Electronically Delivered

June 2, 2026

Licensee
Caring Nurses LLC
7723 Brooklyn Boulevard
Brooklyn Center, MN 55443

RE: Project Number(s) SL29536015

Dear Licensee:

On April 11, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on August 20, 2024, and the follow-up survey completed on December 17, 2024. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Benjamin Zwart

Benjamin J. Zwart, P.E., Supervisor
State Engineering Services Section
Health Regulation Division
Email: Benjamin.Zwart@state.mn.us
Telephone: 651-201-3715 Fax: 1-866-890-9290

JMD

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

February 7, 2025

Licensee
Caring Nurses LLC
7723 Brooklyn Boulevard
Brooklyn Center, MN 55443

RE: Project Number(s) SL29536015

Dear Licensee:

On December 17, 2024, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on August 20, 2024. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the August 20, 2024 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on August 20, 2024, found not corrected at the time of the December 17, 2024, follow-up survey and/or subject to penalty assessment are as follows:

0830 - Local Laws Apply - 144g.45 Subd. 3

The details of the violations noted at the time of this follow-up survey completed on December 17, 2024 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

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

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

We urge you to review these orders carefully. If you have questions, please contact Benjamin J. Zwart at 651-201-3715.

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

Sincerely,

Benjamin J. Zwart, P.E., Supervisor
State Engineering Services Section
Health Regulation Division
Email: Benjamin.Zwart@state.mn.us
Telephone: 651-201-3715 Fax: 1-866-890-9290

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29536	A. BUILDING: _____ B. WING _____	R 12/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING NURSES LLC	7723 BROOKLYN BOULEVARD BROOKLYN CENTER, MN 55443

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been 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: SL29536015-1 On December 17, 2024, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on August 20, 2024. At the time of the survey, there were 5 residents; 5 receiving services under the Assisted Living license. As a result of the follow-up survey, the following orders were issued or reissued.	{0 000}		
{0 480} SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a	{0 480}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CARING NURSES LLC	7723 BROOKLYN BOULEVARD BROOKLYN CENTER, MN 55443

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{0 480}	Continued From page 1 certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and	{0 480}		

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{0 480}	Continued From page 2 (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:	{0 480}	Not reviewed during this survey	
{0 570} SS=C	144G.42 Subdivision 1 Display of license The original current license must be displayed at the main entrance of each assisted living facility. The facility must provide a copy of the license to any person who requests it. This MN Requirement is not met as evidenced by:	{0 570}	Not reviewed during this survey	
{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	{0 680}		

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{0 680}	Continued From page 3 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:	{0 680}		
{0 830} SS=D	144G.45 Subd. 3 Local laws apply Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements, except a facility with a licensed resident capacity of six or fewer is exempt from rental licensing regulations imposed by any town, municipality, or county. This MN Requirement is not met as evidenced by: Based on observation, record review and interview, the licensee failed to comply with all state and local governing laws, and codes for fire safety, building, and zoning requirements. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	{0 830}		

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CARING NURSES LLC	7723 BROOKLYN BOULEVARD BROOKLYN CENTER, MN 55443

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{0 830}	Continued From page 4 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: On December 17, 2024, at 1:30 p.m., on a follow up survey, survey staff toured the facility with LALD. At the time of the survey, the basement was still under construction. There was new bedrooms, office, laundry and a family room. The rooms were missing trim, lights and plug in outlets. The LALD stated that the rest of the construction would be done soon. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	{0 830}		
{01500} SS=D	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 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	{01500}		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{01500}	Continued From page 5 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 (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.	{01500}		

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{01500}	Continued From page 6 This MN Requirement is not met as evidenced by:	{01500}	Not reviewed during this survey	
{01530} SS=D	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care 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 employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by:	{01530}	Not reviewed during this survey	

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{01750}	Continued From page 7	{01750}		
{01750} SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by:	{01750}	Not reviewed during this survey	
{01760} SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced	{01760}		

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{01760}	Continued From page 8 by:	{01760}	Not reviewed during this survey	

Electronically Delivered

September 11, 2024

Licensee
Caring Nurses LLC
7723 Brooklyn Boulevard
Brooklyn Center, MN 55443

RE: Project Number(s) SL29536015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 20, 2024, 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 . . ."

