Electronically Delivered

April 24, 2026

Licensee
We Care Home Health Services LLC
2000 Edinbrook Court
Brooklyn Park, MN 55443

RE: Project Number(s) SL36554016

Dear Licensee:

On April 8, 2026, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on February 13, 2026. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Renee L. Anderson

Renee L. Anderson, Supervisor
State Evaluation Team
Email: Renee.L.Anderson@state.mn.us
Telephone: 651-201-5871 Fax: 1-866-890-9290

CLN

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March 17, 2026

Licensee
We Care Home Health Services LLC
2000 Edinbrook Court
Brooklyn Park, MN 55443

RE: Project Number(s) SL36554016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on February 13, 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.

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 - 0780 - 144g.45 Subd. 2 (a) (1) - Fire Protection And Physical Environment - $500.00
St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - $1,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $1,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

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

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

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you

may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

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

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

If you have any questions, please contact me.

Sincerely,

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

CLN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36554	A. BUILDING: _____ B. WING _____	02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WE CARE HOME HEALTH SERVICES LLC	2000 EDINBROOK COURT BROOKLYN PARK, MN 55443

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(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: SL36554016-0 On February 9, 2026, through February 13, 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 five (5) residents, all whom received services under the Assisted Living Facility license. On February 10, 2026, immediate correction orders were issued for tag identifications 1290 and 0470. During the course of the survey, the licensee took action to mitigate the imminent risks. Noncompliance remained and the scopes and levels remain unchanged. During supervisory review, the immediate order for tag identification 1290 was amended to	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.	

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0 000	Continued From page 1 correct an identifier in the February 9, 2026, at 10:20 a.m., interview/observation.	0 000		
0 330 SS=D	144G.30 Subd. 4 Information provided by facility (a) The assisted living facility shall provide accurate and truthful information to the department during a survey, investigation, or other licensing activities. (b) Upon request of a surveyor, assisted living facilities shall within a reasonable period of time provide a list of current and past residents and their legal representatives and designated representatives that includes addresses and telephone numbers and any other information requested about the services to residents. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide any incident reports upon request and failed to provide services based on resident service plans, but documented services were provided for two of two residents (R2, R3) who received assisted living services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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:	0 330		

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0 330	Continued From page 2 Upon a survey initiation phone call on February 9, 2026, at 8:24 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-D stated she was out of the country and expected to return on February 11, 2026. An entrance email was sent to the licensee at 8:35 a.m., which requested the licensee to have accident/incident reports for the past six (6) months for review. INCIDENT REPORT During entrance conference on February 9, 2026, at 3:21 p.m., the surveyor requested incident reports within six (6) months. Supervisor (S)-J stated R3 had a behavior incident resulting hospitalization about eight (8) months ago. On February 10, 2026, at 1:35 p.m., during unlicensed personnel (ULP)-A's record review, the surveyor observed a written explanation by ULP-A dated November 5, 2025, indicating R3 entered the bathroom while ULP-A was inside, then chased ULP-A, then went back to his room. ULP-A contacted 911 where R3 was taken to the hospital. R3's Resident Notes dated November 5, 2025, at 3:35 p.m., LALD/CNS-D indicated staff reported R3 exhibited physically aggressive behavior by destroying property, throwing items, yelling, screaming, and banging, resulting hospitalization. R3's Resident Notes dated November 11, 2025, at 10:18 p.m., LALD/CNS-D indicated R3 returned from the hospital with medication changes and requests to follow up with psychologist and therapist. On February 10, 2026, at 3:45 p.m., the surveyor requested the incident/behavior report for R3, and S-J stated it occurred eight months ago, and the	0 330		

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0 330	Continued From page 3 surveyor explained it was still requested. On February 11, 2026, at 11:43 a.m., the surveyor showed LALD/CNS-D the document found in ULP-A's file and asked why this incident was not provided at the initial request. LALD/CNS-D stated they were trying to locate the incident report and would provide it when found (even though the licensee had previously attested not to have any incident reports in the past six months). The report was not provided to the surveyor upon survey completion. R2 R2 had diagnoses of bipolar disorder (mood swings of mania and depression), anxiety, and post-traumatic stress disorder. R2's Service Plan (Waiver)-Addendum to Contract signed January 27, 2026, indicated R2 received assistance with medication administration, medication setup by the registered nurse (RN), safety checks, health monitoring, and shopping assistance. R2's Service Recap Summary dated February 1-12, 2026, included daily initials for LALD/CNS-D under R2's medication setup except on February 4, 2026, which was left blank. R3 R3 had diagnoses of schizoaffective disorder (mix of schizophrenia symptoms, such as hallucinations and delusions, mania and depression), generalized anxiety disorder (excessive, uncontrollable worry about everyday issues, affecting daily functioning and quality of life), and suicidal ideation. R3's Service Plan (Waiver)-Addendum to	0 330		

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0 330	Continued From page 4 Contract signed January 27, 2026, indicated R3 received assistance with activities, appointment reminder/assistance by RN daily, behavior management, medication administration, medication reconciliation by RN twice daily, and medication setup by RN daily. R3's Service Recap Summary dated January 29, 2026, through February 12, 2026, included initials for LALD/CNS-D on the following services: -medication setup daily except it was blank on February 4; -appointment reminder/assistance daily except it was blank on February 5, 9, 10); -medication reconciliation every 60 days on February 1; and -medication review/reorder, monitoring/set up every 14 days on February 7. During phone interview on February 12, 2026, at 1:23 p.m., LALD/CNS-D stated she left for her trip on January 29, 2026, and returned February 11, 2026. When asked how she completed the above services while out of the country, LALD/CNS-D stated she had access to the resident's electronic health record (Residex) and stated it was her completing the documentation, not someone else. RN medication setup would occur when a resident had a medication change and would set up the new medication in the pill box but stated that should be on a as needed basis, not daily. For appointment reminder/assistance, she stated she would call the resident or staff to provide appointment reminders, but said it was a weekly service, not daily. For medication reconciliation/review, she stated she completed that service while at the facility because she reviewed medications against the medication administration record and orders. LALD/CNS-D stated she was documenting that the service was	0 330		

