



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

October 1, 2026

Licensee

The Guardian Home Care LLC

7814 Unity Avenue North

Brooklyn Park, MN 55443

RE: Project Number(s) SL36296016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 20, 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 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - \$1,000.00

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 \$1,500.00**. 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

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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,



Jess Schoenecker, Supervisor

State Evaluation Team

Email: Jess.Schoenecker@state.mn.us

Telephone: 651-201-3789 Fax: 1-866-890-9290

CLN

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36296	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/20/2026
NAME OF PROVIDER OR SUPPLIER THE GUARDIAN HOME CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 7814 UNITY AVENUE NORTH BROOKLYN PARK, MN 55443		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL#36296016-0 On August 17, 2026, through August 20, 2026, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were four (4) residents; 4 receiving services under the Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
0 470 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

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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 observation and interview, the licensee failed to develop and implement a written staffing plan that included an evaluation completed by the clinical nurse supervisor (CNS) at least twice a year. 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	0 470			

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0 470	Continued From page 2 resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living facility license for a capacity of four (4) residents and had a current census of 4 residents. On August 17, 2026, at approximately 10:20 a.m., during the entrance conference, licensed assisted living director/CNS (LALD/CNS)-A stated two (2) unlicensed personnel (ULP) worked 8:00 a.m. to 3:00 p.m. on the day shift and 3:00 p.m. to 10:00 p.m. on the evening shift. LALD/CNS-A also stated one (1) ULP worked 10:00 p.m. to 8:00 a.m. on the night shift. On August 17, 2026, at 10:25 a.m., LALD/CNS-A stated the licensee lacked a written staffing plan that included an evaluation completed by LALD/CNS-A at least twice a year and they were unaware of the staffing plan requirement. The licensee's Staffing policy, dated August 1, 2021, indicated the CNS would develop and implement a written staffing plan that included an evaluation completed by the CNS as required. Minnesota Administrative Rule 4659.0180, Subpart 4 dated August 11, 2021, indicated the clinical nurse supervisor must develop a 24-hour daily staffing schedule. The schedule must: (1) include direct-care staff work schedules for each direct-care staff member showing all work shifts, including days and hours worked; and	0 470			

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0 470	Continued From page 3 (2) identify the direct-care staff member's resident assignments or work location. The daily work schedule must be posted, after redacting direct-care staff members' resident assignments, at the beginning of each work shift in a central location in each building of a facility or campus, accessible to staff, residents, volunteers, and the public. The facility shall not disclose any information that is protected by law from public disclosure. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470			
0 650 SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place	0 650			

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0 650	Continued From page 4 and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records included all required content for two of two employees (licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A, house manager (HM)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On August 17, 2026, at approximately 10:10 a.m., during the entrance conference, LALD/CNS-A stated they were responsible for all the licensee's onboarding and orientation requirements for the licensee. LALD/CNS-A LALD/CNS-A was hired on November 12, 2019. LALD/CNS-A's employee record included a TB Screening Tool document, dated December 20, 2020, that indicated a TB history and symptom screen was completed but a TB test was not completed. LALD/CNS-A's employee record also included a Chest X-ray (CXR) Reading	0 650			

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0 650	Continued From page 5 document, dated December 7, 2020, indicated a CXR was completed for diagnosing TB. LALD/CNS-A's employee record lacked documentation for a completed Tuberculosis (TB) baseline screening. LALD/CNS-A's employee record also included performance evaluations for the years 2022, 2023, and 2024, but lacked documentation for a completed performance evaluation for the year 2025. On August 17, 2026, at approximately 3:00 p.m., LALD/CNS-A stated they completed the TB baseline screening and they were working on obtaining the document. LALD/CNS-A also stated her performance evaluation for 2025 was not completed because the licensee had not found the time yet to complete the evaluation. HM-B HM-B was hired on November 12, 2019. HM-B's employee record included a TB Screening Tool document, dated May 1, 2020, that indicated a TB history and symptom screen was completed but a TB test was not completed. HM-B's employee record also included a CXR Reading document, dated September 29, 2020, indicated a CXR was completed for diagnosing TB. HM-B's employee record lacked documentation for a completed Tuberculosis (TB) baseline screening at time of hire. On August 17, 2026, at approximately 3:05 p.m., HM-B stated they completed the TB baseline screening and they were working on obtaining the	0 650			

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0 650	Continued From page 6 documents. The licensee's Personnel Records policy, dated August 1, 2021, indicated the licensee would include the required TB screening documents in the employee's records. The licensee's Performance Evaluation policy, dated August 1, 2021, indicated the licensee would complete a performance evaluation on all employees annually. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually	0 680			

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0 680	Continued From page 7 available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all residents receiving services under the provisional 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 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: The licensee's undated EPP lacked the following required content: -maintain and annual EPP updates; -process for emergency preparedness collaboration; -policies and procedures for development of EPP; -policies and procedures for subsistence needs for staff and residents; -policies and procedures for tracking staff and residents; -policies and procedures including evacuation; -policies and procedures for sheltering in place;	0 680			