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
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.

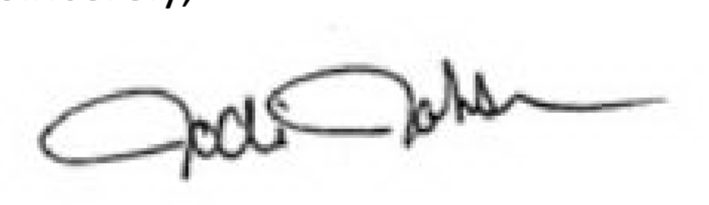
To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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,



Jodi Johnson, Supervisor
State Evaluation Team
Email: Jodi.Johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29536	A. BUILDING: _____ B. WING _____	08/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING NURSES LLC	7723 BROOKLYN BOULEVARD BROOKLYN CENTER, MN 55443

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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: SL# 29536015-0 On August 19, 2024, through August 20, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were five residents; five receiving services under the provider's 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 Subd 1 (13) (i) (B) Minimum requirements	0 480		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and 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) 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: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated August 19, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 570 SS=C	144G.42 Subdivision 1 Display of license The original current license must be displayed at the main entrance of each assisted living facility. The facility must provide a copy of the license to any person who requests it. This MN Requirement is not met as evidenced by:	0 570		

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	29536	A. BUILDING: _____ B. WING _____	08/20/2024

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CARING NURSES LLC	7723 BROOKLYN BOULEVARD BROOKLYN CENTER, MN 55443

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0 570	Continued From page 2 Based on observation and interview, the licensee failed to display the original current license at the main entrance of the assisted living facility as required. This had the potential to affect all the licensee's current residents, staff, and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a 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 the residents). The findings include: During the initial tour on August 19, 2024, at 1:05 p.m., with housing manager (HM)-C the surveyor did not observe the facility's current license at the main entrance as required. HM-C stated the license was not posted in the facility. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 570		
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;	0 680		

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0 680	Continued From page 3 (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 evaluate it's missing person policy at least quarterly. 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) 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: The licensee's undated, Missing Resident policy was included in the emergency preparedness (EP) plan. The policy lacked evidence the	0 680		

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0 680	Continued From page 4 assisted living director and clinical registered nurse reviewed or updated the policy and documented any changes, at least quarterly as required. On August 20, 2024, 2:39 p.m. clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated the missing resident policy had not been reviewed quarterly and they were not aware of the requirement. On August 20, 2024, at 3:36 p.m. administrator (A)-E stated the missing resident policy was last reviewed January 30, 2024. Per Assisted Living Facilities: Minnesota Rules Chapter 4659, 4659.0110, Subp. 4. Review missing resident plan. The assisted living director and clinical nurse supervisor must review the missing person plan at least quarterly and document any changes to the plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each	0 780		

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0 780	Continued From page 5 separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee also failed to provide a smoke alarm in each sleeping room and on each story. This deficient condition had the ability to affect all staff and residents. 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 a facility tour on August 20, 2024, at approximately 11:46 a.m., with clinical nurse supervisor/licensed assisted living director	0 780		

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0 780	Continued From page 6 (CNS/LALD)-A, survey staff observed that resident bedroom #7 smoke alarm was not working and removed from its base on the ceiling. It was also observed that there was not a functioning smoke alarm in the basement. CNS/LALD-A verbally confirmed survey staff observations during the facility tour. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain 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. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	0 800		

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0 800	Continued From page 7 cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On August 20, 2024, from approximately 11:27 a.m. to 12:30 p.m., survey staff toured the facility with clinical nurse supervisor /licensed assisted living director (CNS/LALD)-A. The following was observed. GENERAL MAINTENANCE: Bedroom #1 vinyl flooring coming up in places and bedroom #2 has a hole in the vinyl floor. Dining room wall had several areas that were patched with putty and in need of some paint. Dining room wooden floor had its finish coming off. Vent in main floor bathroom was heavily soiled with dust. Main entrance door and door frame was loose. Deck finish was coming off and wood was deteriorating. Basement was under construction and remodeling. Old walls were torn down and new walls being framed in with new electrical wiring running throughout. CNS/LALD-A stated they understood the above-listed deficiencies.	0 800		

