



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

August 12, 2025

Licensee

Agape Home Health Care LLC
7516 67th Aveue North
Brooklyn Park, MN 55428

RE: Project Number(s) SL40327015

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 June 13, 2025, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

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

STATE CORRECTION ORDERS

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

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 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this survey:

St - 0 - 0780 - 144g.45 Subd. 2 (a) (1) - Fire Protection And Physical Environment - \$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. 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,

A handwritten signature in black ink, appearing to read "Casey DeVries". The signature is written in a cursive, flowing style.

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

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40327	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/13/2025
NAME OF PROVIDER OR SUPPLIER AGAPE HOME HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 7516 67TH AVEUE NORTH BROOKLYN PARK, MN 55428		
(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: SL40327015-0 On June 9, 2025, through June 13, 2025, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were two residents, both received services under the Provisional Assisted Living license.		0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
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		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 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 allowed provided the facility keeps them clean	0 480			

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0 480	Continued From page 2 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) 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 June 15, 2025, 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			

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0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post the required information related to the grievance procedure and reporting contact information for the Office of Health Facility Complaints (OHFC). 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 of the residents). The findings include:	0 550			

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0 550	Continued From page 4 On June 9, 2025, at 11:00 a.m., during a facility tour, the surveyor observed contact information for the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, and Minnesota Adult Abuse Reporting Center, posted on the wall in the living room. The surveyor observed the licensee lacked the contact information for: - OHFC. On June 9, 2025, at 11:08 a.m., licensed assisted living director (LALD)-D stated they were not aware of the requirement to post OHFC's contact information. LALD-D stated, "I have not been asked about it before." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550			
0 650 SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance	0 650			

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0 650	Continued From page 5 reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records included all required content for two of two employees (unlicensed personnel/owner (ULP/O)-A, ULP/O-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP/O-A ULP/O-A was hired on September 20, 2024, to provide direct care to residents. ULP/O-A's employee record lacked the following - job description; and - training and competency evaluation record. ULP/O-B ULP/O-B was hired on September 20, 2024, to provide direct care to residents.	0 650			

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0 650	Continued From page 6 ULP/O-B's employee record lacked the following - job description; and - training and competency evaluation record. On June 9, 2025, at 1:38 p.m., clinical nurse supervisor (CNS)-C stated they had only done medication competency for ULPs since they started working for the licensee, on January 21, 2025. On June 9, 2025, at 1:50 p.m., CNS-C stated they were not aware the ULPs were missing skills competency evaluations. On June 9, 2025, at 1:54 p.m., ULP/O-A stated the previous CNS, who was the licensee's current on call RN, did the evaluation before the ULPs started giving services to residents, and stated the previous CNS had the record for all employees with them. On June 10, 2025, at 8:24 a.m., ULP/O-A provided the surveyor with training and competency evaluation records for all ULPs and stated the previous nurse brought the records to the facility. On June 10, 2025, at 12:43 p.m., licensed assisted living director (LALD)-D stated the job description should be kept in the employee record for the above listed employees and stated it was an oversight. The licensee's Personnel Records policy dated October 17, 2022, read "1. A personnel record will be started for each staff member upon hire. 2. At a minimum, all documents related to the	0 650			

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0 650	Continued From page 7 following are kept in the personnel record, as applicable to job requirements o Evidence of current professional licensure, registration or certification o Results of background studies o Records of annual training and infection control training o Documentation of orientation o Documentation of supervision, as applicable o Performance reviews o Competency evaluations o Signed job description o Documentation of annual performance reviews identifying areas of improvement needed and training needs 3. A job description is maintained that includes qualifications, responsibilities and identification of supervisors for each job classification 4. Each personnel record shall be maintained for at least three years after an employee, volunteer or contractor ceases to be employed by or under contract with [the licensee's name]. The Director/Owner will arrange for safe storage in the event that the agency is closed. 5. Results of required health screening and medical examinations will be maintained in a separate, private file." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650			
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current	0 660			

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0 660	Continued From page 8 tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included a two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test, was completed within 90 days before hire for two of two employees (unlicensed personnel/owner (ULP/O)-A, ULP/O-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP/O-A	0 660			

