, 9 at bedtime; -haloperidol 1mg, take 0.5mg by mouth twice daily; August 2 in AM, August 1, 6, 7, 8, 9 at bedtime; -quetiapine 50mg, take one tablet by mouth every night at bedtime; August 1, 6, 7, 8, 9 at bedtime; and -trazodone 100mg, give one tablet by mouth every evening; August 1, 6, 7, 8, 9 at bedtime. On August 11, 2026, at 9:33 a.m., registered	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34809	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/11/2026
NAME OF PROVIDER OR SUPPLIER COMFORT CARE HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 2018 UPTON AVENUE NORTH MINNEAPOLIS, MN 55411		
(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
01760	Continued From page 45 nurse (RN)-E reviewed R2's MAR and stated there was missing documentation. RN-E stated R2 had not received ferrous sulfate, methimazole, and senna due to the pharmacy not refilling them. RN-E stated the documentation was incorrect (i.e., missing documentation and incorrect documentation) on R2's MAR and should have been documented accurately. On August 11, 2026, at 11:34 a.m., clinical nurse supervisor (CNS)-A reviewed R2 and R3's MAR's and stated there was missing documentation. CNS-A stated there should be "no holes" or blanks on the MAR. CNS-A stated they expected all documentation on the MAR to be completed accurately. A facility policy titled Medication Documentation dated December 27, 2024, indicated: "Complete documentation of medication administration includes the following -Resident's name -Medication name -Medication dosage -Date and time of administration -Method/route of administration -Signature and Title of staff administering the medication If the administration of one or more medications was not completed, staff will document the following -The reason why the medication was not administered -Follow up procedures to meet the resident's needs in compliance with the Medication Management Plan -Appropriate notification to RN Supervisor or other persons as instructed regarding missed dosages -Medication Error report, if appropriate."	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34809	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/11/2026
NAME OF PROVIDER OR SUPPLIER COMFORT CARE HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 2018 UPTON AVENUE NORTH MINNEAPOLIS, MN 55411			
(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
01760	Continued From page 46 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			
01820 SS=F	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure updated medication orders were received and reviewed by the nurse as indicated by the individualized medication plan for two of two residents (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2 R2 was admitted to the licensee on December 12, 2023. R2's Service Plan dated August 11, 2026,	01820			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34809	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/11/2026
NAME OF PROVIDER OR SUPPLIER COMFORT CARE HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 2018 UPTON AVENUE NORTH MINNEAPOLIS, MN 55411		
(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
01820	Continued From page 47 unsigned, indicated R2 received medication management, appointment reminder/assistance, bathing assistance, housekeeping, laundry, behavior management (agitation, anxiety, physical aggression, property destruction, verbal aggression, paranoia), meal assistance, vital signs, and shopping assistance. R2's Clinical Update Assessment 90-day dated August 7, 2026, indicated R3 required assistance managing prescription medication orders and communication with their provider. R2's August 2026 Med Admin Summary (medication administration record (MAR)) indicated R2 took the following medications: -clozapine 100 milligram (mg) orally disintegrating tablet (ODT), dissolve one tablet by mouth twice daily with 75mg tablets; -clozapine 25 mg ODT, dissolve three tablets (75 mg) by mouth twice daily with 100mg for total daily dose of 175mg twice a day; -ferrous sulfate 325mg, take one tablet by mouth on Mon, Wed, Fri; -methimazole 5mg, take one tablet by mouth daily; -senna 8.6mg, take one tablet by mouth twice a day; -lithium carbonate 300 mg, take two tablets by mouth every day at bedtime; and -melatonin 3mg, take one tablet by mouth at bedtime as needed for sleep. On August 10, 2026, at 10:36 a.m., the surveyor observed unlicensed personnel (ULP)-B administer medications for R2. The surveyor observed R2's medications were in one bubble pack prepackaged by the pharmacy which lacked R2's ferrous sulfate 325mg tablet, methimazole 5mg tablet, and senna 8.6mg tablet. ULP-B	01820			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34809	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/11/2026
