



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

September 29, 2026

Licensee

Champions Village II LLC

8001 82nd Avenue North

Brooklyn Park, MN 55445

RE: Project Number(s) SL41545001

Dear Licensee:

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

The Minnesota Department of Health completed an initial survey on September 10, 2026, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

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

STATE CORRECTION ORDERS

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

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:

0510 - 144g.41 Subd. 3 - Infection Control Program - \$500.00

The total amount you are assessed is \$500.00. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

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 MDH 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.

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

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41545	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/10/2026
NAME OF PROVIDER OR SUPPLIER CHAMPIONS VILLAGE II LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 8001 82ND AVE N BROOKLYN PARK, MN 55445		
(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: SL41545001-0 On September 8, 2026, through September 10, 2026, the Minnesota Department of Health conducted an initial survey at the above provider and the following correction orders are issued. At the time of the survey, there were three residents all of whom received services under the provisional Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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0 480	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 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 September 9, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.	0 480			

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0 480	Continued From page 3	0 480			
	TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.				
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program to comply with accepted health care, medical, and nursing standards for infection control related to shared medical equipment for one of three employees (unlicensed personnel (ULP)-A). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	0 510			

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0 510	Continued From page 4 The findings include: On September 9, 2026, at 8:20 a.m., the surveyor observed ULP-A complete a blood pressure (bp) with an electronic blood pressure cuff, temperature (t) with a temporal thermometer, and oxygen saturation (SpO2) with a SpO2 monitor. Prior to the application of the SpO2 monitor, ULP-A disinfected the SpO2 monitor with a Clorox wipe. The surveyor observed ULP-A place all diagnostic machines listed above back into a basket once they completed R3's vital signs without disinfecting the equipment. On September 9, 2026, at 8:44 a.m., the surveyor observed ULP-A place the same blood pressure cuff listed above on R2 without disinfecting the device. In addition, the surveyor observed ULP-A clean the SpO2 monitor and the temporal thermometer with Purell hand sanitizer prior to using the equipment on R2. Once ULP-A took R2's vital signs with the equipment listed above they placed the devices back into the basket without disinfecting the equipment. On September 9, 2026, at 9:08 a.m., ULP-A stated they were trained to sanitize medical equipment before they used the equipment on each resident with hand sanitizer or alcohol wipes. ULP-A stated, "I forgot" to disinfect the blood pressure cuff between residents. On September 9, 2026, at 12:04 p.m., clinical nurse supervisor (CNS)-C stated ULPs were trained to clean shared medical equipment with a disinfectant wipe or by placing Purell hand sanitizer on a paper towel and wiping the device between resident usages. The CDC's Disinfection of Healthcare Equipment	0 510			

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0 510	Continued From page 5 dated November 28, 2023, indicated shared medical equipment should be clean and disinfected before and after each use with a compatible disinfectant. Additionally indicated, "Medical equipment surfaces (e.g., blood pressure cuffs, stethoscopes, hemodialysis machines, and X-ray machines) can become contaminated with infectious agents and contribute to the spread of health-care-associated infections. For this reason, noncritical medical equipment surfaces should be disinfected with an EPA [United States Environmental Protection Agency]-registered low- or intermediate-level disinfectant." The U.S. Food & Drug Administration dated April 12, 2023, indicated, "Hand sanitizers are regulated as over-the-counter (OTC, or nonprescription) drugs by the U.S. Food and Drug Administration." Therefore, hand sanitizer is not regulated nor registered by the EPA, and it should not be used for the disinfection of shared noncritical medical equipment such as blood pressure cuffs. The licensee's Infection Control policy dated August 1, 2021, indicated the licensee would observe the recommended precautions as identified by the CDC. In addition, equipment used for resident care was properly cleaned and reprocessed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510			

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0 790	Continued From page 6	0 790			
0 790 SS=D	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, 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 September 9, 2026, for the specific violations related the physical environment under Minnesota	0 790			

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0 790	Continued From page 7 Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790			
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, record review, and interview, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. daysThis 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:	0 800			