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0 680	Continued From page 8 -policies and procedures for medical documents; -policies and procedures for volunteers; -policies and procedures for arrangements with other facilities; -policies and procedures for roles under a waiver declared by secretary; -primary and alternate means for communication; -methods for sharing information; -procedure for sharing information on occupancy and or needs; -long term care family notifications; and -emergency prep testing requirements. On August 17, 2026, at approximately 12:45 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee was still working on updating their EPP to be compliant with state requirements. LALD/CNS-A and house manager (HM)-B verified the licensee's EPP lacked the above listed required content and confirmed the licensee's EPP was last updated on November 20, 2023. The licensee's Emergency Preparedness policy, dated August 23, 2020, indicated the licensee would have an identified EPP in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services. Minnesota Administrative Rule 4659.0100 dated August 11, 2021, indicated assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.72, or successor requirements. This part referenced documents, specifications, methods, and standards in State Operations Manual Appendix Z - Emergency Preparedness for All Provider and Certified Supplier Types:	0 680			

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0 680	Continued From page 9 Interpretive Guidance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 775 SS=I	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, 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 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). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated August 18, 2026, for the specific violations related the physical environment under Minnesota Statute 144G.	0 775			

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0 775	Continued From page 10 TIME PERIOD FOR CORRECTION: TWO (2) days.	0 775			
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, 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	0 800			

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0 800	Continued From page 11 August 18, 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 (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	0 810			

Minnesota Department of Health
STATE FORM 6899 ENZE11 If continuation sheet 13 of 22

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36296	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/20/2026
NAME OF PROVIDER OR SUPPLIER THE GUARDIAN HOME CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 7814 UNITY AVENUE NORTH BROOKLYN PARK, MN 55443		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01530	Continued From page 13 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 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;	01530			

Minnesota Department of Health

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01530	Continued From page 14 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received two hours of mental illness and de-escalation training within the first 120 working hours of employment for supervisors of direct care staff as required for one of one supervisor (licensed assisted living director/clinical registered nurse (LALD/CNS)-A) and within the first 160 working hours of employment for direct care employees as required for one of one employee (house manager (HM)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On August 17, 2026, at approximately 10:10 a.m., during the entrance conference, LALD/CNS-A stated they were responsible for all the licensee's employee orientation requirements for the licensee. LALD/CNS-A LALD/CNS-A was hired on November 12, 2019, to supervise direct care staff working two (2) to three (3) days a week for the licensee. LALD/CNS-A's employee record did not include any mental illness and de-escalation training.	01530			

Minnesota Department of Health

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01530	Continued From page 15 HM-B HM-B was hired on November 12, 2019, to provide direct care working full time (40 hours a week) for the licensee. HM-B's employee record did not include any mental illness and de-escalation training. On August 17, 2026, at approximately 2:30 p.m., LALD/CNS-A stated the required mental illness and de-escalation training were not completed by any employee for the licensee and they were unaware of the required mental illness and de-escalation training. The licensee's Dementia Education policy, dated August 1, 2021, indicated the licensee would provide the required training to employees. The licensee's Staff Orientation and Education policy, dated August 1, 2021, indicated the licensee would provide the required training by a thorough orientation to employees. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530			
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan	01620			

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01620	Continued From page 16 prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a	01620			

Minnesota Department of Health

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01620	Continued From page 17 facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN) completed comprehensive assessments to include all required content identified by Minnesota Administrative Rule 4659.0150 Uniform Assessment Tool for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted and started to receive services on September 20, 2025. R1's 90-day [licensee] Nursing Assessments, dated June 15, 2026, and April 15, 2026, were two-page documents identified by licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A as R1's last two (2) consecutive RN assessments completed by the licensee. The two-page assessments did not reference any completed comprehensive assessment that included all the elements of the uniform assessment tool and lacked a full physical and cognitive assessment as required on the uniform	01620			

Minnesota Department of Health

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01620	Continued From page 18 assessment tool per Minnesota Administrative Rule 4659.0140 Subp. 2. B. (3). R2 R2 was admitted and started to receive services on December 8, 2023. R2's 90-day [licensee] Nursing Assessments, dated June 15, 2026, and April 15, 2026, were two-page documents identified by LALD/CNS-A as R2's last 2 consecutive RN assessments completed by the licensee. The two-page assessments did not reference any completed comprehensive assessment that included all the elements of the uniform assessment tool and lacked a full physical and cognitive assessment as required on the uniform assessment tool per Minnesota Administrative Rule 4659.0140 Subp. 2. B. (3). On August 17, 2026, at approximately 3:40 p.m., LALD/CNS-A stated the licensee performed a comprehensive assessment on residents upon admission and on change of condition that included all the elements of the uniform assessment tool, then used the two-page RN assessment for all other assessments during the year and was not aware of the Uniform Assessment Tool requirement for reassessments. The licensee's Comprehensive Resident Assessment policy, dated August 1, 2021, indicated the licensee would complete a RN comprehensive assessment for the initial assessment and all reassessments for the residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	01620			