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0 330	Continued From page 5 completed when it wasn't. The licensee's Service Plan policy dated August 1, 2021, indicated an individualized service plan was implemented for all residents. The licensee would provide all services required by the current service plan. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 330		
0 450 SS=E	144G.41 Subdivision 1 Minimum requirements All assisted living facilities shall: (1) distribute to residents the assisted living bill of rights; (2) provide services in a manner that complies with the Nurse Practice Act in sections 148.171 to 148.285; (3) utilize a person-centered planning and service delivery process; (4) have and maintain a system for delegation of health care activities to unlicensed personnel by a registered nurse, including supervision and evaluation of the delegated activities as required by the Nurse Practice Act in sections 148.171 to 148.285; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide services in a person-centered manner 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	0 450		

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0 450	Continued From page 6 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: R2 During observation between February 9, 2026, and February 11, 2026, at various times, the surveyor observed R2 in and out of the facility, receive medications, take smoke breaks outside, and interact with staff. R2 had diagnoses including bipolar disorder (mood swings of mania and depression), anxiety, and post-traumatic stress disorder. R2's Service Plan (Waiver)-Addendum to Contract signed January 27, 2026, indicated R2 received assistance with medication administration, daily medication setup by the registered nurse (RN), COVID-19 screening twice daily, daily temperature check, and appointment reminder/assistance twice daily. R2's Service Recap Summary dated February 1-12, 2026, included the following: -appointment reminder/assistance scheduled at 8:00 a.m. twice, initialed daily by staff (12 initials had an asterisk indicating a note was made); -COVID-19 screening scheduled at 9:00 a.m., and 9:00 p.m., initialed daily by staff (6 initials had an asterisk); -temperature check daily at 9:00 a.m., was initialed daily by staff; and	0 450		

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0 450	Continued From page 7 -daily initials for LALD/CNS-D under R2's medication setup except on February 4, 2026, which was left blank. R3 On February 10, 2026, at 12:00 p.m., the surveyor observed R3 sitting on their bed reading a book and utilizing their phone. R3 had diagnoses including schizoaffective disorder (mix of schizophrenia symptoms, such as hallucinations and delusions, mania and depression), generalized anxiety disorder (excessive, uncontrollable worry about everyday issues, affecting daily functioning and quality of life), and suicidal ideation. R3's Service Plan (Waiver)-Addendum to Contract signed January 27, 2026, indicated R3 received assistance with medication administration, appointment reminder/assistance by RN daily and as needed by unlicensed personnel (ULP), COVID-19 screening twice daily, medication reconciliation by RN twice daily, take temperature twice daily, and medication setup by RN twice daily. R3's Service Recap Summary dated February 1-12, 2026, included initials for the following services: -appointment reminder/assistance scheduled at 8:00 a.m., LALD/CNS-D initialed daily except for February 4, which was left blank; -COVID-19 screening scheduled at 9:00 a.m., and 9:00 p.m., initialed daily by staff (6 initials had an asterisk); -Medication setup initialed by LALD/CNS-D daily at 8:00 a.m., except February 4 was left blank; and -temperature checks at 9:00 a.m., and 9:00 p.m.,	0 450		

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0 450	Continued From page 8 initialed daily by staff (one initial had an asterisk). During phone interview on February 12, 2026, at 1:23 p.m., LALD/CNS-D stated medication setup on the service plan was a service provided if medications needed to be set up in the medication pill box due to a medication change and stated it should be as needed, not once or twice daily. For appointment reminder/assistance, that service meant the nurse provided appointment reminders, and said it should have been once a week, not daily. The COVID-19 screening began during the COVID period where they checked temperatures and checked for symptoms. LALD/CNS-D stated the screening was no longer necessary and should be removed. LALD/CNS-D stated the provider did not order twice daily temperature checks, they "were doing this to make sure residents were okay," and not everyone had this service but stated it should be once weekly. LALD/CNS-D stated she reviewed the service plan every time a nursing assessment is completed and on December 29, 2025, she did not make any changes to R3's service plan. The licensee's Comprehensive Nursing Assessment policy dated August 1, 2021, indicated the registered nurse would conduct a comprehensive assessment for all residents to determine the services required and to develop an individualized care plan for staff to implement. The licensee's Service Plan policy dated August 1, 2021, indicated the service plan must be revised, if needed, based on resident reassessment. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	0 450		

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0 450	Continued From page 9 days	0 450		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure that one or more awake staff were available in the assisted living, 24 hours per day, seven days per week, to	0 470	During the course of the survey, the licensee took action to mitigate the imminent risk. Noncompliance remained and the scope and level remain	

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0 470	Continued From page 10 be responsible for responding to the requests of residents for assistance with health or safety 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 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: During facility tour and interview with unlicensed personnel (ULP)-B on February 9, 2026, at 10:15 a.m., the surveyor observed a multi-level home with three bedrooms upstairs and two bedrooms downstairs which all were occupied. The upper level had a living room area with a large couch and small couch. The lower level also had a living room area with a futon. During review of the posted schedule, ULP-B stated shifts were 12-hour shifts-8:00 a.m. to 8:00 p.m. (day shift) and 8:00 p.m. to 8:00 a.m. (night shift) where one ULP worked each shift. ULP-B stated all residents were ambulatory, received minimal assistance, and had the ability to come and go. During observation on February 9, 2026, between 10:15 a.m. and 4:00 p.m., the surveyor observed R1 and R2 in and out of their rooms multiple times to use the restroom, go upstairs, and go outside to smoke. The posted undated staff schedule (week 1 and	0 470	unchanged.	