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0 660	Continued From page 9 ULP/O-A was hired on September 20, 2024, to provide direct care to residents. ULP/O-A's employee record contained a negative chest x ray result for current TB dated June 19, 2023. The chest x ray result indicated ULP/O-A had a positive TB gold (a blood test used for the diagnosis of infection with Mycobacterium tuberculosis complex organisms (M. tuberculosis, M. bovis, M. africanum). It is used as an alternative to tuberculin skin testing for latent tuberculosis (TB)) but did not include the date the TB gold test was conducted or read. ULP/O-A's employee record did not include the TB gold result. ULP/O-A's employee record lacked baseline TB symptom screening, a completed health history, and TST or other evidence of TB screening such as a blood test, was completed within 90 days before hire. ULP/O-B ULP/O-B was hired on September 20, 2024, to provide direct care to residents. ULP/O-B's employee record contained a negative chest x ray result for active TB dated June 5, 2023. The chest x ray result indicated ULP/O-B had a positive TB skin test but did not include the date the TB skin test was conducted or read. ULP/O-B's employee record did not include the TB skin test result. ULP/O-B's employee record lacked baseline TB symptom screening, a completed health history, and TST or other evidence of TB screening such as a blood test, was completed within 90 days before hire	0 660			

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0 660	Continued From page 10 On June 10, 2025, at 9:00 a.m., clinical nurse supervisor (CNS)-C stated there was no record of TB screening for any employee other than chest X-ray. CNS-C was not aware of the TB screening requirement. The CDC Tuberculosis Screening, Testing, and Treatment of U.S. Health Care Personnel dated May 17, 2019, indicated all health personnel should have a baseline screening and an individual risk assessment, which is necessary for interpreting any test result. The Minnesota Department of Health document titled Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, indicated baseline TB screening is required for all health care workers. Baseline TB screening consists of three components: 1. Assessing for current symptoms of active TB disease, 2. Assessing TB history, and 3. Testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step TST or single TB blood test (IGRA). An employee may begin working with patients after a negative TB symptom screen (i.e., no symptoms of active TB disease) and a negative IGRA or TST (i.e., first step) dated within 90 days before hire. The second TST may be performed after the HCW starts working with patients. The licensee's Tuberculosis Screening/Prevention policy dated October 17, 2022, indicated the licensee will observe the recommended precautions related to TB prevention as identified by the Centers for Disease Control and Prevention and the	0 660			

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0 660	Continued From page 11 Minnesota Department of Health. The precautions include, risk assessment, TB screening and staff education. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced	0 680			

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0 680	Continued From page 12 by: Based on interview and record review, the licensee failed to develop a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all residents receiving services under the assisted living license. The licensee also failed to post the plan in prominent area. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's Assisted Living Emergency Preparedness Manual revised July 2021, lacked evidence of the following required content: - EPP reviewed and updated annually; - quarterly review of missing resident; - hazard vulnerability assessment; - emergency program patient population; - policies and procedures including evacuation; - policies and procedure for volunteers; - development of communication plan; - names and contact information; - sharing information on occupancy and needs; - emergency prep training program; - long term care family notifications; - roles under a wavier declared by secretary; and - emergency preparedness testing requirements. POSTING	0 680			

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0 680	Continued From page 13 On June 9, 2025, at 11:00 a.m., during a facility tour the surveyor observed the EPP was not posted in prominent area. On June 10, 2025, at 9:58 a.m., unlicensed personnel/owner (ULP/O)-A stated the EPP was in a locked office. ULP/O-A stated licensed assisted living director (LALD)-D was responsible for the EPP. ULP/O-A also stated they did not know why the EPP was incomplete. On June 10, 2025, at 9:59 a.m., clinical nurse supervisor (CNS)-C stated they were not aware of the requirement to review the missing resident policy quarterly. The missing resident policy was dated October 17, 2022, and there was no evidence the policy was reviewed or any evidence of missing resident drills. On June 10, 2025, at 10:30 a.m., LALD-D stated they were aware there were some documents missing from the EPP and stated the EPP should be complete and they were working on it. LALD-D stated the EPP was in locked office but there was some contact information posted on the board for who to call during an emergency and the facility was staffed 24/7. LALD-D further stated that they agreed the EPP was supposed to be posted in a prominent area and they would make it available. The licensee's Emergency Preparedness policy dated October 17, 2022, indicated the licensee would have an identified plan in place to assure the safety and well-being of resident and staff during periods of an emergency or disaster that disrupts services. The licensee's Missing Resident policy dated October 17, 2022, indicated the missing resident procedure will be reviewed by the Director and	0 680			