NAME OF PROVIDER OR SUPPLIER COMFORT CARE HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 2018 UPTON AVENUE NORTH MINNEAPOLIS, MN 55411		
(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
01820	Continued From page 48 stated R2 had not had those medications for at least 6 months. The surveyor observed ULP-B document the three medications as, "med not in medication box." On August 10, 2026, at 10:50 a.m., ULP-B and the surveyor reviewed the locked medication cabinet where all medications for residents were stored. ULP-B stated R2's ferrous sulfate, methimazole, and senna were not in the medication cabinet or bubble packs. The surveyor observed R2 had two bottles of Miralax 3350 powder in the medication cabinet with prescription labels indicating R2 took 17 grams (g) daily mixed with four-eight ounces of beverage. R2's August 2026 MAR did not list Mirilax as an active order. R2's record lacked discontinuation orders for the following medications: -ferrous sulfate 325mg, take one tablet by mouth on Mon, Wed, Fri; -methimazole 5mg, take one tablet by mouth daily; -miralax 3350 powder, take 17g mixed with four-eight ounces of beverage; and -senna 8.6mg, take one tablet by mouth twice a day. R3 R3 was admitted to the licensee on November 16, 2025. R3's Service Plan dated August 11, 2026, unsigned, indicated R3 received services for medication management. R3's August 2026 MAR indicated R3 took the	01820			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34809	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/11/2026
NAME OF PROVIDER OR SUPPLIER COMFORT CARE HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 2018 UPTON AVENUE NORTH MINNEAPOLIS, MN 55411		
(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
01820	Continued From page 49 following medications: -benztropine 2mg, give 2mg tablet by mouth twice daily; -haloperidol 1mg, take 0.5mg by mouth twice daily; -quetiapine 50mg, take one tablet by mouth every night at bedtime; and -trazodone 100mg, give one tablet by mouth every evening. R3's July 2026 MAR indicated R3 took the following medication in addition to medication listed for August 2026: -haloperidol decanoate injection100milligram/milliliter (mg/ml), give 300mg/3ml intramuscular (IM) every 28 days. The surveyor was unable to observe R3 as he was out of the facility. On August 10, 2026, at 10:50 a.m., ULP-B and the surveyor reviewed the locked medication cabinet where all medications for residents were stored. ULP-B and the surveyor reviewed R3's bubble packs which contained the above-mentioned oral medications. The surveyor also observed two Invega Sustenna 234mg/1.5ml injection kits with prescription labels for R3 with fill dates of May 6, 2026, and May 29, 2026. Additionally, there were six vials of haloperidol decanoate 100mg/mL with prescription labels for R3 with half of the vials fill date of January 27, 2026, and the other half February 27, 2026. ULP-B stated they were unsure of which injection R3 received stating the nurse handled injections. R3's record lacked discontinuation orders for Invega Sustenna or haloperidol decanoate and the medications were not listed on R3's MAR. Furthermore, R3's record lacked evidence of	01820			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34809	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/11/2026
NAME OF PROVIDER OR SUPPLIER COMFORT CARE HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 2018 UPTON AVENUE NORTH MINNEAPOLIS, MN 55411		
(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
01820	Continued From page 50 attempts to coordinate with the prescriber. On August 10, 2026, at 11:08 a.m., registered nurse (RN)-E stated she was responsible for reviewing medications which they completed monthly. RN-E stated if medications were missing, they would call the pharmacy to get them filled. RN-E stated R2 and R3 required medication management. RN-E stated they completed both individualized medication management plans for R2 and R3. On August 11, 2026, at 9:33 a.m., RN-E stated the medications (senna, methimazole, and ferrous sulfate) for R2 had been discontinued. RN-E stated they did not have orders to discontinue the medications and the medications remained listed on the MAR. RN-E reviewed R2's record and stated the order Miralax was not on the August MAR. RN-E stated communication with the pharmacy and provider would be documented in the residents' progress notes. RN-E and the surveyor reviewed R2's progress notes for January 2026, through August 10, 2026, which lacked information about orders to discontinue medications or attempts