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0 800	Continued From page 8 TIME PERIOD FOR CORRECTION: twenty-one (21) 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) employee 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) Employees 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 employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.	0 810		

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0 810	Continued From page 9 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 the required content and provide the required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On August 20, 2024, at 12:15 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A 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 FSEP (fire safety and evacuation plan) included standard employee procedures but failed to provide 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 plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate) but the plan was designed for a building with life safety systems such as fire alarm pull stations. The policy had not been	0 810		

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0 810	Continued From page 10 updated to provide complete actions for employees to take in the event of a fire or similar emergency at the licensed facility which did not have life safety systems or a fire-resistant construction type. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 830 SS=D	144G.45 Subd. 3 Local laws apply Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to comply with all state and local governing laws, and codes for fire safety, building, and zoning requirements. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include:	0 830		

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0 830	Continued From page 11 On August 20, 2024, from approximately 11:27 a.m. to 12:30 p.m., survey staff toured the facility with clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A. At the time of the survey, the lower level of the home was under construction. CNS/LALD-A stated the lower level was not being used and is currently being remodeled with old walls torn down and new walls framed in with newly electrical wiring throughout. CNS/LALD-A stated that the planned future use of this space will be offices for staff and resident activities. Residents will not be using this space for sleeping. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 830		
01500 SS=D	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 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;	01500		

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01500	Continued From page 12 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 (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 annual	01500		

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01500	Continued From page 13 training included all required topics for each 12 months of employment for one of one employee (unlicensed personnel (ULP)-D). 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: ULP-D began providing assisted living services on January 16, 2023. On August 20, 2024, at 7:50 a.m. ULP-D was observed to administer medications to R1 in his room. ULP-D's employee record lacked documented evidence of the following required annual training: -Training on reporting of maltreatment of vulnerable adults under section 626.557; -Review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; -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 -Review of provider's policies and procedures; and -Principles of person-centered planning and service delivery.	01500		

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01500	Continued From page 14 On August 20, 2024, at 1:09 p.m. clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated ULP-D had not completed the annual training as noted above. The licensee's undated, Annual Training Requirements policy noted all staff that provide direct care services in assisted living must complete at least eight (8) hours of annual training for each 12 months of employment. Evidence that each employee has completed the training will be in the employee file. Annual training must include: - Training on reporting of maltreatment of vulnerable adults under section 626.557; - Review of the Assisted Living Bill of Rights and staff responsibilities related to ensuring the exercise and protection of those rights; - 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 -Review of the facilities policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; - The principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		
01530 SS=D	144G.64 TRAINING IN DEMENTIA CARE REQUIRED	01530		

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01530	Continued From page 15 (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care 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 employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia 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 one of one employee (unlicensed personnel (ULP)-D) received the required amount of dementia care training in the required time frame. 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	01530		

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01530	Continued From page 16 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 provided services under an Assisted Living license. ULP-D began providing assisted living services on January 16, 2023. On August 20, 2024, at 7:50 a.m. ULP-D was observed to administer medications to R1 in his room. ULP-D's employee record lacked documented evidence the employee received the required eight hours of dementia care training within 160 working hours of the employment start date. On August 20, 2024, at 1:09 p.m. clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated ULP-D had seven hours of dementia hours and was short one hour of the requirement. CNS/LALD-A further indicated ULP-D was a full-time employee and had worked more than 160 hours. CNS/LALD-A stated the dementia classes were assigned and office staff were in charge of tracking completion, but somehow ULP-D was missed. The licensee's undated, Dementia Care Training policy noted all assisted living facilities must meet the following training requirements: 2. Direct care employees must have completed at least eight hours of initial training on required topics in the 160 hours from employment. Until this training is complete, the employee must not	01530		

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	29536	A. BUILDING: _____ B. WING _____	08/20/2024