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0 800	Continued From page 8 Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated September 9, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800			
0 810 SS=E	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	0 810			

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0 810	Continued From page 9 every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated September 9, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
0 940 SS=C	144G.50 Subd. 2 (e; 5-7) Contract information	0 940			

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0 940	Continued From page 10 (5) a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: (i) whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; (ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); (iii) whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; (iv) whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; (v) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; (vi) a statement that residents may be eligible for assistance with rent through the housing support program; and (vii) a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; (6) the contact information to obtain long-term care consulting services under section 256B.0911; and (7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on interview and record review, the	0 940			

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0 940	Continued From page 11 licensee failed to execute a written assisted living contract with all required content. This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's undated blank Resident Contract / Agreement included section 22 titled Statements Related to Public Assistance Programs and read, "Resident may be eligible to receive certain public funds to assist him or her in paying for or reducing the cost of resident's rent and/or service fees. For example, [the licensee] participates in certain programs through Hennepin County. For additional information on the availability of public funds, contact the Director. Resident may also contact the Hennepin County Department of Human Services and Public Health at (612) 348-4500. If Resident is eligible for Medicare, he or she may be able to obtain Medicare-covered home care services through a Medicare-certified home care [the licensee] of Resident's choice. If Resident has long-term care insurance, neither Landlord nor its arranged home care provider can bill Resident's insurer directly. Resident must pay either Landlord or its arranged home care provider directly and seek reimbursement from Resident's long-term care insurance company. Resident may wish to contact Hennepin County Human Services and Public Health at (612) 348-4500 for long-term care consultation services or for assistance in evaluating Resident's housing	0 940			

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0 940	Continued From page 12 and service needs and in identifying available community resource options. Resident may also contact the Senior Linkage Line at 1-800-333-2433 to access long-term care consultation services. Once on Medical Assistance, EW or CADl will pay for services." The licensee's contract lacked the following required content: - whether the facility was enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; and - whether the facility had and agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b). - whether there was a limit on the number of people residing at the facility who could received customized living services or participate in the housing support program at any point of time; - a statement that medical assistance waivers provided payment for services, but did not cover the cost of rent; - a description of the rent requirement for people who are eligible for medical assistance waivers but who were not eligible for assistance through the housing support program. On September 9, 2026, at approximately 10:15 a.m., clinical nurse supervisor (CNS)-C stated they were unaware of the requirements listed above however, the licensed assisted living director (LALD)-D mostly dealt with the contracts. CNS-C stated the same contract was used for all residents who resided at the facility. LALD-D then joined the interview via phone and stated the contract provided was a newer document as the licensee looked at multiple contracts for their business. LALD-D stated they believed the document met the requirements.	0 940			

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0 940	Continued From page 13 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 940			
01530 SS=E	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related 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	01530			

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01530	Continued From page 14 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 interview and record review, the licensee failed to ensure direct-care staff received at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date for two of three direct care employees (unlicensed personnel (ULP)-A, ULP-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-A ULP-A was hired on May 11, 2026, to provide assisted living services. ULP-A's employee record included an EduCare (training software) transcript dated September 8,	01530			

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01530	Continued From page 15 2026, which indicated ULP-A completed six hours and 45 minutes of dementia care training on May 2, 2026. ULP-A's employee record lacked one hour and 15 minutes of dementia care training. ULP-B ULP-B was hired on June 22, 2026, to provide assisted living services. ULP-B's employee record included an EduCare transcript dated September 8, 2026, which indicated ULP-B completed five hours and 15 minutes of dementia care training on May 2, 2026. ULP-B's employee record lacked two hours and 45 minutes of dementia care training. On September 9, 2026, at 11:02 a.m., via email, licensed assisted living director (LALD)-D wrote the following: - ULP-A worked 458 hours since date of hire; and - ULP-B worked 858 hours since date of hire. On September 9, 2026, at 12:31 p.m., clinical nurse supervisor (CNS)-C stated employees received eight hours of dementia care training via EduCare. CNS-C verified ULP-A and ULP-B's employee records lacked the hours listed above and stated they were not sure how the ULP-A and ULP-B did not receive all of the required dementia training. CNS-C stated LALD-D assigned the courses. LALD-D was then brought into the interview via phone. LALD-D stated dementia training was completed via EduCare and staff received at minimum eight hours of dementia care training. LALD-D stated they would take another look at EduCare for the dementia hours and provide it to the surveyor if found. The surveyor did not receive additional dementia care training hours for ULP-A or ULP-B prior to the completion of the survey.	01530			