to get new prescriptions from prescribers. RN-E reviewed R3's current orders and stated R3 was supposed to be getting benztropine, trazodone, Invega Sustenna, haloperidol, and haloperidol decanoate administered. RN-E reviewed R3's July and August MAR and stated the August MAR did not include the Invega Sustenna injection and the haloperidol decanoate injection was not on the July or August MAR. RN-E stated they had been attempting to administer an injection (did not specify which medication) to R3 and stated they were not sure when R3 last received either injection. RN-E stated they did not have orders to discontinue either injection for R3 and stated	01820			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34809	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/11/2026
NAME OF PROVIDER OR SUPPLIER COMFORT CARE HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 2018 UPTON AVENUE NORTH MINNEAPOLIS, MN 55411		
(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
01820	Continued From page 51 there were no injections listed on R3's August MAR. RN-E stated if the pharmacy didn't refill a medication, it meant it was discontinued. RN-E and the surveyor reviewed R3's progress notes from January 2026 to August 10, 2026, which lacked information about orders to discontinue medications or attempts to get new prescriptions from the prescriber. On August 11, 2026, at 11:34 a.m., clinical nurse supervisor (CNS)-A stated they had trouble with residents attending their provider appointments, so it was difficult to get orders to discontinue medications, and they relied on the pharmacy for order updates. CNS-A stated they could use after visit summary (AVS) orders if they had them and stated there were no AVS's for R2 or R3. A facility policy titled Prescription Policy, dated December 27, 2024, included the following: - "Written orders from an authorized prescriber will be obtained for all medications and treatments with which the assisted living facility assists residents, including over the counter medications. -Verbal orders may be accepted by a nurse who records and signs the order and then forwards it to the prescriber for signature no later than seven days after receipt of the verbal order. -Telephone, facsimile, or computer-generated orders will be kept confidential. An order received by facsimile must have been signed by the prescriber and a durable copy placed in the clinical record by assisted living staff. -All orders must be signed and dated by the prescriber. If the prescriber omitted a date, the facility will date the order when received from the prescriber. -Medication orders will include the name of the medication, dosage, and directions for use.	01820			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34809	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/11/2026
NAME OF PROVIDER OR SUPPLIER COMFORT CARE HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 2018 UPTON AVENUE NORTH MINNEAPOLIS, MN 55411			
(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
01820	Continued From page 52 -The Registered Nurse is responsible for implementing medication and treatment orders or for delegating the orders to the appropriate paraprofessional. -Medication and treatment orders will be renewed at least every year or when changes occur." A facility policy titled Mediation orders, dated December 27, 2024, included the following: - "Comfort Care Homes will maintain a current written or electronically recorded prescription for all prescribed medications managed for the resident. -Medication orders will be renewed at least every 12 months or as required by the physician, the RN assessment and/or regulation. -Verbal prescription orders from an authorized prescriber will be received by a nurse or pharmacist. -The pharmacist, LPN or RN acting on behalf of the prescriber may communicate to the pharmacy provider a prescription drug order by a practitioner authorized to prescribe drugs or devices. -The prescription drug orders will be transmitted via facsimile or a secure electronic format to the pharmacy -Schedule II controlled substances require an original written prescription drug order manually signed by the authorized practitioner except in an emergency -Immediate administration of the controlled substance is necessary for the proper treatment of the intended user -No appropriate alternative treatment is available -It is not reasonably possible for the prescribing practitioner to provide a written prescription drug order to the pharmacy. -When a written or electronic prescription is received, it must be communicated to the	01820			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34809	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/11/2026