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0 470	Continued From page 11 week 2) indicated two staff person names for each day of the week. The schedule included the following information: Week 1- Monday- ULP-A for both day/night shifts; Tuesday- ULP-A for day shift, and ULP-E for night shift; Wednesday- ULP-B for both day/night shifts; Thursday- ULP-B for day shift, and ULP-H for night shift; Friday- ULP-B for day shift, ULP-G for night shift; Saturday- ULP-G for day shift, and ULP-I for night shift; and Sunday- ULP-G for day shift, ULP-C for night shift. Week 2- Monday- ULP-B for day shift, ULP-A for night shift; Tuesday- ULP-A for both day/night shifts; Wednesday- ULP-B for day shift, ULP-H for night shift; Thursday- ULP-B for day shift, ULP-G for night shift; Friday- ULP-B for day shift, ULP-G for night shift; Saturday- ULP-G for day shift, and ULP-I for night shift; and Sunday- ULP-G for day shift, and ULP-C for night shift. The licensee's Current Resident Roster: State Evaluations form dated January 7, 2026, indicated all five residents' diagnoses included diagnoses such as schizoaffective Bipolar, schizoaffective disorder, anxiety, and bipolar. All 5 residents received medication management, but none received any treatments. The licensee's undated Staffing Plan indicated one ULP was assigned for 8:00 a.m. to 8:00 p.m.	0 470		

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0 470	Continued From page 12 shift and one ULP for 8:00 p.m. to 8:00 a.m. shift. Each ULP was assigned to a 12-hour shift, ensuring consistent presence and support for residents throughout the day and night. On February 9-10, 2026, during the survey, an undisclosed number of residents stated one ULP worked each shift (12-hour shift) and slept overnight on the couch in the living room on the upper level. The residents stated staff were available should an urgent need arise. On February 10, 2026, at 9:00 a.m., while observing the posted staff schedule, ULP-A stated they were scheduled to work three 12-hour shifts in a row (yesterday starting at 8:00 p.m. through tomorrow ending at 8:00 a.m.) totaling 36 hours. ULP-A stated they worked 36 hours straight every week. ULP-A stated they did not sleep at any time and was used to staying awake for that long. During phone interview on February 10, 2026, at 2:14 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-D stated staff were supposed to remain awake at all times and take breaks whenever needed. For staff that worked 36 hours straight, LALD/CNS-D was under the impression that staff were capable of working those hours without difficulty because she was not told otherwise. She also explained if someone had concerns of staff sleeping, she would review her cameras to verify. LALD/CNS-D stated since she knew staff were sleeping, she would switch the schedule around. The licensee's Staffing policy dated August 1, 2021, indicated the licensee would provide adequate staffing to meet resident's needs at all times, including reasonably foreseeable needs.	0 470		

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0 470	Continued From page 13 The residents are provided with a means to request assistance for health and safety needs 24 hours/day 7 days/week; during night shifts, the ULP would respond to resident requests for assistance as soon as possible. The policy did not indicate ULPs needed to be awake. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE Based on observation, interview, and record review, the licensee also failed to maintain a written staffing plan that included an evaluation completed by the clinical nurse supervisor (CNS) (as indicated in Minnesota Administrative Rule 4659.0180) at least twice a year. In addition, the licensee failed to ensure the daily staff schedule was posted for residents, staff, and visitors to review as required. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: DAILY SCHEDULE On February 9, 2026, at 10:20 a.m., in the kitchen area, the surveyor observed an undated posted staff schedule with two-week rotation. For week one and week two, it listed two first names under each day of the week but did not identify title of	0 470		

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0 470	Continued From page 14 staff. ULP-B stated shifts were 12-hour shifts (8:00 a.m. to 8:00 p.m. and 8:00 p.m. to 8:00 a.m.) and one person worked the shift alone. On February 9, 2026, at 11:38 a.m., the surveyor went to the top-level living room and observed a posting titled "Staffing Schedule Edinbrook House," dated December 4, 2023, through December 18, 2023. The daily staff schedule lacked scheduled hours and identification of direct-care staff member's resident assignment. The licensee's Staffing policy dated August 1, 2021, indicated the CNS would prepare and implement a 24-hour daily staffing plan that addressed ULP work schedules for each ULP showing all work shifts with days/hours worked and ULP's resident assignments or work location. The policy also indicated the schedule would be posted at the beginning of the shift in a central location accessible to staff, residents, volunteers, and the public. STAFFING PLAN The licensee's undated and unsigned staffing plan titled Staffing Plan indicated there was one staff member at the facility on day shift (8:00 a.m. to 8:00 p.m.) and one staff member at the facility on night shift (8:00 p.m. to 8:00 a.m.). In addition, there was one registered nurse (RN) or licensed practical nurse (LPN) on call 24 hours per day. The staffing plan was not reviewed twice per year and the surveyor was unable to identify who created the staffing plan. On February 11, 2026, at 10:20 a.m., LALD/CNS-D stated she reviewed the staffing plan semi-annually but did not have	0 470		

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0 470	Continued From page 15 documentation showing it was completed. She also stated resident acuity had not changed over the years so changes to the staffing plan were not needed. The licensee's Staffing policy dated August 1, 2021, indicated the staffing plan was prepared by the CNS based on an evaluation of the appropriateness of the staffing levels in the facility and was reviewed at least twice a year. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570;	0 480		

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0 480	Continued From page 16 (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 (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.	0 480		

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0 480	Continued From page 17 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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, Food and Beverage Establishment Inspection Report (FBEIR) dated February 9, 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		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines.	0 660		

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0 660	Continued From page 18 (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 maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), to include an updated facility TB risk assessment and a baseline TB screening that included a two-step tuberculin (TST) skin test or other evidence of TB testing such as IGRA (a blood test) for three of three employees (unlicensed personnel (ULP)-A, ULP-C, ULP-E). This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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: TB RISK ASSESSMENT On February 11, 2026, at 9:55 a.m., the licensee provided two Facility TB Risk Assessment forms updated April 2025. The assessments contained the following number of people who were diagnosed with active TB disease: First assessment provided completed on January 10, 2025 (beyond annual due by date), by licensed assisted living director/clinical nurse	0 660		