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01530	Continued From page 16 The licensee's Dementia Education policy dated August 1, 2021, indicated direct care employees must have completed at least eight hours of initial dementia education within 160 working hours of the employment start date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530			
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, a registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed	01730			

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01730	Continued From page 17 personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have an accurate medication management plan for one of three residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 was admitted to the licensee on April 27,	01730			

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01730	Continued From page 18 2026, and began receiving assisted living services. R2 diagnoses included chronic heart failure, hypertension, schizophrenia (mental disorder that affects how a person thinks, feels, and behaves often leading to hallucinations, delusions, and disorganized thinking), and chronic obstructive pulmonary disease (COPD). On September 9, 2026, at 8:49 a.m., the surveyor observed unlicensed personnel (ULP)-A retrieve two pills from R2's adaptive flipper dose health pill dispenser located in R2's room and two pills for R2 from the licensee's medication closet. In addition, the surveyor observed two Ventolin inhalers located within R2's four wheeled walker basket. R2's medication administration record (MAR) dated September 2026, indicated R2 could receive albuterol sulfate as needed every four hours for shortness of breath or wheezing. The MAR indicated R2 was able to keep the rescue inhaler with them. The MAR indicated all other medications were to be administered by the licensee's staff. R2's assessment dated August 8, 2026, contained R2's individualized medication management plan. The plan indicated the following: - R2 has an adaptive flipper dose health pill dispenser that dispensed their medications at scheduled times. Staff were to remind R2 when it was time to take medication; - the adaptive flipper dose health pill dispenser may be kept safely in R2's room for self-administration; - R2 required assistance with medication	01730			

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01730	Continued From page 19 administration; - all medications were to be stored in locked cabinet; - ULP were delegated inhalers, topical, and oral medications; - R2 was not able to self-administer medications safely. There was evidence of forgetfulness and confusion; and - R2 was able to correctly administer inhalant medication with assistance. On September 9, 2026, at 12:50 p.m., clinical nurse supervisor (CNS)-C stated they placed the names of the medications on the Medi planner so the ULP would know which medications were located in the medication closet. CNS-C stated R2 did not self-administer the medications located in the adaptive flipper dose health pill dispenser located in R2's room. CNS-C stated they continued to use the adaptive flipper dose health pill dispenser because R2 would have increased behaviors if the licensee removed it. CNS-C stated they discussed the current use of the pill dispenser with the prescriber, and both were in agreement to keep the device. R2's medication management plan contained contradicting information without necessary explanations. The MAR did not identify where medications would be located in the facility as R2's medication management plan indicated multiple locations for medication storage or who would be responsible for administration of the medications. In addition, the practices of the licensee's administration of the medications did not match what was written in the medication management plan, i.e., the medication management plan indicated R2 would self-administer the medication from the adaptive flipper dose health pill dispenser in their room	01730			

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01730	Continued From page 20 however, the surveyor observed ULP-A obtain the medication from R2's room and bring them to R2 outside of their room. ULP-A then administered the medications to R2 and documented on the administration of medication. This deficient practice increased the risk for potential medications errors and may have contributed to the medication error observed during the survey (see tag identification number 1760). The licensee's Medication Management Program policy dated 2021 indicated the following services were included in the medication management program: - performing medication set up; - administering medications; - storing and securing medications; - documenting medication activities; and - verifying and monitoring the effectiveness of systems to ensure safe handling and administration. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730			
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	01760			