NAME OF PROVIDER OR SUPPLIER COMFORT CARE HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 2018 UPTON AVENUE NORTH MINNEAPOLIS, MN 55411			
(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
01820	Continued From page 53 registered nurse in charge and recorded or placed into the resident's clinical record. -All prescriptions and orders received by Comfort Care Homes either verbally, in writing or electronically will be kept confidential." -When staff become aware of any medications or dietary supplements being used by a resident that are not included in the assessment, the information will be documented, and the RN will be notified. -Comfort Care Homes has determined not to require a prescription for over-the-counter medications and dietary supplements. These medications will be included on the Medication Profile annually renewed by the physician." A facility policy titled Individulized Medication Management Policy dated December 27, 024 indicated: "At the time of the assessment, the RN determines with the resident and the resident's representative(s) what medication management services will be provided. The following services are included in the Medication Management Program. -Performing medication setup -Administering medications -Storing and securing medications -Documenting medication activities -Verifying and monitoring the effectiveness of systems to ensure safe handling and administration -Coordinating refills -Handling and implementing changes to prescriptions -Communicating with the pharmacy about the resident's medications -Coordinating and communicating with the prescriber."	01820			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34809	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/11/2026
NAME OF PROVIDER OR SUPPLIER COMFORT CARE HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 2018 UPTON AVENUE NORTH MINNEAPOLIS, MN 55411			
(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
01820	Continued From page 54 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820			
01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document the name, strength, prescription number and quantity of medications for two of two discharged resident (R1, R4) who received medication management services. This practice resulted in a level two violation (a violation that did not harm a resident's health or	01910			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34809	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/11/2026
NAME OF PROVIDER OR SUPPLIER COMFORT CARE HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 2018 UPTON AVENUE NORTH MINNEAPOLIS, MN 55411			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01910	Continued From page 55 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted to the licensee on March 15, 2024, and discharged on February 16, 2026. R1's Current Medications at Discharge form indicated R4 took the following medications but lacked a medication quantity: -Invega Sustenna 156 milligram (mg)/milliliter (ml), inject one syringe intramuscularly (IM) every four weeks. R4 R4 was admitted to the licensee on April 28, 2026, and discharged on July 21, 2026. R4's Discharge/Transfer Summary indicated R2 indicated R2 received medication management services. R4's Current Medications at Discharge form indicated R4 took the following medications but lacked a medication quantity: -amlodipine, take one tablet 10mg by mouth (PO) daily; -fluticasone and salmeterol 500/50mcg inhalant PO twice daily; -furosemide 80mg, take one tablet PO twice daily; -gabapentin, take one 100mg capsule PO three times daily; -triphrocaps, take one 1mg capsule PO daily;	01910			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34809	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/11/2026
NAME OF PROVIDER OR SUPPLIER COMFORT CARE HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 2018 UPTON AVENUE NORTH MINNEAPOLIS, MN 55411			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01910	Continued From page 56 -hydroxyzine, take one to two 25mg capsules every eight hours PO as needed (PRN); and -sennosides, take one 8.6mg tablet PO twice daily PRN. On August 11, 2026, at 12:31 p.m., clinical nurse supervisor (CNS)-A stated R1 and R4 received medication management services. CNS-A stated they thought they completed a medication count for R1 and R4's medication dispositions. CNS-A stated they were aware of the medication disposition requirements. The licensee's Disposition and Disposal of Medications policy dated December 27, 2024, did not indicate medication disposition documentation requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910			



