Electronically Delivered

May 13, 2026

Licensee
Caring Hearts Home Care, Inc.
2916 Bloomington Avenue
Minneapolis, MN 55407

RE: Project Number(s) SL36157016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on March 4, 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 - 0495 - 144g.41 Subdivision. 1 (13) - Minimum Requirements - $1,000.00
St - 0 - 0780 - 144g.45 Subd. 2 (a) (1) - 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

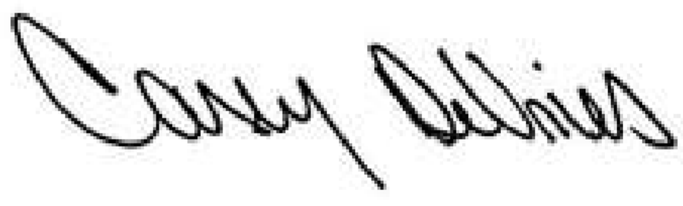
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

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

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

If you have any questions, please contact me.

Sincerely,



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

KKM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36157	A. BUILDING: _____ B. WING _____	03/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING HEARTS HOME CARE INC	2916 BLOOMINGTON AVENUE MINNEAPOLIS, MN 55407

(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: SL36157016-0 On March 2, 2026, through March 4, 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 four residents; four receiving services under the Assisted Living Facility license. An immediate correction order was identified on March 2, 2026, issued for SL36157016-0, tag identification 0495. During the survey, the licensee took action to mitigate the immediate risk. However, noncompliance remained, and the scope and level remain unchanged.	0 000	Minnesota Department of Health is documenting the State Licensing 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 pursuant to 144G.31 Subd. 1, 2 and 3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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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, existing floor, wall, and ceiling finishes are	0 480		

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic 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 March 4, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee on March 4, 2026.	0 480		

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0 480	Continued From page 3 TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 495 SS=I	144G.41 Subdivision. 1 (13) Minimum Requirements (13) provide staff access to an on-call registered nurse 24 hours per day, seven days per week. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide staff access to a registered nurse (RN) twenty-four (24) hours per day, seven (7) days per week. This had the potential to affect all residents and staff. 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: On March 2, 2026, during the survey, the licensee had a census of four residents. The licensee's Employee List dated March 2, 2026, indicated clinical nurse supervisor (CNS)-A was hired on January 7, 2026. R2 R2 was admitted to the licensee on July 9, 2025. R2's diagnoses included type one diabetes with	0 495		

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0 495	Continued From page 4 diabetic nephropathy, acute kidney failure, hyperglycemia, depression, opioid abuse in remission. R2's Service Plan dated November 4, 2025, indicated R2 received services for ambulation, dressing, incontinence care, medication administration, safety checks, and blood glucose supervision. It further indicated R2 received behavioral management for agitation, anxiety, physical aggression, property destruction, self-isolation, self-injurious behavior, verbal aggression, and other mental health needs. R2's face sheet indicated R2 took gabapentin, Lantus insulin, and Novolog insulin. R2's Individual Abuse Prevention Plan (IAPP) within R2's 90-day assessment dated December 4, 2025, indicated R2 was at risk for self-harm due to history of drug and substance abuse and the above-mentioned behaviors. On March 2, 2026, at 10:50 a.m., during the facility tour, the surveyor observed R2 in their room sleeping in their bed. R3 R3 was admitted to the licensee on July 10, 2025. R3's diagnoses included depression and post-traumatic stress disorder (PTSD). R3's Addendum to Contract service plan, dated September 22, 2025, indicated R3 received services for safety checks and medication administration. It further indicated R3, received behavioral management for agitation, anxiety, repetitive behaviors, and self-isolation.	0 495		

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0 495	Continued From page 5 R3's face sheet indicated R3 took bupropion, olanzapine, and quetiapine. R3's IAPP dated February 18, 2026, indicated R3 was at risk due to the above-mentioned behaviors. R4 R4 was admitted to the licensee on August 8, 2025. R4's diagnoses included type two diabetes, alcohol abuse, alcoholic cirrhosis of liver, anxiety, catatonic disorder, and traumatic brain injury. R4's Addendum to Contract service plan dated August 13, 2025, indicated R4 received services for bathing assistance, medication administration, and safety checks. It further indicated R4 received behavioral management for agitation, anxiety, physical aggression, repetitive, self-isolation, catatonia, and depression. R4's face sheet indicated R4 took gabapentin and quetiapine. R4's IAPP dated February 24, 2026, indicated R4 was at risk for elopement and the above-mentioned behaviors. On March 2, 2026, at 12:30 p.m., the surveyor observed unlicensed personnel (ULP)-B administer gabapentin 300 milligrams (mg) to R4. R5 R5 was admitted to the licensee on October 6, 2025. R5's diagnoses included anoxic brain damage.	0 495		

