Electronically Delivered

November 10, 2025

Licensee
Promise Care LLC
6559 Upper 20th Street North
Oakdale, MN 55128

RE: Project Number(s) SL41073015

Dear Licensee:

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

The Minnesota Department of Health completed an initial survey on October 28, 2025, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

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

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

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

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

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

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

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

If you have any questions, please contact me.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41073	A. BUILDING: _____ B. WING _____	10/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMISE CARE LLC	6559 UPPER 20TH STREET NORTH OAKDALE, MN 55128

(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: SL41073015-0 On October 27, 2025, through October 28, 2025, 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 was one resident; one receiving services under the Provisional Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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

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0 480	Continued From page 2 existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 October 28, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24	0 480		

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0 480	Continued From page 3 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have all the written requirements in the emergency preparedness	0 680		

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0 680	Continued From page 4 plan (EPP) as defined in Appendix Z (a section of the Centers for Medicare and Medicaid Services (CMS) state operations manual which includes the emergency preparedness guidelines). In addition, the licensee failed to ensure the missing resident policy was reviewed quarterly as required under section 4659.0110. This had the potential to affect all residents, staff and visitors of the 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 potential to affect a large portion or all of the residents). The findings include: On October 27, 2025, at 11:40 a.m., house manager/unlicensed personnel (HM/ULP)-C provided the licensee's EPP binder. The EPP binder contained emergency preparedness planning templates which some had not yet been filled out or updated with facility specific information. The licensee's emergency disaster preparedness plan dated August 1, 2025, lacked evidence of annual review and the following required content: -quarterly review of missing resident policy; -communication plan containing all required elements; -process for emergency plan collaboration; -subsistence needs for staff and residents; -policies and procedures for medical documents;	0 680		

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0 680	Continued From page 5 -emergency officials contact information; -methods for sharing information; -sharing information on occupancy and needs; -long term care family notifications; and -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. On October 28, 2025, at 9:56 a.m., licensed assisted living director (LALD)-A stated, via phone, she recently purchased the emergency preparedness program manual from a consulting agency but has not yet completed or documented the facility specific emergency planning for the facility. LALD-A stated she was familiar with Appendix Z, but the licensee had not fully developed and implemented the facility's emergency preparedness plan/program to include the above requirements. Additionally, LALD-A verbalized she was not aware of the requirement to participate in an annual full-scale exercise that is community based or conduct an annual, individual, facility-based functional exercise. The licensee's Emergency Preparedness policy dated March 24, 2025, indicated, "[Licensee] will have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services. The plan considers the organization's commitment to provide services while ensuring the safety of its employees and residents. [Licensee] will implement the Emergency Management program as soon as the agency becomes aware of the existence of	0 680		

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0 680	Continued From page 6 an emergency." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 775 SS=E	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to comply with the requirements of Minnesota State Fire Code Rules, Chapter 7511. This had the potential to affect all of the building occupants. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On October 27, 2025, at 11:00 a.m., the surveyor toured the facility with house manager/unlicensed personnel (HM/ULP)-C. During the tour, the surveyor observed the following:	0 775		

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0 775	Continued From page 7 OBSTRUCTED EGRESS The egress window was obstructed by the storage of personal items and furniture stored in front of the window in occupied resident sleeping room 1. All paths of egress must provide unobstructed exiting. SMOKING MATERIAL DISPOSAL Burnt cigarettes and ashes were disposed of on the concrete approach in front of the building and on the back deck on top of a non-functional portable propane patio fire pit. A disposal container for smoking materials was provided at the front of the building. During the facility tour interview, HM/ULP-C stated the fire pit was not used, the propane tank eliminated, and the fire pit had not been removed as the resident had suggested it be used as a bird feeder. Improper disposal of smoking materials creates a fire hazard. ELECTRICAL A cover plate was not installed on the electrical wall switch in the closet under the stairs in the basement. Covers shall be installed to prevent accidental contact with live electrical components. During the facility tour interview, HM/ULP-C verified the above listed observations. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775		
0 790 SS=C	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers	0 790		