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0 680	Continued From page 14 Clinical Nurse Supervisor at least quarterly. Changes to the plan will be documented. 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 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	0 780			

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0 780	Continued From page 15 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 failed to provide smoke alarms that functioned and were interconnected so that the actuation of one alarm caused all alarms in the dwelling unit to actuate. 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 June 12, 2025, from 10:00 a.m. to 11:30 a.m., the surveyor toured the facility with unlicensed personnel/owner (ULP/O)-A and unlicensed personnel/owner (ULP/O)-B. The surveyor asked ULP/O-A to initiate a test of the smoke alarms throughout the home. Upon testing, it was found that the smoke alarms in the facility were not interconnected. The facility had hardwired (receiving power from the building electrical system) smoke alarms	0 780			

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0 780	Continued From page 16 installed in the basement living room and basement bedroom 4 and 5. The hardwired smoke alarms were not interconnected with the battery operated smoke alarms in the facility. All smoke alarms in the facility must be interconnected. Existing hardwired smoke alarms are required to be maintained as installed previously and interconnected to additional battery-operated alarms so activation of one alarm activates all alarms throughout the facility. The hardwired smoke alarm in bedroom 4 was unplugged at the time of survey and was not working. There was no smoke alarm installed outside the sleeping area of bedrooms 1-3. These deficient conditions were visually verified by ULP/O-A and ULP/O-B accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780			
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement,	0 810			

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0 810	Continued From page 17 evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content, to provide the required training, and to conduct evacuation 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	0 810			

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0 810	Continued From page 18 the residents). The findings include: On June 12, 2025, unlicensed personnel/owner (ULP/O)-A and unlicensed personnel/owner (ULP/O)-B provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP, Fire Safety, dated October 17, 2022, failed to include the following: The FSEP 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 provided FSEP was from a third-party provider and had not been updated to the specific facility. The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. On June 12, 2025, at 12:30 p.m., ULP/O-A stated they didn't understand that the third-party policy they were using was not correct. The policy reviewed was an unedited policy from a third-party provider that was not specific to the facility. TRAINING: The licensee failed to provide evacuation training to residents at least once per year. ULP/O-A lacked documentation showing any training was offered or training was scheduled for a future date	0 810			

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0 810	Continued From page 19 for residents on the fire safety and evacuation plan. The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. The licensee's training records, Fire Emergency, dated March 15, 2025, indicated staff were trained one time since the licensee started providing service on September 20, 2024. No other training documentation was provided. On June 12, 2025, at 12:30 p.m., ULP/O-A stated they understood the requirements for training residents and staff and would implement a training program that was compliant with statute requirements. DRILLS: The licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. Record review of licensee's evacuation drill log, Fire Drill Form, undated, indicated evacuation drills were conducted on October 2, 2024 and March 15, 2025. No other documentation was provided. On June 12, 2025, at 12:30 p.m., ULP/O-A stated there were no additional documented drills for the facility. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility.	0 910			

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0 910	Continued From page 20 (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for two of two residents (R1, R2). 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: R1 R1 was admitted to the licensee on September 20, 2024, and received assisted living services. R1's Assisted Living Contract signed on September 20, 2024, lacked the following required content: - in a conspicuous place and manner on the contract the Health Facility Identification number (HFID#) of the licensee.	0 910			

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0 910	Continued From page 21 R2 R2 was admitted to the licensee on May 21, 2025, and received assisted living services. R2's Assisted Living Contract signed on May 21, 2025, lacked the following required content: - in a conspicuous place and manner on the contract the HFID# of the licensee. On June 10, 2025, at 12:15 p.m., licensed assisted living director (LALD)-D stated they did not know the licensee's HFID was one of the required contents of the assisted living contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 910			
0 950 SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney	0 950			

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0 950	Continued From page 22 ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide the required verbatim notice on its own separate page for two of two residents (R1, R2). 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 the potential to affect a large portion or all the residents). The findings include: R1 R1's Assisted Living Contract was signed on September 20, 2024. The licensee's Assisted Living Contract form utilized for R1, included the required verbatim "right to designate a representative for certain purposes" notice on the first paragraph, page six of the assisted living contract followed by other	0 950			