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0 495	Continued From page 6 R5's Addendum to Contract service plan dated October 6, 2025, indicated R5 received services for medication administration. It further indicated R5 received behavioral management for anxiety, self-isolation, and sexual inappropriateness. R5's IAPP dated January 21, 2026, indicated R5 was at risk for the above-mentioned behaviors. On March 2, 2026, at 10:27 a.m., during the entrance conference, licensed assisted living director (LALD)-D and CNS-A stated they did not have a backup nurse on staff; CNS-A was the only nurse employed by the licensee. CNS-A stated they held a second job as an hourly paid private nurse where they took care of a patient on a ventilator during their shift and were the only registered nurse (RN) present during the shift. CNS-A stated there was another nurse who also worked at their second job (who was not employed by the licensee) who could be contacted to cover the remainder of their shift if they had to leave. LALD-D and CNS-A stated they were the only two licensed staff employed by the licensee. LALD-D and CNS-A stated they were not using staffing agencies to fill staffing needs at the time of the survey. On March 2, 2026, at 11:13 a.m., CNS-A stated the licensee did have a backup RN who left at the end of January. CNS-A stated they had since been on a search for a new backup RN. The licensee's Staffing policy dated August 4, 2025, indicated, "The Clinical Nurse Supervisor will prepare and implement a 24-hour daily staffing plan that ensures adequate staffing to meet residents' needs at all times, including reasonably foreseeable needs."	0 495		

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0 495	Continued From page 7 On March 2, 2026, at 10:27 a.m. and 1:35 p.m., the surveyor requested the licensee's Staffing Plan twice but it was not provided. Minnesota Statute 144G.62 Subdivision 1. (a) indicated assisted living facilities must have a registered nurse available for consultation by staff performing delegated nursing tasks, and (b) the appropriate contact person must be readily available either in person, by telephone or other means to the staff at times when the staff are providing services. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	0 495		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by:	0 660		

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0 660	Continued From page 8 Based on interview and record review, the licensee failed to ensure an employee's TB test chest Xray (CXR) was completed within 90 days of a documented positive Mantoux skin test or blood test for one of two employees (unlicensed personnel (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) 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: The licensee's Facility TB Risk Assessment dated January 17, 2026, indicated the facility was at a low risks level for TB transmission. ULP-C was hired on October 9, 2024, to provide direct care to residents. The licensee's Employee List dated March 2, 2026, indicated ULP-C was a current employee for the licensee. ULP-C's employee record included a Medical Imaging Report CXR result document dated October 4, 2024, which indicated ULP-C did not have active signs of TB. ULP-C's employee record lacked evidence of a Mantoux skin test or blood test completed within 90 days prior to ULP-C's CXR on October 4, 2024. On March 3, 2026, at 11:00 a.m., licensed	0 660		

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0 660	Continued From page 9 assisted living director (LALD)-D and clinical nurse supervisor (CNS)-A stated they were unaware a CXR was required to have a correlating positive TB Mantoux skin test or blood test completed within 90 days prior to the CXR. The Minnesota Department of Health TB FAQ dated October 13, 2025, indicated if the health care worker had a prior positive TB test result, and they only have the CXR but no other test documentation, then they need to take a new TB test. If the result is positive, a new CXR needs to be completed. The CXR needs to be done within 90 days of the positive test date or dated any time after the positive test date. The licensee's Tuberculosis Screening/Prevention policy dated August 4, 2025, indicated: "1. Employees receive baseline TB screening upon hire to test for infection with M. tuberculosis. 2. Baseline screening includes an assessment for TB history and current TB symptoms. 3. An employee's history of BCG vaccination will be disregarded when administering and interpreting TST results. 4. The baseline test may be either TST (2-step) or BAMT. 5. If the first-step TST is negative, the second-step TST will be administered 1--3 weeks after the first TST result was read. 6. If the first and second-step TST results are both negative, the person is classified as not infected with M. tuberculosis. Additional TB screening is not necessary unless an exposure to M. tuberculosis occurs. 7. Written documentation for all TST results includes the mm induration, the interpretation (either positive or negative), the date read and a signature on letterhead.	0 660		