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01760	Continued From page 21 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 medications were administered as prescribed for one of three residents (R2). In addition, the licensee failed to ensure accurate documentation was completed for all medications administered for one of three residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 was admitted to the licensee on April 27, 2026, and began receiving assisted living services. R2's diagnoses included chronic heart failure, hypertension, schizophrenia (mental disorder that affects how a person thinks, feels, and behaves often leading to hallucinations, delusions, and disorganized thinking), and chronic obstructive pulmonary disease (COPD). R2's assessment dated August 8, 2026,	01760			

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01760	Continued From page 22 contained R2's individualized medication management plan. The plan indicated the following: - R2 has an adaptive flipper dose health pill dispenser that dispensed medications their medications at scheduled times. Staff were to remind R2 when it was time to take medication; - the adaptive flipper dose health pill dispenser may be kept safely in R2 room for self-administration; - R2 required assistance with medication administration; - all medications were to be stored in locked cabinet; - ULP were delegated inhalers, topical, and oral medications; - R2 was not able to self-administer medications safely. There was evidence of forgetfulness and confusion; and - R2 was able to correctly administer inhalant medication with assistance. R2's medication administration record (MAR) dated September 2026, indicated R2 received the following medications at 8:00 a.m. daily: - Chantix 1 milligram (mg) - metoprolol succinate 25 mg; - metronidazole gel 1 percent (%); - spironolactone 25 mg; and - Stiolto Respimat 2.5 micrograms (mcg) inhaler. In addition, the MAR indicated R2 could receive albuterol sulfate (inhaler) as needed every four hours for shortness of breath or wheezing. The MAR indicated R2 was able to keep the rescue inhaler with them. On September 9, 2026, at 8:49 a.m., the surveyor observed ULP-A open R2's MAR on the computer, count four oral medications on the MAR, one topical medication, and one inhaler R2	01760			

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01760	Continued From page 23 was to receive. ULP-A went into R2's room and retrieved two pills from R2's adaptive flipper dose health pill dispenser then went to the medication closet and retrieved two pills. ULP-A stated R2 had a cream for their face that they were going to offer to R2 however, R2 refused the cream a majority of the time. In addition, ULP-A stated the two medications in the medication closet were R2's blood pressure medications and were kept in the closet due to them having parameters of when not to administer them. ULP-A then went to R2 and administered the four oral medications. ULP-A offered the cream and R2 stated they would do it later. ULP-A asked R2 to take two puffs of their inhaler. R2 pulled a Ventolin inhaler (albuterol sulfate) 90 mcg from their four wheeled walker basket and inhaled two puffs. ULP-A then went to the computer and documented R2's refusal of metronidazole gel in the MAR and documented the following medications as administered: - Chantix 1 milligram (mg); - metoprolol succinate 25 mg; - spironolactone 25 mg; and - Stiolto Respimat 2.5 mcg inhaler. The surveyor did not observe ULP-A administer stiolto Respimat (scheduled medication) to R2. In addition, the surveyor did not observe ULP-A document the administration of Ventolin 90 mcg (PRN albuterol sulfate) inhaler. On September 9, 2026, at 9:08 a.m., the surveyor inquired what type of inhaler R2 was supposed to receive scheduled. ULP-A went to the computer, opened the MAR, and stated Stiolto Respimat. The surveyor inquired if R2 received that medication during the medication pass. ULP-A stated yes. The surveyor asked ULP-A to go back to R2's four wheeled walker and view the inhaler that R2 administered. ULP-A then stated, "that is	01760			