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0 950	Continued From page 23 contents of the contract. R1's assisted living contract failed to provide the required verbatim notice on a document separate from the contract. R1's assisted living contract also lacked a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. R2 R2's Assisted Living Contract was signed on May 21, 2025. The licensee's Assisted Living Contract form utilized for R2, included the required verbatim "right to designate a representative for certain purposes" notice on the first paragraph, page six of the assisted living contract followed by other contents of the contract. R2's assisted living contract failed to provide the required verbatim notice on a document separate from the contract. On June 10, 2025, at 12:21 p.m., licensed assisted living director (LALD)-D stated they were not aware of the requirement to include "right to designate a representative for certain purposes" notice in the assisted living contract on a document separate from the contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 950			
01610 SS=F	144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an	01610			

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01610	Continued From page 24 initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to conduct a nursing assessment by a registered nurse (RN) of the physical and cognitive needs prior to the date on which a prospective resident executed a contract with a facility or the date on which a prospective resident moved in, whichever was earlier, for one of two 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) 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: R2 was admitted to the licensee on May 21,	01610			

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01610	Continued From page 25 2025, and received assisted living services. R2's diagnosis included diabetic, bipolar disorder, hallucination, delusions, schizophrenia, anxiety, and depression. R2's unsigned and undated service plan generated during the survey with effective date of June 10, 2025, indicated R2 received services for medication administration, blood glucose, and blood pressure checks. R2's handwritten medication administration record (MAR) dated May 21, 2025, through May 31, 2025, indicated R2 started receiving medication administration services on May 21, 2025. R2's record included an admission assessment completed on May 27, 2025. The admission assessment completed on May 27, 2025, was late by six days. On June 10, 2025, at 10:42 a.m., clinical nurse supervisor (CNS)-C stated R2 was either sleeping or out of the facility when they came in to do the admission assessment. CNS-C stated they did write a progress notes on the days they came in to do this assessment. R2's progress notes dated May 22, 2025, indicated CNS-C stopped by to do the admission assessment on May 22, 2025 (on the next day after R2's admission date), but R2 was absent from home. On June 10, 2025, at 10:47 a.m., licensed assisted living director (LALD)-D stated the admission assessment had to be completed on the day of admission. LALD-D stated CNS-C was not at the licensee's facility when R2 was	01610			

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NAME OF PROVIDER OR SUPPLIER AGAPE HOME HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 7516 67TH AVEUE NORTH BROOKLYN PARK, MN 55428		
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01610	Continued From page 26 admitted and stated they (LALD-D) did R2's intake and completed the assisted living contract form with R2. On June 10, 2025, at 10:54 a.m., CNS-C stated their understanding was that they had couple of days to complete the admission assessment after admitting residents, if they were unable to complete the assessment upon admission. The licensee's Assessment and Reassessment Policy dated October 17, 2022, indicated the initial RN assessment shall be completed prior to the date on which the prospective resident executes a contract or on the date on which the prospective resident moves in, whichever is earlier. If necessary, based on geography or urgent or unexpected circumstances, the assessment may be conducted via telecommunications based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01610			
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident	01620			

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01620	Continued From page 27 executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective	01620			

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01620	Continued From page 28 resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident assessment and reassessment, no more than 14 calendar days after initiation of services for one of two 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 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: R2 was admitted to the licensee on May 21, 2025, and received assisted living services. R2's diagnosis included diabetic, bipolar disorder, hallucination, delusions, schizophrenia, anxiety, and depression. R2's unsigned and undated service plan generated during the survey with effective date of June 10, 2025, indicated R2 received services for medication administration, blood glucose, and blood pressure checks. R2's handwritten medication administration record (MAR) dated May 21, 2025, through May 31, 2025, indicated R2 started receiving medication administration services on May 21, 2025.	01620			

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01620	Continued From page 29 R2's record included an admission assessment completed on May 27, 2025. The admission assessment completed on May 27, 2025, was late by six days. R2's record lacked a 14-day nursing assessment which was supposed to be completed no more than 14 calendar days after the initiation of services, which was due on June 4, 2025. On June 10, 2025, at 10:53 a.m., clinical nurse supervisor (CNS)-C stated their understanding of 14-day assessment was 14 days counted from the last assessment, which was May 27, 2025, and stated the 14-day assessment was due today (June 10, 2025). The licensee's Assessment and Reassessment policy dated October 17, 2022, indicated the RN will provide a reassessment visit to update the evaluation of the resident and services no more than 14 calendar days after initiation of services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620			
01630 SS=F	144G.70 Subd. 3 Temporary service plan When a facility initiates services and the individualized assessment required in subdivision 2 has not been completed, the facility must complete a temporary plan and agreement with the resident for services. A temporary service plan shall not be effective for more than 72 hours. This MN Requirement is not met as evidenced	01630			