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0 660	Continued From page 10 8. Employees with written documentation of a previous positive TST or BAMT do not need a repeat TST or BAMT: .. Assess for current TB symptoms .. If they provide written documentation of the results of a chest x-ray indicating no active TB disease that is dated after the date of the positive TST or TB blood test result, they do not need another chest x-ray at the time of hire. .. If they do not have the written documentation from above, they must receive a chest x-ray to exclude a diagnosis of infectious TB disease before having direct patient contact. .. Assess these employees annually for current TB symptoms. Instruct them to seek medical evaluation if TB symptoms develop at any time. .. After the baseline chest x-ray is performed and the result is documented, repeat x-rays are not needed unless symptoms or signs of TB disease develop or a clinician recommends a repeat chest radiograph. 9. Employees with a verbal, but undocumented, history of a previous positive TST or BAMT will undergo the same screening process as those without previous positive results. Staff should be encouraged to keep copies of the results of the TB screening, for future use. 10. Employees with a documented history of prior treatment for LTBI or active TB disease do not need a TST or BAMT: .. Assess for current TB symptoms. © Home Care Consultants, LLC 2022 Policy 4.14 Tuberculosis Screening/Prevention .. Keep written documentation on file of a chest x-ray indicating no active TB disease that is dated after the date of the initial diagnosis of LTBI or active TB disease. .. Assess these employees annually for current TB symptoms. Instruct them to seek medical evaluation if TB symptoms develop at any time.	0 660		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING HEARTS HOME CARE INC	2916 BLOOMINGTON AVENUE MINNEAPOLIS, MN 55407

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0 660	Continued From page 11 .. Repeat chest x-rays are not needed unless symptoms or signs of active TB disease develop or a clinician recommends a repeat chest radiograph. .. Consult with the MDH TB Prevention and Control Program (651-201-5414) regarding employees with a history of previous active TB disease, as needed." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
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	0 780		

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0 780	Continued From page 12 buildings may be battery operated; 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 3-4-26, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 800 SS=D	144G.45 Subd. 2 (a) (4) Fire protection and physical environment	0 800		

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0 800	Continued From page 13 (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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated 3-4-26, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		

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0 810	Continued From page 14	0 810		
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 required to initiate the evacuation drill. This MN Requirement is not met as evidenced by:	0 810		

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0 810	Continued From page 15 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 3-4-26, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and	01500		

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01500	Continued From page 16 staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or	01500		

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01500	Continued From page 17 (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employees received at least eight hours of annual training for each 12 months of employment on required annual training topics for two of two employees who were employed more than 12 months (unlicensed personnel (ULP)-B, 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 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: ULP-B ULP-B was hired on January 31, 2022, to provide direct care to residents. On March 3, 2026, at 8:02 a.m., the surveyor observed ULP-B administer medication for R2. ULP-B's employee record included an Educare (online training platform) transcript which lacked evidence annual training was completed for the following required topics:	01500		

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01500	Continued From page 18 - reporting maltreatment of vulnerable adults or minors; - effective approaches to use to problems solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; - review of provider's policies and procedures; - principles of person-centered planning/service delivery; and - hearing loss training (optional). ULP-C ULP-C was hired on October 9, 2024, to provide direct cares to residents. ULP-C's employee record included two Educare transcripts which lacked evidence annual training was completed for the following required topics: - reporting maltreatment of vulnerable adults or minors; - infection control techniques; - effective approaches to use to problems solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; - review of provider's policies and procedures; - principles of person-centered planning/service delivery; and - hearing loss training (optional). On March 3, 2026, at 11:00 a.m., licensed assisted living director (LALD)-D and clinical nurse supervisor (CNS)-A stated annual trainings were completed on an employees work anniversary; they stated they were using Educare to complete all annual training. LALD-D and CNS-A stated if the annual training was not found on the Educare transcript then it wasn't	01500		