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0 660	Continued From page 19 supervisor (LALD/CNS)-D: -National rate for 2024: 3.0 per 100,000 population; -Minnesota rate for 2024: 3.4 per 100, 000 population; and -Hennepin county rate for 2024: 5.8 per 100,000 population. Second assessment: -National case rate for 2023: 2.9 per 100,000 population; -Minnesota case rate for 2023: 2.8 per 100,000 population; and -Hennepin county rate for 2024: 5.8 per 100,000 population. The second assessment used a mix of 2023 and 2024 data indicating inaccuracy. The form lacked the date, name, and title of the person completing it. On February 11, 2026, at 9:37 a.m., LALD/CNS-D stated she completed the TB risk assessment annually then emailed the surveyor the updated risk assessment when she was asked if a current one was available. On February 13, 2026, at 11:00 a.m., LALD/CNS-D stated she had completed the TB risk assessment for this year (2026), but she realized she used the wrong form (old form) but used current data. TB SCREENING ULP-A, ULP-C, and ULP-E, were hired on June 27, 2022, August 26, 2020, and April 10, 2025, respectively, and provided direct care and services to assisted living residents. ULP-A ULP-A's assessment of history and current symptoms of active TB form dated June 14,	0 660		

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0 660	Continued From page 20 2022, indicated ULP-A circled "no" for history of positive TB skin test or TB blood test and circled "yes" for having Bacille Calmette-Guerin (BCG) vaccine. ULP-A's Radiology Report dated June 27, 2022, indicated ULP-A's chest x-ray showed no evidence of active tubercular disease. During observation on February 10, 2026, between 8:30 a.m., and 3:10 p.m., ULP-A worked the day shift and the surveyor observed ULP-A complete medication administration, supervision, and housekeeping. At 2:50 p.m., ULP-A stated she did not have a positive TB test in the past but had the BCG vaccine. She stated she was told by "company" to get a chest x-ray done which she did. She could not recall if a TB skin test or TB gold test was completed prior to the chest x-ray. ULP-C ULP-C's assessment of history and current symptoms of active TB form dated August 19, 2020, indicated ULP-C circled "no" for history of positive TB skin test or TB blood test and circled "no" for having had BCG vaccine. ULP-C's Radiology Report dated August 25, 2020, indicated ULP-C's chest x-ray showed no radiographic evidence of active tubercular disease. During observation and interview on February 9, 2026, at 10:15 a.m., ULP-C greeted surveyor upon entering facility and stated he was "a driver" for licensee and was there to help with the survey. ULP-C was seen at the facility assisting with bringing groceries inside at 4:02 p.m., when the surveyor left for the day.	0 660		

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0 660	Continued From page 21 ULP-E ULP-E's assessment of history and current symptoms of active TB form dated March 25, 2025, indicated ULP-E circled "no" for history of positive TB skin test or TB blood test and circled "no" for having had BCG vaccine. ULP-E's Radiology Report dated March 28, 2025, indicated ULP-E's chest x-ray was negative for active tuberculosis. ULP-A, ULP-C, and ULP-E's records lacked documentation of a positive TB skin test or TB gold test or documentation of refusal of both the TB skin test and TB gold test. On February 13, 2026, at 9:37 a.m., LALD/CNS-D stated she could accept TB screening completed within 90 days of hire. If staff had a positive TB skin test, the staff refused to have another skin test so the licensee would have staff get a chest x-ray done. LALD/CNS-D stated staff did not use TB gold test, rather staff just get the chest x-ray. LALD/CNS-D acknowledged some of the staff's history screening was not accurate because she knew staff have had a positive test in the past. She also stated she did not have documentation of refusals or documentation of those positive tests in the records. LALD/CNS-D stated she used to use a "refusal form" in the past but had not used it anymore but would start using it. The licensee's Recruitment and Hiring policy dated August 1, 2021, indicated each new hire would complete a TB skin test/TB screening. The policy did not include any additional information. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control	0 660		

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0 660	Continued From page 22 in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines indicated, Baseline TB screening consists of three components: 1. Assessing for current symptoms of active TB disease; 2. Assessing TB history; and 3. Testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step TST or single IGRA. In addition, "An employee may begin working with patients after a negative TB symptom screen (i.e., no symptoms of active TB disease) and a negative IGRA or TST (i.e., first step) dated within 90 days before hire. The second TST may be performed after the healthcare worker (HCW) starts working with patients." Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, indicated on page 12, before the health care worker (HCW) has direct patient contact, the following should be documented in their record: test result, assessment for current TB symptoms, chest X-ray to rule out infectious TB disease if there was a positive TST or IGRA, and medical evaluation to rule out a diagnosis of infectious TB disease. 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	0 680		

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0 680	Continued From page 23 contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to have a written emergency preparedness (EP) plan with all the required content and failed to post the EP prominently. This had the potential to affect all five residents receiving services under the assisted living license. 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	0 680		

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	36554	A. BUILDING: _____ B. WING _____	02/13/2026

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0 680	Continued From page 24 has affected or has the potential to affect a large portion or all of the residents). The findings include: During observation on February 9, 2026, at 11:15 a.m., the signage on the wall near main entrance indicated the EP could be found on top of the refrigerator. The surveyor went to the kitchen and observed a clear bin with some food inside. The EP was nowhere to be found. Unlicensed personnel (ULP)-B was at the employee desk within the kitchen area so surveyor asked where the EP was. ULP-B went to the red metal tool cart in the same area and dug below through many binders to locate the EP. The licensee's emergency disaster preparedness plan last reviewed/revised on October 10, 2022, lacked evidence of the following required content: -develop and maintain the EP: -hazard vulnerability assessment last reviewed September 14, 2023; -maintain and annual EP updates: -failure to update and document annual EP review; -failure to review Missing Resident Plan quarterly; -arrangement with other facilities (arrangement did not include address of facility receiving residents); -develop P/P to address role of facility under a waiver declared by the Secretary in accordance with section 1135 of the Act; -communication plan must include all the following names/contact information: staff, entities providing services under agreement, residents' physicians, other facilities, volunteers (facility address was listed being in Coon Rapids when facility was located in Brooklyn Park); -communication plan must include all of the	0 680		