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01760	Continued From page 24 not the correct inhaler." ULP-A stated that was the only inhaler they had provided to R2 during any medication administration. On September 9, 2026, at 12:57 p.m., clinical nurse supervisor (CNS)-C stated when they trained ULP on medication administration they reviewed the five rights of medication administration. CNS-C stated after medications were administered, ULP were trained to document the administration and to call the nurse if a medication was not administered. CNS-C stated the facility did not have R2's Stiolto Respimat at the facility and they had called the pharmacy yesterday to refill it. CNS-C stated Stiolto Respimat would arrive to the facility later in the day. CNS-C stated they mentioned to the ULP that stiolto respimat was out of stock on September 8, 2026. The licensee's Medication Administration policy dated August 1, 2021, indicated residents of the licensee were entitled to the safe administration of medications by qualified personnel according to a written medication management plan. The licensee's Medication Documentation policy dated August 1, 2021, indicated each medication administered by the licensee's employees would be documented in the resident's clinical record. Documentation would be complete, accurate, and legible. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41545	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/10/2026
NAME OF PROVIDER OR SUPPLIER CHAMPIONS VILLAGE II LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 8001 82ND AVE N BROOKLYN PARK, MN 55445		
(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	01890			
01890 SS=D	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 discard expired medication for one of three residents (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 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 September 8, 2026, at approximately 10:30 a.m., during a facility tour, the surveyor observed the licensee's medication closet and observed trazodone 50 milligrams (mg) with an expiration date of June 15, 2026, for R1. Clinical nurse supervisor (CNS)-C stated they removed expired medications from the medication closet weekly when they performed medication set up services or when medications were delivered from the pharmacy. CNS-C stated, "I did not see that one in there."	01890			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41545	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/10/2026
NAME OF PROVIDER OR SUPPLIER CHAMPIONS VILLAGE II LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 8001 82ND AVE N BROOKLYN PARK, MN 55445		
(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 26 The licensee's Medication Administration policy dated August 1, 2021, indicated the licensed nurse was responsible for assessing medications to assure that all medications were current and ordered by the prescriber and to identify any expired or outdated medications, which would be disposed according to policy. The licensee's Disposition and Disposal of Medications policy dated August 1, 2021, indicated expired medication may be provided for disposal. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			



Rochester District Office
Minnesota Department of Health
3425 40th Ave NW, Suite 115
Rochester, MN 55901
Phone: 651-201-4500

Food & Beverage Inspection Report

Page: 1

Establishment Info

CHAMPIONS VILLAGE II LLC
8001 82ND AVE N
Brooklyn Park, MN 55445
Hennepin County
Parcel:

Phone:

License Info

License: HFID 41545

Risk:
License:
Expires on:
CFPM: King David Dickson
CFPM #: 30163; Exp: 08/21/2028

Inspection Info

Report Number: F8044261336
Inspection Type: Full - Single
Date: 9/9/2026 Time: 10:27:16 AM
Duration: minutes
Announced Inspection: Yes
Total Priority 1 Orders: 2
Total Priority 2 Orders: 1
Total Priority 3 Orders: 0
Delivery: Emailed

! New Order: 5-200B Plumbing: cross connections

5-203.14A Priority Level: Priority 1 CFP#: 51

MN Rule 4626.1085A Water used under pressure in equipment in food and beverage establishments must be drained to a sanitary sewer through an air gap. Examples: refrigeration cooling water, water softener, and drained steam jacketed kettles.
COMMENT: No air gap with floor drain for water softener discharge line.

Fact sheet provided with report.

Comply By: 9/22/2026 Originally Issued On: 9/9/2026

New Order: 5-200C Plumbing: Maintenance, fixture location

5-205.11AB Priority Level: Priority 2 CFP#: 10

MN Rule 4626.1110AB The handwashing sink must be accessible at all times for employee use, and must be used only for handwashing.

COMMENT: Beef thawing in handwashing sink.

Comply By: 9/9/2026 Originally Issued On: 9/9/2026

! New Order: 7-200 Toxic Supplies and Applications

7-204.11 Priority Level: Priority 1 CFP#: 28

MN Rule 4626.1620 Discontinue using chemical sanitizers, including chemical sanitizing solutions generated on site and other chemical antimicrobials on food-contact surfaces that do not meet the requirements specified in 40 CFR part 180, section 180.940, or part 180, subpart E, section 180.2020.

COMMENT: Lysol wipes used on counters are not approved for food contact surfaces.

Comply By: 9/9/2026 Originally Issued On: 9/9/2026

Food & Beverage General Comment

HRD inspection conducted with nurse evaluator Ashley Crews. Inspection report reviewed on site with King Dickson.

Domestic kitchen consists of Vinyl flooring, painted gypsum walls, wooden hollow-base cabinets, laminate counters, and domestic equipment.