Minnesota Department of Health

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01620	Continued From page 19 (21) days	01620			
02310 SS=F	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medical oxygen tanks were secured and stored properly in noncombustible racks to prevent injury to all residents who resided in the assisted living facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On August 17, 2026, at approximately 11:15 a.m., during a tour of the facility with house manager (HM)-B, surveyor observed in the upper-level living room, in between a couch and a wood end table, to the right of the television, there were three (3) unsecured oxygen tanks stored upright next to a wall. Of the 3 oxygen tanks, two (2)	02310			

Minnesota Department of Health

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02310	Continued From page 20 oxygen tanks were full, and one (1) oxygen tank was partially full. On August 17, 2026, at approximately 11:20 a.m., HM-B confirmed that the 3 oxygen tanks were not stored securely and acknowledged the unsecured oxygen tanks were a safety issue. HM-B stated R1 had an oxygen concentrator in his lower-level bedroom and the oxygen tanks stored in the living room were for convenience when R1 was on the upper level of the facility. R1 was admitted on September 20, 2025, with diagnoses that included end stage renal disease and chronic respiratory failure. R1's Nurse Reassessment, dated June 15, 2026, indicated R1 required the use of an oxygen tank with mobility and had improved respiratory function when R1 used oxygen. R1's physician signed oxygen order, dated April 21, 2026, indicated four (4) liters (L) via nose cannula (NC), six (6)L NC with activity, length of need: lifetime. On August 17, 2026, at approximately 12:30 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A acknowledged R1's oxygen tanks were stored unsecured and was unaware the oxygen tanks were required to be stored in a rack or similar holding device. The licensee's Equipment Safety policy, dated August 1, 2021, indicated the licensee would follow equipment safety guidelines for equipment used by residents. The Department of Health (MDH) Oxygen Cylinder Storage Requirements dated June 2020,	02310			

Minnesota Department of Health

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02310	Continued From page 21 recommends oxygen tanks must be secured in racks or by chains. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310			



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

THE GUARDIAN HOME CARE LLC
7814 Unity Ave N
Brooklyn Park, MN 55443
Hennepin County
Parcel:

Phone:

License Info

License: HFID 36296

Risk:
License:
Expires on:
CFPM: Adeshola Wilson
CFPM #: 119522; Exp: 10/13/2026

Inspection Info

Report Number: F1025261169
Inspection Type: Full - Single
Date: 8/17/2026 Time: 12:30 PM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery:

No orders were issued for this inspection report.

Food & Beverage General Comment

Facility has residential finishes, two compartment sink.

New stainless steel cooking utensils provided, to replace utensils which had damaged non-stick coating. TMD and min/max thermometer for dishwasher available. Discussed date marking of cold, ready to eat TCS foods, cook/service of TCS foods, pest control, recalls, cooking temperatures.

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 F1025261169 from 8/17/2026

Adeshola


Casey Kipping, MA RS
Public Health Sanitarian 3
651-201-4513
casey.kipping@state.mn.us



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

Temperature Observations/Recordings

Page: 1

Establishment Info

THE GUARDIAN HOME CARE LLC
Brooklyn Park
County/Group: Hennepin County

Inspection Info

Report Number: F1025261169
Inspection Type: Full
Date: 8/17/2026
Time: 12:30 PM

Equipment Temperature: Product/Item/Unit: Ambient; **Temperature Process:** Cold holding

Location: Refrigerator at 40 Degrees F.

Comment:

Violation Issued?: No

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL36296016	Date: 8/18/2026
Facility Name: The Guadian Home Care LLC	
Facility Address: 7814 Unity Ave. N Brooklyn Park, MN 55443	

☒ **TAG IDENTIFICATION: 0775**

SCOPE/ SEVERITY: Level 3; Widespread

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. Lighted matches, cigarettes, cigars or other burning object shall not be discarded in such a manner that could cause ignition of other combustible material. [Minn. Stat. 144G.45 subd. 2; MSFC 310.7]

Comments: The residents had a designated smoking area in a screened porch on the deck off the dining room. The cigarette disposal receptacle was a damaged metal planter with a large open top and dirt in the bottom. Cigarette butts were found on the deck and all over the ground below the deck by the house. There was evidence of burn marks on the wooden deck boards and on the deck railing.

☒ **TAG IDENTIFICATION: 0800**

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Seven (7) days

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

Comments: The sliding closet door in the main entryway was falling off the track on one side. The vinyl floor in the dining room had a hole in it. The exterior wood siding and concrete block at the foundation had significant damage and a hole was observed that opened to the foundation inside of the concrete block. The carpet going to the upstairs and downstairs was heavily stained and soiled.

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Seven (7) days

1. Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. [Minn. Stat. 144G.45 subd.2]

Comments: Fire safety and Evacuation drills were conducted once per year. Licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated that the fire drills were being done once per year, and they were not aware of the requirements.

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-A failed to provide documentation showing that the required training was offered for employees on the fire safety and evacuation plan (FSEP). The documentation that was provided indicated fire safety evacuation plan training was done by employees one time per year instead of twice per year and upon hire.