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0 680	Continued From page 25 following: means to providing information about the facility's occupancy needs, and it's ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee (three of five residents were included); -must develop and maintain EP training and testing program (not reviewed/updated annually); and -emergency prep testing requirements; -participate in an annual full-scale exercise that is community based OR conduct an annual, individual, facility-based functional exercise OR if the facility experiences an actual emergency requiring activation of plan, facility is exempt from engaging in its next required full-scale exercise; -conduct an additional annual exercise that may include: a second full-scale exercise that is community-based or an individual, facility based functional exercise OR mock disaster drill OR table-top exercise; and -analyze the facility's response to and maintain documentation of all drills, tabletop exercises and emergency events & revise plan as needed. On February 11, 2026, at 12:00 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-D stated she reviewed the plan annually, but did not document the reviews. The two binders provided were both part of the EP which the agency's address was their former business address which was not updated. She also stated the backup incident commander listed was no longer employed and would need to be updated. LALD/CNS-D stated they had not completed any emergency testing besides drills. The licensee's Emergency Operations Plan (EOP) dated October 10, 2022, indicated the plan would be reviewed and updated if necessary on	0 680		

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0 680	Continued From page 26 an annual basis. The licensee's Missing Resident policy, effective August 1, 2021, directed the missing resident procedure would be reviewed by the Director and Clinical Nurse Supervisor at least quarterly. Changes to the plan would be documented. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated;	0 780		

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0 780	Continued From page 27 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated 2-12-26, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) Days.	0 780		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and	0 810		

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0 810	Continued From page 28 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, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G.	0 810		

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0 810	Continued From page 29 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated 2-12-26, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty One (21) Days	0 810		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office	01060		

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01060	Continued From page 30 of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation to the resident, legal representative, or designated representative and failed to provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC) of the emergency relocation greater than four days for one of one resident (R3).	01060		

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01060	Continued From page 31 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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: During survey preparation on February 11, 2026, at 11:28 a.m., the surveyor received an email from the regional ombudsman of long-term care, stating they had not received any emergency relocation notices from the licensee. R3 was admitted for assisted living services on February 17, 2021, and had diagnoses of schizoaffective disorder (mix of schizophrenia symptoms, such as hallucinations and delusions, mania and depression), generalized anxiety disorder (excessive, uncontrollable worry about everyday issues, affecting daily functioning and quality of life), and suicidal ideation. R3's Resident Notes dated November 5, 2025, at 7:38 a.m., unlicensed personnel (ULP)-A indicated at 5:12 a.m., staff was using bathroom and resident opened the door and joined staff at the bathroom and R3 was asking staff who is God? Staff was able to get out then R3 went to his room, screaming and breaking things, so staff called 911. R3 was taken to the hospital at 6:00 a.m. R3's Resident Notes dated November 5, 2025, at 6:28 p.m., ULP-A indicated R3 experienced a mental health crisis early that morning and was	01060		

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01060	Continued From page 32 admitted at the hospital. Staff and family were relieved, as everyone had growing concerns of recent behaviors. R3's Resident Notes dated November 11, 2025, at 4:00 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-D indicated R3 returned from the hospital and had significant medication changes. The case manager and family had been updated. R3's record lacked evidence the licensee provided the resident or resident's representative a written emergency relocation notice. The record also lacked evidence to indicate the licensee provided the notification to the OOLTC of the emergency relocation greater than four days as required. During interview on February 11, 2026, at 12:00 p.m., LALD/CNS-A stated they had not been using the emergency relocation notice but were aware of it. After reviewing the statute requirement, supervisor (S)-J began creating a form to use. The licensee's Discharge and Transfer of Residents policy dated August 1, 2021, indicated in the event of an emergency relocation, the license would provide the written notice to the resident, the resident's legal representative/designated representative, and the resident's case manager, and if the resident had been relocated and not returned to licensee within four (4) days, then they would notify the OOLTC. The policy did not include the required content of the notice. No further information was provided.	01060		

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01060	Continued From page 33 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a background study was cleared for one of 12 employees (unlicensed personnel (ULP)-C). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident), and was issued at 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).	01290	During the course of the survey, the licensee took action to mitigate the imminent risk. Noncompliance remained and the scope and level remain unchanged.	

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01290	Continued From page 34 The findings include: On February 9, 2026, at 10:15 a.m., the surveyor arrived at the facility to initiate the survey and was greeted by ULP-C in the driveway coming out of a van. ULP-C escorted the surveyor into the facility and helped the surveyor find an area to set up. When asked if ULP-C was working the shift, ULP-C explained he was the "driver," and ULP-B was the person working. The surveyor observed ULP-C at the facility throughout the day, and ULP-C was still at the facility when the surveyor left at 4:00 p.m. During facility tour on February 9, 2026, at 10:20 a.m., the surveyor observed an undated posted staff schedule with two-week rotation. For week one and week two, it included ULP-C was scheduled every Sunday for the second shift. ULP-B stated shifts were 12-hour shifts (8:00 a.m. to 8:00 p.m. and 8:00 p.m. to 8:00 a.m.) and one person worked the shift alone. The licensee's Employee List dated January 6, 2026, indicated ULP-C was listed as a direct caregiver and had a hire date of August 26, 2020, under the licensee's comprehensive home care license, and began providing assisted living services on August 1, 2021. ULP-C's Background Study Clearance dated August 18, 2020, indicated ULP-C was cleared and affiliated to health facility identification (HFID) number 32613, a different licensee owned by the same owner. On February 9, 2026, at 11:47 a.m., the surveyor received the licensee's NetStudy 2.0 roster dated February 9, 2026 (web-based system used by the Minnesota Department of Human Services (DHS)	01290		

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01290	Continued From page 35 to submit and process background study requests). The surveyor did not see ULP-C on the licensee's NetStudy 2.0 roster. On February 9, 2026, at 12:44 p.m., the surveyor observed the NetStudy 2.0 website and observed ULP-C's COVID-19 study expired on December 31, 2022. During phone interview on February 9, 2026, at 2:31 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-D stated she was responsible for conducting background studies (BGS) and about a month ago, an audit was completed to ensure all staff were cleared and affiliated. LALD/CNS-D stated they must have skipped ULP-C somehow and stated ULP-C would get fingerprinted right away. LALD/CNS-D stated ULP-C was responsible for providing transportation for all residents including residents of the other licensee. The licensee's Recruitment and Hiring policy dated August 1, 2021, indicated that all persons were appropriately screened prior to employment. NetStudy 2.0 (or current version) would be used for the background check. The policy did not include any additional information related to background studies. The Minnesota DHS Emergency background studies end website dated August 7, 2025, indicated emergency studies were no longer valid after December 31, 2022. The website stated that entities were responsible for identifying who needed to submit a new fully compliant, fingerprint-based background study. No further information was provided.	01290		