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01500	Continued From page 19 completed. The licensee's Staff Orientation and Education policy dated August 4, 2025, indicated: "All staff providing assisted living services will complete at least eight (8) hours of education for every twelve (12) months of employment. 14. Education topics will include, but not be limited to, the following a. Reporting of maltreatment of adults b. Review of Assisted Living Bill of Rights and staff responsibilities related to ensuring the exercise and protection of those rights c. Review of the organization ' s policies and procedures related to provision of assisted living services and how to implement them d. Infection control techniques used in the home i. Implementation of infection control standards based on current recommendations per the CDC****** ii. Hand washing techniques iii. Need for/use of personal protective equipment (PPE), including: 1. Gloves 2. Gowns 3. Masks iv. Appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes and razor blades v. Disinfection of reusable equipment vi. Disinfection of environmental surfaces vii. Reporting of communicable diseases e. Effective approaches to use to problem solve when working with a resident ' s challenging behaviors and how to communicate with residents who have dementia, Alzheimer ' s Disease or related disorders (2 hours) f. The principles of person-centered planning and service delivery and how they apply to direct support services provided by staff	01500		

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01500	Continued From page 20 g. Mental illness with de-escalation (1 hour) 15. Annual education may include training on providing services to residents with hearing loss. This training will be research-based and include: a. An explanation of age-related hearing loss and how it manifests itself, its prevalence and the challenges it poses to communication; b. Health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation and depression c. Information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time and closed captions." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
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	01530		

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01530	Continued From page 21 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; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure two hours of initial mental illness and de-escalation training was conducted within 160 hours of providing direct care to residents for two of two direct care staff (unlicensed personnel (ULP)-B, ULP-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01530		

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01530	Continued From page 22 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: ULP-B ULP-B was hired on January 31, 2022, to provide direct care to residents. On March 3, 2026, at 8:02 a.m., the surveyor observed ULP-B administer medication for R2. ULP-B's employee record included an Educare (online training platform) transcript which included 1.5 hours of initial mental health training and lacked de-escalation training. ULP-C ULP-C was hired on October 9, 2024, to provide direct care to residents. ULP-C's employee record included an Educare (online training platform) transcript which included zero hours of initial mental illness and de-escalation training. On March 3, 2026, at 11:00 a.m., licensed assisted living director (LALD)-D and clinical nurse supervisor (CNS)-A stated they used Educare to complete the mental health and de-escalation trainings. LALD-D and CNS-A stated ULP-B was short on hours and they were unsure if the assigned Educare modules included de-escalation training. CNS-A stated ULP-C was assigned mental health and de-escalation training	01530		

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01530	Continued From page 23 but did not complete it. The licensee's Staff Orientation and Education policy dated August 4, 2025, indicated, "All direct care staff and supervisors providing direct services must receive training on dementia*** and mental illness with de-escalation." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure time-sensitive medications were labeled with a legible opened-on date for one of one resident (R2) with insulin. Further, the licensee failed to ensure insulin pens were labeled with resident identifying pharmacy labels for one of one resident (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	01890		

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CARING HEARTS HOME CARE INC	2916 BLOOMINGTON AVENUE MINNEAPOLIS, MN 55407

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01890	Continued From page 24 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: R2 was admitted to the licensee on July 9, 2025. R2's Service Plan dated November 4, 2025, indicated R2 received services for medication administration and blood glucose supervision. R2's Med Admin Summary (medication administration record (MAR)) for March 2026, indicated R2 took Novolog insulin on March 1, 2026. It further indicated Lantus insulin was administered on March 1-3, 2026. On March 2, 2026, at 10:59 a.m., the surveyor observed R2's medication bin with clinical nurse supervisor (CNS)-A which included a Novolog FlexPen with an illegible opened-on date label written with permanent marker, and a Lantus Solostar insulin pen without an opened-on date labeling of any kind; both insulin pens lacked patient identifying information or pharmacy labels. CNS-A stated the insulin pens should have had opened-on date labels which were legible and with pharmacy labels. CNS-A stated it was the responsibility of the person who opened the insulin pen to label it with an opened-on date. On March 3, 2026, at 8:02 a.m., the surveyor observed ULP-B administer Lantus insulin for R2 with a Lantus Solostar insulin pen. The pen was labeled with the date opened. The manufacturer instructions for Lantus Solostar insulin pens, last updated 2022, indicated after 28	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36157	A. BUILDING: _____ B. WING _____	03/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING HEARTS HOME CARE INC	2916 BLOOMINGTON AVENUE MINNEAPOLIS, MN 55407