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01530	Continued From page 17 provide direct care unless there is another employee on site who has completed the initial eight hours of training related to dementia care and who can act as a resource and assist if issues arise. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01530		
01750 SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to document the site of insulin injections and patch application for one of one resident (R1). 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	01750		

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01750	Continued From page 18 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: R1 had diagnoses of bipolar disorder (mental illness characterized by extreme mood swings), diabetes, and dementia. R1's Service Plan - Modification dated February 9, 2024, indicated R1 received assistance with bathing, dressing, grooming, mobility, incontinence care, repositioning, blood sugar checks, skin treatment per instructions, and medication administration. R1's prescriber's orders dated July 2, 2024, included orders for: - Novolog (fast-acting insulin) 100 units (u)/milliliter (ml) 6 units before meals PLUS sliding scale insulin blood sugar ranges: 140-164 = 1 units 165-189 = 2 units 190-214 = 3 units 215-239 = 4 units 240-264 = 5 units 265-289 = 6 units 290-314 = 7 units 315-339 = 8 units 340-364 = 9 units 365 or more = 10 units Notify nurse if blood sugar is above 400; - rivastigmine (for dementia) 13.3 milligrams (mg)/24 hours transdermal apply one patch to skin daily. R1's medication administration record (MAR) dated August 1, 2024, through August 20, 2024,	01750		

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01750	Continued From page 19 included the same orders for Novolog FlexPen 6 units before meals PLUS sliding scale insulin and rivastigmine 13.3 mg/24 hours apply one patch to skin daily. The medication sheet included a spot for each date and staff initials to indicate the medication had been administered. However, it lacked a space to indicate the site the insulin was administered or the site the patch had been placed on the resident's body. On August 20, 2024, at 7:26 a.m. the surveyor observed ULP-D prepare R1's insulin for administration. ULP-D checked R1's blood sugar and obtained a result of 132 milligrams/deciliter (mg/dL). ULP-D stated before she could administer the insulin, she needed to verify the dose with the on-call nurse. ULP-D then placed a telephone call to on-call nurse who directed her to only administer the scheduled NovoLog FlexPen 6 units as no additional units would be required per sliding scale orders. On August 20, 2024, at 7:50 a.m. ULP-D sanitized her hands, applied gloves, and administered Novolog 6 units subcutaneously to R1's right lower abdomen and applied the rivastigmine patch to R1's left front shoulder. ULP-D then removed gloves, sanitized hands, and documented the medication administration on R1's MAR. ULP-D did not document a location of the insulin injection given or where the patch had been applied, but stated she rotated sites. On August 20, 2024, at 11:15 a.m. clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated R1's records lacked identification of the site the NovoLog insulin was being administered or where the patch had been applied. CNS/LALD-A stated they should add a	01750		

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01750	Continued From page 20 location on the MAR, so staff knew where the previous insulin and patch had been administered. NovoLog FlexPen Instructions for use leaflet dated revised February 2023, instructed: NovoLog can be injected under the skin (subcutaneously) of your stomach area (abdomen), buttocks, upper legs (thighs) or upper arms. Change (rotate) your injections sites within the area you choose for each dose to reduce your risk of getting lipodystrophy (pits in skin or thickened skin) and localized cutaneous amyloidosis (skin with lumps) at the injection sites. Do not use the same injection site for each injection. The rivastigmine Patient Information leaflet dated revised June 2020, instructed: - Change your application site every day to avoid skin irritation. You can use the same area, but do not use the exact same spot for at least 14 days after your last application. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of	01760		

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01760	Continued From page 21 administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of one unlicensed personnel (ULP-D) administered medications as prescribed. 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: R1 had diagnoses of bipolar disorder (mental illness characterized by extreme mood swings), diabetes, and dementia. R1's Service Plan - Modification dated February 9, 2024, indicated R1 received assistance with bathing, dressing, grooming, mobility, incontinence care, repositioning, blood sugar checks, skin treatment per instructions, and medication administration. R1's prescriber's orders dated July 2, 2024, included orders for:	01760		