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

COMFORT CARE HOMES
2018 Upton Ave N
Minneapolis, MN 55411
Hennepin County
Parcel:

Phone:

License Info

License: HFID 34809

Risk:
License:
Expires on:
CFPM: Fatumo Abdi
CFPM #: 53816; Exp: 12/12/2027

Inspection Info

Report Number: F1063261207
Inspection Type: Full - Single
Date: 8/10/2026 Time: 1:30 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

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

MN Rule 4626.0033D Post the certified food protection manager certificate.

COMMENT: CFPM certificate was not posted. Staff member sent picture of certificate to the operator during the inspection. Comply with rule above.

Comply By: 8/10/2026 Originally Issued On: 8/10/2026

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: No temperature indicator was available for measuring dish machine hot water temperature. Provide thermometer or test strips to measure dish machine temperature.

Comply By: 8/10/2026 Originally Issued On: 8/10/2026

! New Order: 4-700 Sanitizing Equipment and Utensils

4-703.11B Priority Level: Priority 1 CFP#: 16

MN Rule 4626.0905B Sanitize food contact surfaces of equipment and utensils after cleaning by using mechanical hot water operations that achieve a utensil surface temperature of 160 degrees F (71 degrees C) and are set up and maintained in accordance with the specifications of NSF International and the manufacturer's data plate.

COMMENT: Utensil surface temperature measured <150 degrees F. Service dish machine so that the maximum utensil surface hot water temperature reaches sanitizing temperature.

Comply By: 8/17/2026 Originally Issued On: 8/10/2026

Food & Beverage General Comment

Inspection was completed with MDH Joey Keen as the lead Health Regulation Division Nurse Evaluator completing the site survey.

Discussed highly susceptible populations, glove use, same day food service, food storage & temperature control, cleaning procedures ware washing, test kits, facility maintenance, vomit cleanup procedures, and employee illness policy.

REFRIGERATOR FOOD TEMPERATURES (DEGREES F): SOUR CREAM 43

DISH MACHINE UTENSIL SURFACE TEMPERATURE (DEGREES F): <150

The facility has a residential kitchen. Food must be prepared for same day service only. The kitchen has paneled flooring, smooth painted walls with tile backsplash, textured ceiling, smooth countertops, and wooden cabinetry. All found to be in

good condition.

Equipment includes a two-basin sink with one compartment designated for handwashing, and ANSI residential fridge/freezer & dish machine.

Contact Health Regulation Division for plan review approval when facility/kitchen undergoes remodeling, major equipment additions, or changes of equipment due to a menu change.

If any customer complains of illness, establishment is required to notify the Minnesota Department of Health and provide the foodborne illness hotline phone number to the customer: 1-877-366-3455

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 F1063261207 from 8/10/2026

Deka Addulle
Nurse



Laura Yang,
Public Health Sanitarian 1
651-201-3581
laura.yang@state.mn.us

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL34809016-0	Date: August 10, 2026
Facility Name: Comfort Care Homes	
Facility Address: 2018 Upton Avenue North, Minneapolis, MN 55411	

☒ **TAG IDENTIFICATION: 0775**

SCOPE/ SEVERITY: Level 2; Isolated

TIME PERIOD OF CORRECTION: Two (2) days

1. Each assisted living facility must comply with the provisions of the Minnesota State Fire Code (MSFC) in Minnesota Rules chapter 7511. [Minn. Stat. 144G.45 subd. 2]
2. A working space of not less than 30 inches in width, 36 inches in depth and 78 inches in height shall be provided in front of electrical service equipment. Where the equipment is wider than 30 inches, the working space shall be not less than the width of the equipment. Storage of materials shall not be located within the designated working space. [Minn. Stat. 144G.45 subd. 2; MSFC 604.3]

Comments: In the basement mechanical room, the area in front of the electrical panel was used for storage. The minimum working space requirements in front of the panel were not met.

☒ **TAG IDENTIFICATION: 0780**

SCOPE/ SEVERITY: Level 2; Isolated

TIME PERIOD OF CORRECTION: Two (2) days

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

Comments: A smoke alarm was not installed outside occupied resident bedroom one. There was an empty hardwired smoke alarm bracket in the main level hallway outside bedroom one. Clinical nurse supervisor (CNS)-A stated they were not aware this smoke alarm was missing. The smoke alarm was reinstalled at the end of the building tour. After the smoke alarm was reinstalled, it started to chirp indicating low battery.