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01290	Continued From page 36 TIME PERIOD FOR CORRECTION: Immediate Based on observation, interview, and record review, the licensee failed to ensure a background study was affiliated to the current HFID number for one of one employee (ULP-E) on the facility provided employee roster. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During facility tour on February 9, 2026, at 10:20 a.m., the surveyor observed an undated posted staff schedule with two-week rotation. For week one and week one, it included ULP-E was scheduled every Tuesday for the second shift. ULP-B stated shifts were 12-hour shifts (8:00 a.m. to 8:00 p.m. and 8:00 p.m. to 8:00 a.m.) and one person worked the shift alone. The licensee's Employee List dated January 6, 2026, indicated ULP-E was listed as a direct caregiver and had a hire date of June 27, 2022. On February 9, 2026, at 11:47 a.m., the surveyor received the licensee's NetStudy 2.0 roster dated February 9, 2026. The surveyor did not see ULP-E affiliated with licensee's HFID 36554. On February 9, 2026, at 1:31 p.m., the surveyor's supervisor located ULP-E's Person Summary on	01290		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01290	Continued From page 37 DHS's website showing ULP-E was affiliated with three other licenses owned by the same owner; 1123349, 1123554, on April 22, 2025, and 1123348 on April 10, 2025. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01530 SS=F	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related	01530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36554	A. BUILDING: _____ B. WING _____	02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WE CARE HOME HEALTH SERVICES LLC	2000 EDINBROOK COURT BROOKLYN PARK, MN 55443

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01530	Continued From page 38 to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure required mental health training was completed for one of two employees (unlicensed personnel (ULP)-A). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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: The licensee's Current Resident Roster dated January 7, 2026, indicated residents had primary diagnoses of schizoaffective disorder (mix of schizophrenia symptoms, such as hallucinations and delusions with mania and depression), anxiety and bipolar (episodes of mania and	01530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36554	A. BUILDING: _____ B. WING _____	02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WE CARE HOME HEALTH SERVICES LLC	2000 EDINBROOK COURT BROOKLYN PARK, MN 55443

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01530	Continued From page 39 depression). ULP-A was hired on June 27, 2022, and provided direct care and services to assisted living residents. ULP-A's employee record lacked evidence they completed 2 hours of initial training on mental illness effective July 1, 2025, to include the following topics: Mental Health Training (1) recognizing symptoms of common mental illness diagnoses, including but not limited to mood disorders, anxiety disorders, trauma- and stressor-related disorders, personality and psychotic disorders, substance use disorder, and substance misuse; (2) de-escalation techniques and communication; and (3) crisis resolution and suicide prevention, including procedures for contacting county crisis response teams and 988 suicide and crisis lifelines. During observation on February 10, 2026, between 8:30 a.m., and 3:10 p.m., ULP-A worked the day shift and observed ULP-A complete medication administration, supervision, and housekeeping. On February 11, 2026, at 9:00 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-D stated staff completed training on two online programs (Educare and Rtasks) but they were working on switching all training to Rtasks because staff utilized the program for their residents' health record. She assigned two-hours of mental health training to all staff initially but did not have annual training assigned to any staff. LALD/CNS-D stated she would contact Rtasks to	01530		

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	36554	A. BUILDING: _____ B. WING _____	02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WE CARE HOME HEALTH SERVICES LLC	2000 EDINBROOK COURT BROOKLYN PARK, MN 55443

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01530	Continued From page 40 get that added. LALD/CNS-D stated ULP-A was cross trained between 144G and their other license they held (245D) and would try to locate ULP-A's missing initial mental health training requested. The missing mental health training was not provided before survey completion. On February 11, 2026, at 5:02 p.m., via email, LALD/CNS-D attached the "Mental Health & Crisis Response Policy" after the surveyor requested a policy on mental health training. The licensee's Mental Health & Crisis Response Policy last reviewed on February 11, 2026, indicated staff received mental health training at hire and annually. The policy did not provide additional information on training requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance	01760		

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01760	Continued From page 41 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 verify correct medication dose and transcribe a provider order timely 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 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: R2 R2 had diagnoses including bipolar disorder (mood swings of mania and depression), anxiety, and post-traumatic stress disorder. On February 10, 2026, at 11:45 a.m., the surveyor observed unlicensed personnel (ULP)-A administer medications to R2 in the kitchen area. R2's (nursing) Assessment dated December 29, 2025, noted R2 received assistance with behavior management, housekeeping, laundry, and medication administration. R2's Service Plan (Waiver)-Addendum to Contract signed January 27, 2026, indicated R2 received assistance with medication administration, reminders, housekeeping, behavior management, safety checks, and	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36554	A. BUILDING: _____ B. WING _____	02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WE CARE HOME HEALTH SERVICES LLC	2000 EDINBROOK COURT BROOKLYN PARK, MN 55443

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01760	Continued From page 42 shopping assistance. R2's prescriber orders dated April 17, 2025, included: - melatonin 5 milligram (mg) tablet, take 1 to 2 tablets by mouth every night at bedtime for sleep. R2's Med (Medication) Admin (Administration) Summary for February 1-12, 2026, included: - melatonin 5 milligram (mg) tablet, take 1 to 2 tablets by mouth every night at bedtime was initialed daily by staff. On February 11, 2026, at 1:50 p.m., the surveyor observed two bottles of over-the-counter melatonin 3 mg tablets. LALD/CNS-D stated R2 bought those bottles but if she purchased them, the dose would be correct. When asked how many tablets of melatonin were given, LALD/CNS-D stated staff would indicate a note, but after reviewing R2's medical record, notes were not available. LALD/CNS-D stated R2 always wanted two tablets. R3 R3 had diagnoses including schizoaffective disorder (mix of schizophrenia symptoms, such as hallucinations and delusions, mania and depression), generalized anxiety disorder (excessive, uncontrollable worry about everyday issues, affecting daily functioning and quality of life), and suicidal ideation. R3's Service Plan (Waiver)-Addendum to Contract signed January 27, 2026, indicated R3 received assistance with medication administration, reminders, housekeeping, laundry, and manage behaviors. R3's Assessment by Date dated December 29,	01760		