(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
01890	Continued From page 25 days, throw your opened Lantus pen away even if it still has insulin in it. The manufacturer instructions for Novolog FlexPen, last updated March 2023, indicated the Novolog FlexPen should be used within 28 days or thrown away. The licensee's Storage/Control of Medications policy dated August 4, 2025, indicated: "10. Prescription drugs, prior to being set up for immediate or later administration, must be kept in the original container(s) in which they were dispensed by the pharmacy bearing the original prescription label with legible information. 11. The medication is labeled completely and legibly. The medication label should contain the following. a. Prescription number and name of medication b. Strength and quantity c. Expiration date for time-dated drugs d. Directions for use e. Resident's name f. Prescriber's name g. Date issued h. Name and address of licensed pharmacy issuing the medication." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

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

Caring Hearts Home Care Inc
2916 Bloomington Avenue
Minneapolis, MN 55407
Hennepin County
Parcel:

Phone:

License Info

License: HFID 36157

Risk:
License:
Expires on:
CFPM:
CFPM #: ; Exp:

Inspection Info

Report Number: F1013261013
Inspection Type: Full - Single
Date: 3/2/2026 Time: 01:30 pm
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 3
Total Priority 3 Orders: 2
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: NO MN CFPM EMPLOYED AT THE FACILITY. COMPLY WITH RULE. MN CFPM INFORMATION WAS PROVIDED.

Comply By: 3/31/2026 Originally Issued On: 3/2/2026

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: HOT WATER SANITIZING DISH MACHINE IS USED IN THE KITCHEN. NO TEST KIT MEETING THE ABOVE REQUIREMENT WAS AVAILABLE. COMPLY WITH RULE.
Comply By: 3/9/2026 Originally Issued On: 3/2/2026

New Order: 4-300 Equipment Numbers and Capacities
4-302.14 *Priority Level: Priority 2 CFP#: 48*
MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.
COMMENT: CHLORINE SANITIZER IS USED TO SANITIZE WARE UNTIL THE DISH MACHINE IS REPAIRED. NO CHLORINE TEST KIT WAS AVAILABLE. COMPLY WITH RULE.
Comply By: 3/2/2026 Originally Issued On: 3/2/2026

New Order: 4-500 Equipment Maintenance and Operation
4-501.11AB *Priority Level: Priority 3 CFP#: 47*
MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.
COMMENT: FACILITY'S DISH MACHINE DOES NOT WORK. OPERATOR STATED A TECH WAS SCHEDULED TO SERVICE THE DISH MACHINE ON 3/2/26. COMPLY WITH RULE. STAFF ARE USING CHLORINE SANITIZER IN A LARGE BIN TO SANITIZE WARE UNTIL DISH MACHINE IS REPAIRED.
Comply By: 3/2/2026 Originally Issued On: 3/2/2026

New Order: 6-300 Physical Facility Numbers and Capacities
6-301.12 *Priority Level: Priority 2 CFP#: 10*
MN Rule 4626.1445 Provide and maintain a supply of individual disposable towels, a continuous towel system, a heated-air hand drying device, or an approved ambient air temperature hand drying device at each handwashing sink or group of adjacent handwashing sinks.
COMMENT: NO PAPER TOWELS OR HAND DRYING DEVICE WERE AVAILABLE AT THE KITCHEN HAND WASHING SINK. COMPLY WITH RULE. STAFF STOCKED PAPER TOWELS.
Comply By: Complied On Site Originally Issued On: 3/2/2026

Food & Beverage General Comment

The inspection was completed with the operator then reviewed with MDH Nurse Evaluator J. Keen.

The establishment has a residential kitchen and serves food prepared on the same day. The kitchen has painted wood cabinets, LVT floor, textured painted walls, laminate counter top, and a textured painted ceiling.

A two basin sink is located in the kitchen. One basin is designated for hand washing.

Residential dish machine is available to wash ware. The dish machine should be run on the sanitize/high temperature cycle.

Discussed hand washing, ware washing, staff illness policy, temperature control, final cook temperatures, cleaning, serving highly susceptible populations, food storage, and food handling procedures.