☒ **TAG IDENTIFICATION: 0790**

SCOPE/ SEVERITY: Level 2; Pattern

TIME PERIOD OF CORRECTION: Seven (7) days

1. Portable fire extinguishers installed and maintained to MN State Fire Code. [Minn. Stat. 144G.45 subd.2]

Comments:

- The fire extinguisher in the upper level was stored on the floor and not mounted on the wall bracket. Fire extinguishers shall be properly installed to prevent them from being moved or damaged.
- There was a fire extinguisher mounted on the wall in the basement with a maintenance tag dated 2023, indicating annual maintenance had not been performed by certified service personnel in the last year. The back of this tag was blank, indicating monthly inspections had not been completed. Fire extinguisher inspections shall be conducted and documented every month to ensure each installed extinguisher is in its designated place, it has not been tampered with, and there is no obvious physical damage or condition that would interfere with its use or operation.
- There was a fire extinguisher sign posted on a kitchen cabinet. A portable fire extinguisher was not provided inside this cabinet. When fire extinguisher locations are not accurately identified, it could cause delay in responding to a fire.
- The portable fire extinguisher mounted on the wall in the basement was obstructed by a large box stored in front of this fire extinguisher.

☒ **TAG IDENTIFICATION: 0800**

SCOPE/ SEVERITY: Level 2; Pattern

TIME PERIOD OF CORRECTION: Seven (7) days

1. The physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment are in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. [Minn. Stat. 144G.45 subd.2]

Comments:

- The basement mechanical room was used for storage. There was a large accumulation of clothing and cardboard improperly stored around the furnace.
- Window screens were torn in occupied resident bedroom one and unoccupied resident bedroom three.
- In the basement bathroom, two sections of the wall above the shower enclosure had been patched but these areas had not been sealed to create a protective barrier.

- In the main level bathroom, one light bulb was missing, and another light bulb was burnt out in the light fixture above the sink. Additionally, the caulking around the shower base was soiled, and the floor vent cover was rusty.
- In occupied resident bedroom two, there were holes and cracks in the wall behind the bed and the door handle was loose. Additionally, the carpet, walls, and vent cover were soiled. Clinical nurse supervisor (CNS)-A stated the resident living in this room had damaged these surfaces.
- In unoccupied resident bedroom three, on the furnishings provided by the licensee, one section of the bed headboard surface was damaged and there was a sticky residue on the top of the dresser.

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Twenty One (21) days

1. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that are readily available at all times within the facility. [Minn. Stat. 144G.45 subd.2]

Comments:

- Floor plans for the basement and upper level of the facility were not displayed in the building.
- Evacuation floor plans were not included with the provided onsite copy of the fire safety and evacuation plans (FSEP) in the emergency binder.
- Individualized resident evacuation procedures not included with the provided onsite copy of the FSEP in the emergency binder, the procedures were maintained electronically. These procedures would not be readily available in the event of an emergency to all employees and emergency responders.

2. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that include the location and number of resident rooms. [Minn. Stat. 144G.45 subd.2]

Comments:

- During the building tour, clinical nurse supervisor (CNS)-A verbally identified resident bedrooms by number. Number identifiers were not posted at the bedroom doors. Resident bedroom identifiers need to be posted, and the numbers installed at the bedroom doors need to correspond with the evacuation floor plans to provide efficient communication for exiting in the event of a fire or similar emergency.
- During the building tour, one resident bedroom was observed on the main level. The evacuation floor plans displayed in the building failed to identify the location of this bedroom.
- The floor plans included with the electronic copy of the fire safety and evacuation plans did not accurately identify the location and number of resident bedrooms.

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

Comments: The licensee failed to maintain the onsite and electronic copies of fire safety and evacuation plans (FSEP) with site specific employee actions to take in the event of a fire or similar emergency. Third party templates were used that had not been developed with procedures relative to the assisted living building and environmental risks.

- The main exit door for the building was not identified on the evacuation floor plans displayed in the building.*

- A third party RACE (Remove, Alarm, Confine, Extinguish/Evacuate) template was used that inaccurately directed employees to use pull fire alarms.*

- The electronic copy of the FSEP included an undated fire emergency staff response procedures with inappropriate actions directing employees to evacuate residents to a safe zone within a building without fire resistant construction and life safety systems. Additionally, elevators were inaccurately referenced.*

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

Comments: The onsite and electronic copies of the fire safety and evacuation plans (FSEP) provided by the licensee failed to include site specific fire safety and evacuation instructions for residents. Additionally, there were no written procedures for use of emergency escape and rescue openings (egress windows) in resident bedrooms.