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01760	Continued From page 43 2025, noted R3 needed assistance with medication administration, reminders to shower, housekeeping, behavior management, safety checks, and shopping assistance. During medication review with ULP-B on February 11, 2026, at 1:23 p.m., the surveyor observed a bottle of hydroxyzine 25 mg, with pharmacy label indicating to give one capsule daily as needed (PRN), which was filled on February 6, 2026. ULP-B stated R3 was given one that morning to help prevent behaviors while out in the community. LALD/CNS-D stated the hydroxyzine was a new order and would obtain the order from the pharmacy. R3's prescriber order dated September 10, 2025, included: -hydroxyzine pamoate 25 mg capsule, give one capsule every day as needed for anxiety. R3's Med (Medication) Admin (Administration) Summary for February 1-12, 2026, lacked hydroxyzine. On February 11, 2026, at 2:45 p.m., LALD/CNS-D stated the pharmacy would input the order on the resident's medication administration record (MAR) and that she had "approved" hydroxyzine that day. She also stated R3 received that medication in the past and it was restarted. LALD/CNS-D stated ULP-B administered hydroxyzine that morning without the MAR, but would chart it because it was recently added. The licensee's Medication Documentation policy dated August 1, 2021, indicated each medication administered by licensee would be documented in the resident's clinical record. Documentation of medication administration would be completed	01760		

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01760	Continued From page 44 promptly. The licensee's Medication Administration policy dated August 1, 2021, indicated all staff providing medication administration must have access to the following: a. Purpose b. Dosage c. Route d. Frequency e. Instructions related to the medication and specific to the residents, as appropriate f. Side effects g. Resident allergies to medications The licensed nurse was responsible for assessing medications to assure that all medications are current and ordered by the prescriber and to identify any expired or outdated medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		

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

Food & Beverage Inspection Report

Establishment Info

WE CARE HOME HEALTH SERVICES LLC
2000 EDINBROOK COURT
Brooklyn Park, MN 55443
Hennepin County
Parcel:

Phone:
wecaremn99@gmail.com; toyinakerele87@gmail.com; Winifredarabaadjei@yahoo.com; tessykwam@yahoo.com

License Info

License: HFID 36554

Risk:
License:
Expires on:
CFPM: MATILDA POKUAAH AGYAPONG
CFPM #: 116139; Exp: 3/21/2026

Inspection Info

Report Number: F1029261043
Inspection Type: Full - Single
Date: 2/9/2026 Time: 12:35:31 PM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 2
Total Priority 2 Orders: 2
Total Priority 3 Orders: 6
Delivery:

! **New Order: 2-200 Employee Health**
2-201.11C *Priority Level: Priority 1 CFP#: 3*
MN Rule 4626.0040C The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority at the specific request of the regulatory authority.
COMMENT: NO EMPLOYEE ILLNESS LOG. NAVIGATE TO MDH SITE DURING INSPECTION AND DOWNLOADED/PRINTED EMPLOYEE ILLNESS LOG. ILLNESS LOGGING, EXCLUSION, AND REPORTING REQUIREMENTS REVIEWED WITH PIC.
Comply By: 2/9/2026 Originally Issued On: 2/9/2026

New Order: 3-300C Protection from Contamination: equipment/utensils, consumers
3-304.14B *Priority Level: Priority 3 CFP#: 41*
MN Rule 4626.0285B Wiping cloths used for wiping counters and other equipment surfaces must be held in an approved sanitizing solution and laundered daily.
COMMENT: DAMP WIPING CLOTH NOT IN SANITIZER SOLUTION. PIC INSTRUCTED TO HOLD IN SANITIZER SOLUTION, AND HAVE ACCOMPANYING TEST STRIPS TO VERIFY SANITIZER CONCENTRATIONS WITHIN SOLUTIONS, OR HAVE MANUFACTURED PACKAGED TOWLETTES INTENDED FOR FOOD CONTACT SERVICES ONSITE.
Comply By: 2/9/2026 Originally Issued On: 2/9/2026

New Order: 3-300C Protection from Contamination: equipment/utensils, consumers
3-307.11 *Priority Level: Priority 3 CFP#: 39*
MN Rule 4626.0337 Protect food from miscellaneous sources of contamination.
COMMENT: PAINT CHIPPING OFF CABINETRY AND DRAWERS IN AREAS NEAR AND ABOVE FOOD PREPARATION AREAS. PIC INSTRUCTED TO REPAIR OR REPLACE TO ELIMINATE POSSIBLE CONTAMINATION.
Comply By: 2/20/2026 Originally Issued On: 2/9/2026

! **New Order: 4-100 Equipment Construction Materials**
4-101.11A *Priority Level: Priority 1 CFP#: 47*
MN Rule 4626.0450A Remove all unsafe multi-use equipment, utensils, and food storage containers that impart color, odors or tastes to food.
COMMENT: NON-STICK SURFACES ON COOKWARE DAMAGED AND FLECKING OFF. PIC INSTRUCTED TO REMOVE DAMAGED NON-STICK COOKWARE FROM SERVICE AND TO USE CLEANING MATERIALS AND COOKING UTENSILS, GOING FORWARD, THAT WILL NOT DAMAGE THE NON-STICK SURFACES.
Comply By: 2/9/2026 Originally Issued On: 2/9/2026

New Order: 4-100 Equipment Construction Materials
4-101.18 *Priority Level: Priority 3 CFP#: 47*
MN Rule 4626.0493 Discontinue using cleaning aids or utensils that can scratch or scour the nonstick coating of pots, pans, griddles, cookie sheets, waffle makers and other cookware.
COMMENT: METAL AND OTHER MATERIALS USED ON NON-STICK COOKING VESSELS. NON-STICK MATERIAL FLECKING AND FALLING OFF. PIC INSTRUCTED TO DISCONTINUE USING MATERIALS (MOSTLY METALS) ON NON-STICK COOKWARE TO PREVENT FAILING COOKING SURFACES.
Comply By: 2/9/2026 Originally Issued On: 2/9/2026