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 F1013261013 from 3/2/2026

Munira Mohamed
Operator

Jerry Malloy

Jerry Malloy,
Public Health Sanitarian Supervisor
651-201-3998
jerry.malloy@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

Caring Hearts Home Care Inc
Minneapolis
County/Group: Hennepin County

Inspection Info

Report Number: F1013261013
Inspection Type: Full
Date: 3/2/2026
Time: 01:30 pm

Food Temperature: Product/Item/Unit: Yogurt**; Temperature Process:** Cold-Holding
Location: Refrigerator at 33 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Milk**; Temperature Process:** Cold-Holding
Location: Refrigerator at 35 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Eggs**; Temperature Process:** Cold-Holding
Location: Refrigerator at 35 Degrees F.
Comment:
Violation Issued?: No

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

Caring Hearts Home Care Inc
2916 Bloomington Avenue
Minneapolis, MN 55407
Hennepin County
Parcel:

Phone:

License Info

License: HFID 36157

Risk:
License:
Expires on:
CFPM:
CFPM #: ; Exp:

Inspection Info

Report Number: F1013261015
Inspection Type: Follow-up - Single
Date: 3/4/2026 Time: 1:53:57 PM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 3
Total Priority 3 Orders: 1
Delivery:

Previous 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: NO MN CFPM EMPLOYED AT THE FACILITY. COMPLY WITH RULE. MN CFPM INFORMATION WAS PROVIDED.

Comply By: 3/31/2026 Originally Issued On: 3/2/2026

Previous 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: HOT WATER SANITIZING DISH MACHINE IS USED IN THE KITCHEN. NO TEST KIT MEETING THE ABOVE REQUIREMENT WAS AVAILABLE. COMPLY WITH RULE.
Comply By: 3/9/2026 Originally Issued On: 3/2/2026

Previous Order: 4-300 Equipment Numbers and Capacities
4-302.14 *Priority Level: Priority 2 CFP#: 48*
MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.
COMMENT: CHLORINE SANITIZER IS USED TO SANITIZE WARE UNTIL THE DISH MACHINE IS REPAIRED. NO CHLORINE TEST KIT WAS AVAILABLE. COMPLY WITH RULE.
Comply By: 3/2/2026 Originally Issued On: 3/2/2026

Previous Order: 6-300 Physical Facility Numbers and Capacities
6-301.12 *Priority Level: Priority 2 CFP#: 10*
MN Rule 4626.1445 Provide and maintain a supply of individual disposable towels, a continuous towel system, a heated-air hand drying device, or an approved ambient air temperature hand drying device at each handwashing sink or group of adjacent handwashing sinks.
COMMENT: NO PAPER TOWELS OR HAND DRYING DEVICE WERE AVAILABLE AT THE KITCHEN HAND WASHING SINK. COMPLY WITH RULE. STAFF STOCKED PAPER TOWELS.
Comply By: Complied On Site Originally Issued On: 3/2/2026

Food & Beverage General Comment

No inspection was completed. The operator sent a picture of the dish machine thermal label (provided by MDH) to the inspector. The dish machine was repaired on 3/2/26. The order for MN Rule 4626.0735AB was cleared.

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 F1013261015 from 3/4/2026

Jerry Malloy

Munira Mohamed
Operator

Jerry Malloy,
Public Health Sanitarian Supervisor
651-201-3998
jerry.malloy@state.mn.us

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

Sanitizer Observations/Recordings

Establishment Info

Caring Hearts Home Care Inc
Minneapolis
County/Group: Hennepin County

Inspection Info

Report Number: F1013261015
Inspection Type: Follow-up
Date: 3/4/2026
Time: 1:53:57 PM

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

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ASSISTED LIVING | ASSISTED LIVING WITH DEMENTIA CARE

Project No: SL36157016-0	**Date:** 3/4/2026
Facility Name: CARING HEARTS HOME CARE INC	
Facility Address: 2916 Bloomington Ave, Minneapolis, Minnesota 55407	

☒ **TAG IDENTIFICATION: 0780**

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

1. Smoke alarms shall be 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.

☒ **TAG IDENTIFICATION: 0800**

SCOPE/ SEVERITY: Level 2; Isolated **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 wall under the stairway window air conditioner had peeling paint and was degraded.

☒ **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 include the location and number of resident rooms. [Minn. Stat. 144G.45 subd.2]

Comments: The evacuation floor plan lacked resident room identification.

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

   Comments: The provided FSEP was from a third-party provider and had not been updated to the specific facility.

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

   Comments: Licensed assisted living director (LALD)-D stated there was no resident policy created at this time.