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0 790	Continued From page 8 in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the portable fire extinguishers as required by statute. This had the potential to affect all of the building occupants. This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On October 27, 2025, at 11:00 a.m., the surveyor toured the facility with house manager/unlicensed personnel (HM/ULP)-C. During the tour, the surveyor observed tags or labels were not attached to the portable fire extinguishers indicating monthly inspections had been completed. During the facility tour interview, HM/ULP-C verified the fire extinguisher observations. Fire	0 790		

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0 790	Continued From page 9 extinguisher inspections must be conducted every month to ensure each extinguisher is in its designated place, it has not been tampered with, and there is no obvious physical damage or condition that would interfere with its use or operation. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
0 800 SS=D	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to affect all of the building occupants. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a	0 800		

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0 800	Continued From page 10 limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: On October 27, 2025, at 11:00 a.m., the surveyor toured the facility with house manager/unlicensed personnel (HM/ULP)-C. During the tour, the surveyor observed the following: - The covers were missing from three exterior light fixtures. - The railings on the back deck were noted as loose. During the facility tour interview, HM/ULP-C verified the above listed observations. 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	0 810		

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0 810	Continued From page 11 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 develop the fire safety and evacuation plan with required content and complete required drills. This had the potential to directly affect all building occupants. 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).	0 810		

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0 810	Continued From page 12 The findings include: On October 27, 2025, housing manager/unlicensed personnel (HM/ULP)-C provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee failed to accurately identify the location and number of resident sleeping rooms evident by the following: On October 27, 2025, at 11:00 a.m., the surveyor toured the facility with house manager/unlicensed personnel (HM/ULP)-C. During the tour, the surveyor observed the following: - Number identifiers were not posted at the unoccupied resident sleeping room doors verbally identified as rooms 2, 3, 4, and 5 by HM/ULP-C. During the facility tour interview, HM/ULP-C stated the licensee planned to post number identifiers at the doors when residents moved into these rooms. - The resident sleeping room number label on the FSEP floor plan did not match the number posted at the door for occupied resident sleeping room 1. Room identifiers are to be installed on or at all resident sleeping room doors. Resident sleeping rooms are to be accurately identified on the FSEP floor plan and correspond with the numbers installed at the sleeping room doors to provide efficient communication for exiting in the event of a fire or similar emergency.	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41073	A. BUILDING: _____ B. WING _____	10/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMISE CARE LLC	6559 UPPER 20TH STREET NORTH OAKDALE, MN 55128

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0 810	Continued From page 13 Record review of the available documentation indicated the licensee failed to develop and maintain the FSEP with site specific procedures for the facility and building occupants evident by the following: - The primary exit for the building (front door) was not clearly labeled on the FSEP floor plan. This door was identified with a black and white circle symbol. Exit labels shall be included on the floor plan in order to direct occupants to the designated exits in the event of an emergency. - The FSEP had been created using templates from a third party provider. The FSEP procedures inaccurately referenced pull fire alarms. - The FSEP included standard employee procedures, but failed to provide site specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The employee actions were limited to the RACE (Remove, Alarm, Confine, Extinguish/Evacuate) acronym. - The FSEP failed to include specific fire safety and evacuation instructions for residents evident by a lack of these procedures in the plan. Instructions were limited to directing residents to stoop or crawl to avoid smoke. - The FSEP included standard resident evacuation procedures, but failed to provide site specific actions for resident movement and evacuation or relocation during a fire or similar emergency evident by a lack of these procedures in the plan. During an interview on October 27, 2025, at 12:05 p.m., HM/ULP-C verified the FSEP was lacking the above content. DRILLS Record review of the available documentation	0 810		

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0 810	Continued From page 14 indicated the licensee failed to conduct evacuation drills at a frequency of every other month evident by a review of fire drill reports lacking the required frequency. - The surveyor requested records for evacuation drills completed between March and October 2025. One fire drill was recorded in August 2025. - The names of the employees who participated in the fire drill conducted on August 1, 2025, were not recorded on the drill log. - Fire drill reports were not completed documenting the simulated conditions. During an interview on October 27, 2025, at 12:05 p.m., HM/ULP-C verified the frequency and documentation were lacking. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure assisted living contracts did not include language waiving the licensee's liability for health, safety, or personal property of a resident for one of one resident (R1).	0 970		