New Order: 4-100 Equipment Construction Materials
4-101.19 *Priority Level: Priority 3 CFP#: 47*
MN Rule 4626.0495 Remove non-food-contact surfaces of equipment that are exposed to splash, spillage, or other food soiling, or that require frequent cleaning, that are not constructed of a corrosion-resistant, non-absorbent, and smooth material.
COMMENT: EXPOSED WOOD IN INTERIORS OF DRAWERS/CABINETS/MILLWORK. PIC INSTRUCTED TO REPAIR OR REPLACE TO COVER/SEAL IN LAMINATE OR SIMILAR APPLICATION TO RENDER FINISHES SMOOTH, DURABLE, EASILY, CLEANABLE, AND NON-ABSORBENT.
Comply By: 2/20/2026 Originally Issued On: 2/9/2026

New Order: 4-300 Equipment Numbers and Capacities
4-302.12B *Priority Level: Priority 2 CFP#: 36*
MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.
COMMENT: NO SMALL DIAMETER PROBE THERMOMETER. VISUAL EXAMPLE OF SMALL DIAMETER PROBE THERMOMETER PROVIDED DURING INSPECTION. PIC INSTRUCTED TO OBTAIN AND MAINTAIN SMALL DIAMETER PROBE THERMOMETER ONSITE.
Comply By: 2/13/2026 Originally Issued On: 2/9/2026

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 THERMAL STICKERS OR MIN/MAX THERMOMETER TO VERIFY DISHWASHER'S HIGH SANITIZING TEMPERATURE. PIC INSTRUCTED TO OBTAIN AND MAINTAIN MEANS OF VERIFYING SANITIZING TEMPERATURES IN THE DISHWASHER. SINGLE THERMAL STICKER PROVIDED TO PIC TO VERIFY DISHWASHER SANITIZING TEMPERATURE.
Comply By: 2/9/2026 Originally Issued On: 2/9/2026

New Order: 4-600 Cleaning Equipment and Utensils
4-601.11C *Priority Level: Priority 3 CFP#: 49*
MN Rule 4626.0840C Clean non-food contact surfaces of equipment and maintain free of accumulations of dust, dirt, food residue, and other debris.
COMMENT: BUILDUP OF RESIDUES AND FOOD DEBRIS IN DRAWERS AND CABINETRY HOUSING DISHES, UTENSILS, DRY GOOD, ETC. PIC INSTRUCTED TO CLEAN AND MAINTAIN CLEAN.
Comply By: 2/9/2026 Originally Issued On: 2/9/2026

New Order: 6-500 Physical Facility Maintenance/Operation and Pest Control
6-501.19 *Priority Level: Priority 3 CFP#: 53*
MN Rule 4626.1555 Keep the toilet room doors closed except during cleaning and maintenance operations.
COMMENT: TOILET ROOM DOOR PROPPED OPEN. PIC CLOSED DURING INSPECTION. PIC INSTRUCTED TO KEEP TOILET ROOM DOORS CLOSED WHEN NOT BEING SERVICED OR MAINTAINED.
Comply By: 2/9/2026 Originally Issued On: 2/9/2026

Food & Beverage General Comment

FOOD AND BEVERAGE INSPECTION CONDUCTED BY TREVOR MCCLIMENT AS PART OF HRD SURVEY OF ALF. ESTABLISHMENT IS RESIDENTIAL IN NATURE: VCT FLOOR, POPCORN CEILING, WOOD CABINETRY/MILLWORK, TILE BACKSPLASH. ESTABLISHMENT SERVES 5 CLIENTS, NONE OF WHOM ARE PART OF A HIGHLY SUSCEPTIBLE POPULATION.

IDENTIFIED ISSUES REVIEWED WITH PIC AND NURSING SURVEYOR.

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 F1029261043 from 2/9/2026

DEBORAH QUINN
PERSON IN CHARGE - DIRECT SUPPORT PROFESSIONAL

Trevor McCliment

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

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

Temperature Observations/Recordings

Establishment Info

WE CARE HOME HEALTH SERVICES LLC
Brooklyn Park
County/Group: Hennepin County

Inspection Info

Report Number: F1029261043
Inspection Type: Full
Date: 2/9/2026
Time: 12:35:31 PM

New Record: Product/Item/Unit: MILK**; Temperature Process:** Cold-Holding
Location: FRIDGE INTERIOR at 36 Degrees F.
Comment:
Violation Issued?: No

New Record: Product/Item/Unit: APPLE SAUCE**; Temperature Process:** Cold-Holding
Location: FRIDGE DOOR at 41 Degrees F.
Comment:
Violation Issued?: No

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

Sanitizer Observations/Recordings

Establishment Info

WE CARE HOME HEALTH SERVICES LLC
Brooklyn Park
County/Group: Hennepin County

Inspection Info

Report Number: F1029261043
Inspection Type: Full
Date: 2/9/2026
Time: 12:35:31 PM

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

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ASSISTED LIVING | ASSISTED LIVING WITH DEMENTIA CARE

Project No: SL36554016-0	**Date:** 2/12/2026
Facility Name: WE CARE HOME HEALTH SERVICES LLC	
Facility Address: 2000 EDINBROOK COURT BROOKLYN PARK, MN 55443	

☒ **TAG IDENTIFICATION: 0780**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Seven (7) days

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

   Comments: Two separate smoke alarm systems were installed, but each separate system was not interconnected.

2. Smoke Alarm power supply complies with MN State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated. [Minn. Stat. 144G.45 subd.2]

   Comments: The smoke alarm in the 4th level notified a low battery alarm during the tour.

☒ **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: The FSEP was not present at the facility when the surveyor requested the document. Licensed living assistant director/certified nurse supervisor (LALD/CNS)-D emailed the FSEP to the surveyor on 2-12-26.

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

   Comments: LALD/CNS-D stated employees were trained during fire drills and no fire safety and evacuation plan training records were available.

3. Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. [Minn. Stat. 144G.45 subd.2]

   Comments: LALD/CNS-D stated residents were trained during fire drills and no fire safety and evacuation plan training records were available.