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01760	Continued From page 22 - bacitracin (topical antibiotic) 500 units (u)/gram (gm) ointment apply topically twice daily to scrotal and chest lesions. R1's medication administration record (MAR) dated August 1, 2024, through August 20, 2024, included the same order for bacitracin 500 u/gm apply topically twice daily to scrotal and chest lesions. The medication sheet included a spot for each date and staff initials to indicate the medication had been administered. On August 20, 2024, at 7:50 a.m. ULP-D sanitized her hands, applied gloves, and applied a thin layer of bacitracin to R1's left big toenail. ULP-D stated the MAR did not match where the bacitracin had been applied indicating she applied it to any abrasions the resident had, further noting R1's chest and scrotal area were currently clear and intact. ULP-D then removed gloves, sanitized hands and documented the medication administration on R1's MAR. On August 20, 2024, at 11:15 a.m. registered nurse (RN)-B stated she had requested an order from the provider to use the bacitracin to other abrasions but had never received an order for it. Clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated ULP-D should have followed the orders as reflected on the MAR for the bacitracin administration. The licensee's undated, Documentation of Medication Administration policy noted each medication administered by the assisted living facility staff will be documented in the resident's record. The documentation will include the signature and title of the person who administered the medication. Documentation will include the medication name, dosage, date and	01760		

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01760	Continued From page 23 time administered, and method and route of administration. Staff will document the reason why medication administration was not competed as prescribed and document any follow-up procedures that were provided to the meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. 3. Staff will administer the medication according to the instructions on the MAR. 4. Follow the facility's protocols for notifying the RN of medications that are not administered consistent as prescribed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		

Minnesota Department of Health

3333 Division St #212
St. Cloud
320 223-7300

Type: Full
Date: *08/19/24*
Time: 12:30:00
Report: 1051241089

Food and Beverage Establishment Inspection Report

Location:
Caring Meadows
7723 Brooklyn Boulevard
Brooklyn Park, MN55443
Hennepin County, 27

Establishment Info:
ID #: 0038008
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7635664325
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

The following orders were issued during this inspection.

3-500B Microbial Control: hot and cold holding

3-501.16A2 ***** Priority 1 *****

MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

KITCHEN REFRIGERATED HAS BEEN OPENED & CLOSED THROUGHOUT THE DAY FOR LUNCH. HAD STAFF TAKE AN AMBIENT WATER TEMPERATURE LATER IN THE DAY. THE TEMPERATURE READ 57 DEG F. TURN UNIT COLDER OR REPLACE UNIT.

Comply By: 08/19/24

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

AT TIME OF INSPECTION, THERE WAS NO CFPM. SEND IN A FULL TIME STAFF TO TAKE AN APPROVED TRAINING CLASS. WITHIN 6 MONTHS OF PASSING THE CLASS, SUBMIT THE RESULTS WITH THE STATE APPLICATION TO THE STATE. APPLICATION WILL BE SENT W/ REPORT.

Comply By: 09/19/24

Food and Equipment Temperatures

Process/Item: Upright Cooler
Temperature: 57 Degrees Fahrenheit - Location: AMBIENT WATER
Violation Issued: Yes

Type: Full
Date: *08/19/24*
Time: 12:30:00
Report: 1051241089
Caring Meadows

Food and Beverage Establishment Inspection Report

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	1	0	1

MET WITH NURSE EVALUATOR, SUSAN KALIS:

DISCUSSED THE FOLLOWING WITH PERSON IN CHARGE, TANAYA:

EMPLOYEE ILLNESS LOG
VOMIT CLEAN-UP PROCEDURE
CERTIFIED FOOD PROTECTION MANAGER

THE KITCHEN HAS A NSF 184 DISHMACHINE, MDF WOODEN CABINETS, CERAMIC TILE FLOORS, POPCORN TEXTURE CEILING, AND LAMINATE COUNTERTOPS.

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 1051241089 of 08/19/24.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed:_____
Tanaya Nash

Signed:_____
Kai Yang
Public Health Sanitarian 1
St. Cloud
320 640-3532
Kai.Yang@state.mn.us