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0 970	Continued From page 15 This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 was admitted on March 26, 2025, with diagnoses post-traumatic stress disorder (PTSD), anxiety, and unspecified personality and behavior disorder. R1's Service Plan dated, August 28, 2025, indicated R1 received services including assistance with housekeeping, laundry, meals, bathing reminders, socialization, and behavior management. R1's Assisted Living Contract dated March 26, 2025, included the following language indicating a waiver of liability: "Miscellaneous Provisions 1. Responsibilities. The resident is responsible to protect their own interests outside what is covered in this Agreement. The resident acknowledges that [Licensee] is not an insurer of the resident's person or property. The resident agrees that resident shall be responsible for any personal injury or property damage (including, without limitation, damage to, or loss or theft of, automobiles or personal property of resident) suffered by the resident or the resident's agents, guests or invitees, unless and to the extent that the injury or damage is caused by the negligence of [Licensee] or its employees or agents."	0 970		

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0 970	Continued From page 16 R1's record included a Residential Rental Agreement dated March 26, 2025, included the following language indicating waivers of liability: "I. Insurance: [R1] acknowledges that [Licensee] property insurance does not cover [R1's] personal property. [Licensee] accepts no liability for damage or loss to [R1's] personal property for any reason. [R1] acknowledges their responsibility to obtain appropriate Renters' Insurance to protect the value of their personal belongings." In addition, included, "S. Additional Provisions: 6. [R1] will indemnify and hold [Licensee] harmless from all liabilities, fines, lawsuits, claims, or other actions arising from [R1's] activities while an occupant of the Property. 7. [R1] agrees that [Licensee] will not be held liable for any injury, theft, or death that occurs during [R1's] occupancy of the Property." On October 27, 2025, at 11:40 a.m., clinical nurse supervisor (CNS)-B stated he was not aware the licensee had a waiver of liability in the licensee's contract but verbalized he was aware of the waiver of liability language requirement. CNS-B verbalized he planned to update the licensed assisted living director (LALD)-A to have the licensee's contract updated. On October 28, 2025, at 9:56 a.m., LALD-A stated, via phone, she planned to remove any waiver of liability language in both the licensee's assisted living contract and rental agreements being used for all residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 970		

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0 970	Continued From page 17 (21) days	0 970		
01380 SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure competency evaluations required for unlicensed personnel (ULP) providing assisted living services were completed for one of two employees (house manager/unlicensed personnel (HM/ULP-C). 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	01380		

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01380	Continued From page 18 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: HM/ULP-C was hired on June 3, 2025, and provided direct cares and services to residents. HM/ULP-C's employee file lacked documentation of a competency evaluations for the following topics: -reading and recording temperature, pulse, and respirations of the resident; -safe transfer techniques and ambulation; and -range of motioning and positioning. On October 27, 2025, at 12:55 p.m., the surveyor observed HM/ULP-C interacting with R1 about what he would like to do today and provided direction for R1 to complete personal cares. On October 28, 2025, at 12:51 p.m., licensed assisted living director (LALD)-A indicated, via email, "I will make sure to correct that for future. For now we don't have it. What's provided is what we have for those 3 items." The licensee's Staff Competency policy dated, March 24, 2025, indicated, "4. Home Health Aides (HHA) providing assisted living services and who have not completed a state-approved formal training and competency evaluation program will demonstrate competency through the following process: a. Satisfactory completion of an oral or written test on the tasks the HHA will perform. Refer to the Competency Manual for criteria. b. Home Health Aides may not work for [Licensee] until they have successfully passed	01380		