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 Rochester District Office inspection report number F8044261336 from 9/9/2026



King Dickson
RN

Michael DeMars, RS
Public Health Sanitarian 3
michael.demars@state.mn.us



Rochester District Office
Minnesota Department of Health
3425 40th Ave NW, Suite 115
Rochester, MN 55901

Temperature Observations/Recordings

Page: 1

Establishment Info

CHAMPIONS VILLAGE II LLC
Brooklyn Park
County/Group: Hennepin County

Inspection Info

Report Number: F8044261336
Inspection Type: Full
Date: 9/9/2026
Time: 10:27:16 AM

Food Temperature: **Product/Item/Unit:** Sliced deli meats; **Temperature Process:** Cold-Holding

Location: Refrigerator at 40.1 Degrees F.

Comment:

Violation Issued?: No

Equipment Temperature: **Product/Item/Unit:** ; **Temperature Process:** Cold-Holding

Location: Refrigerator at 39.0 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: **Product/Item/Unit:** Ground beef; **Temperature Process:** Cooking

Location: Stove at 188.5 Degrees F.

Comment:

Violation Issued?: No



Rochester District Office
Minnesota Department of Health
3425 40th Ave NW, Suite 115
Rochester, MN 55901

Sanitizer Observations/Recordings

Page: 1

Establishment Info	Inspection Info
CHAMPIONS VILLAGE II LLC	Report Number: F8044261336
Brooklyn Park	Inspection Type: Full
County/Group: Hennepin County	Date: 9/9/2026
	Time: 10:27:16 AM

Sanitizing Equipment: Product: Hot Water; **Sanitizing Process:** Dish Machine
Location: Kitchen **Equal To** 160.0 Degrees F.
Comment:
Violation Issued?: No

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL41545001	Date: September 9, 2026
Facility Name: Champions Village II LLC	
Facility Address: 8001 82 nd Avenue North, Brooklyn Park, MN 55445	

☒ **TAG IDENTIFICATION: 0790**

SCOPE/ SEVERITY: Level 2; Isolated

TIME PERIOD OF CORRECTION: Seven (7) days

1. Portable fire extinguishers installed and maintained to MN State Fire Code. [Minn. Stat. 144G.45 subd.2]

Comments: The portable fire extinguisher in the kitchen was mounted on the wall with the top of the extinguisher measuring 75 inches above the floor. Fire extinguishers shall be installed so that the top of the extinguisher is no more than sixty (60) inches above the floor.

☒ **TAG IDENTIFICATION: 0800**

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Seven (7) days

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

Comments:

- The main water line for the building had been turned off as there was a leak in the plumbing system that had directly affected unoccupied resident bedroom three and occupied resident bedroom four in the basement. The licensee was actively working on the repairs while the surveyor was onsite.
- There was water damage on the ceiling in the corner of the storage closet across from the main entrance door. The licensee stated they were unsure what caused the damage and indicated it was not related to the plumbing system leak currently affecting the basement.
- There was a security system with an alarm panel and sensors installed in the building. The licensee stated this was an old system installed by a previous owner, was no longer functional, and would be removed.

- One piece of trim was noted as loose on the stairs leading from the main entrance to the upper floor level, creating a trip/fall hazard.
- There was a small hole in the closet door in occupied resident bedroom four.

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 2; Pattern

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 employee actions to be taken in the event of a fire or similar emergency. [Minn. Stat. 144G.45 subd.2]

Comments: The licensee failed to maintain the fire safety and evacuation plan (FSEP) with site specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout. The emergency evacuation floor plan for the basement directed employees to a fire extinguisher outside the laundry/utility room and a fire extinguisher was not installed in this location.

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

Comments: The individualized evacuation procedures for R1 included an exit route through the attached garage. Emergency exits are required to lead directly to the exterior of the building and not through a higher hazard room.

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

Comments: The surveyor requested records for evacuation drills completed between April and September 2026, from the licensee. Record review of the provided fire drill reports indicated one fire drill had been completed on May 4, 2026. The licensee failed to meet the evacuation drill frequency as required by statute.