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01380	Continued From page 19 the written and demonstration competency evaluation, including satisfactory completion of the following: i. Observation, reporting and documenting of resident status ii. Basic knowledge of body functioning and changes in body function, injuries or other reportable changes iii. Recognizing physical, emotional, cognitive and development needs of the resident iv. Basic infection control, including blood-borne pathogens v. Maintenance of a clean and safe environment vi. Falls prevention vii. Safe transfer techniques and ambulation viii. Range of motion and positioning ix. Administering medications or treatments as required x. Basic nutrition, meal preparation, food safety and assistance with eating xi. Preparation of modified diets xii. Communication skills and barriers xiii. Cultural diversity xiv. Confidentiality/privacy xv. Professional boundaries xvi. Handling of emergencies xvii. Commonly used health technology equipment and assistive devices c. The following topics must be completed by a practical skills test i. Appropriate and safe techniques in personal hygiene and grooming, including bathing, hair care, oral hygiene (teeth, gums and oral prosthetics), care and use of hearing aids, dressing and toileting ii. Safe transfer techniques and ambulation iii. Range of motion and positioning iv. Reading and recording temperature, pulse	01380		

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01380	Continued From page 20 and respirations v. Administration of medications and treatments, as required vi. Other delegated tasks." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the required posting at the main entry way of the facility, included statutory language to disclose electronic monitoring activity, potentially affecting all current residents in the assisted living facility, staff, and any visitors to the facility. This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	03090		

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03090	Continued From page 21 The findings include: On October 27, 2025, at 10:50 a.m., the surveyor observed the licensee's postings within the presence of clinical nurse supervisor (CNS)-B and house manager/unlicensed personnel (HM/ULP)-C. The licensee lacked an electronic monitoring notice posted with the required statutory language. On October 27, 2025, at 10:58 a.m., HM/ULP-C stated he was not aware of the electronic monitoring verbiage required to be posted. -at 11:09 a.m., the surveyor provided, via email, the statutory language for the electronic monitoring posting notification to the licensee. The licensee's Electronic Monitoring policy dated March 24, 2025, indicated., "8. [Licensee] will post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090		

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

Food & Beverage Inspection Report

Establishment Info

PROMISE CARE LLC
6559 UPPER 20TH STREET NORTH
Oakdale, MN 55128
Washington County
Parcel:

Phone:

License Info

License: HFID 41073

Risk:
License:
Expires on:
CFPM: MOHAMUD ISSE
CFPM #: SERVSAFE; Exp:

Inspection Info

Report Number: F1023251199
Inspection Type: Full - Single
Date: 10/28/2025 Time: 09:03:46 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 1
Delivery:

New Order: 2-100 Supervision
2-102.12AMN *Priority Level: Priority 3 CFP#: 2*
MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.
COMMENT: TO GET A CFPM YOU MUST TAKE EIGHT HOUR MANAGER CLASS, PASS TEST, AND CERTIFY WITH MDH WITHIN 6 MONTHS OF PASSING. YOU CAN SIGN UP FOR FOOD MANAGER COURSES AND CERTIFY WITH MDH HERE:
https://www.health.state.mn.us/communities/environment/food/cfpm/howto.html

Comply By: 10/28/2025 *Originally Issued On: 10/28/2025*

Food & Beverage General Comment

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

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

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

THESE TOPICS WERE DISCUSSED WITH THE PERSON IN CHARGE:
- EMPLOYEE ILLNESS EXCLUSION
- HAND WASHING PROCEDURE
- NO BARE HAND CONTACT WITH RTE FOOD
- VOMIT CLEAN UP PROCEDURE
- FULLY COOKING FOOD FOR HIGH RISK POPULATIONS
- ANSI 184 DISH WASHER

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Metro District Office inspection report number F1023251199 from 10/28/2025

Gregory T Nelson

MOHAMUD ISSE
PERSON IN CHARGE

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

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

Temperature Observations/Recordings

Establishment Info

PROMISE CARE LLC
Oakdale
County/Group: Washington County

Inspection Info

Report Number: F1023251199
Inspection Type: Full
Date: 10/28/2025
Time: 09:03:46 AM

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

PROMISE CARE LLC
Oakdale
County/Group: Washington County

Inspection Info

Report Number: F1023251199
Inspection Type: Full
Date: 10/28/2025
Time: 09:03:46 AM

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Kitchen **Greater Than** 150 Degrees F.
Comment: sanitize cycle
Violation Issued?: No

Sanitizing Chemical: **Product:** Chlorine**; Sanitizing Process:** Spray Bottle
Location: Kitchen **Equal To** 50 PPM
Comment:
Violation Issued?: No