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01630	Continued From page 30 by: Based on interview and record review, the licensee failed to complete a temporary service plan agreement when services were initiated without completing the required individualized assessments for one of two 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) 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: R2 was admitted to the licensee on May 21, 2025, and received assisted living services. R2's diagnosis included diabetic, bipolar disorder, hallucination, delusions, schizophrenia, anxiety, and depression. R2's record included an admission assessment completed on May 27, 2025. The admission assessment completed on May 27, 2025, was late by six days. R2's record did not include a temporary service plan or a service plan. Clinical nurse supervisor (CNS)-C provided the surveyor with a service plan generated on June 10, 2025, (during the survey). R2's unsigned and undated service plan generated during the survey with effective date of June 10, 2025, indicated R2 received services for medication administration, blood glucose, and blood pressure checks.	01630			

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01630	Continued From page 31 R2's handwritten medication administration record (MAR) dated May 21, 2025, through May 31, 2025, indicated R2 started receiving medication administration services on May 21, 2025. On June 10, 2025, at 7:45 a.m., the surveyor observed unlicensed personnel/owner (ULP/O)-B provide medication administration, blood pressure checks and blood glucose supervision to R2. R2's record lacked a temporary service plan not to exceed 72 hours, when services were initiated prior to completing individualized assessments. On June 10, 2024, at 10:32 a.m., licensed assisted living director (LALD)-D stated the actual service plan for R2 was not completed because they did not get the community support plan (CSP) form from the waived services case manager. LALD-D further stated they did not want to make assumptions on the dollar amount to complete the service plan and stated they were waiting for the CSP to get the exact dollar amount. On June 10, 2025, at 10:57a.m., CNS-C stated there was no temporary service plan or any other service plan completed for R2 other than the service plan generated during this survey. The licensee's Service Plan policy dated October 17, 2022, read, "1. Beginning with the date assisted living services are first provided, a service plan is developed for the resident based on an agreement with the resident/responsible party and on the assessed needs identified in the comprehensive assessment.	01630			

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01630	Continued From page 32 2. The service plan will be finalized no later than 14 days after the date home care services are first provided, if not already completed. 3. The service plan must be revised, if needed, based on resident review or reassessment. 4. The initial service plan and any revisions are signed by a representative from [the licensee's name], and the resident or resident's representative, indicating agreement with the services to be provided. 5. [the licensee's name] will provide information to the resident about changes to the provider's fee for services and how to contact the Office of the Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. 6. The service plan and all revisions are entered into the resident's clinical record*, including notice of a change in a resident's fees when applicable. 7. [the licensee's name] will implement and provide all services required by the current service plan." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01630			
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date	01640			

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01640	Continued From page 33 that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure all services required by the service plan were implemented and provided for one of two residents (R1). In addition, the licensee failed to ensure a service plan was completed no later than 14-calendar days after the date that services were first provided for one of two 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 a widespread scope (when problems are pervasive or represent a systemic	01640			

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01640	Continued From page 34 failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted to the licensee on September 20, 2024. R1's diagnoses included depression and anxiety. R1's signed service plan form, dated September 20, 2024, indicated R1 received assistance with the following services: - Housekeeping-daily, home making-weekly; - Shopping; - Money management; - Assistance making appointment; - Arranging non-medical transportation; - Congregate meal preparation, breakfast; - Assistance with dressing; - Assistance with grooming; - Assistance with bathing; - Assistance with medication administration; - Verbal and visual medication reminders; - Delegated clinical monitoring; - Medication set up and monitoring; - Manage orientation issues; - Manage anxiety; - Manage repetitive behaviors; - Manage agitation; - Manage verbal aggression; and - Manage other cognitive mental health need. R1's service documentation entitled Service Recap Summary for the month of June 2025, indicated the following services: - Housekeeping - Heavy; - Appointment Reminder/ Assistance (Monday, Wednesday, Friday); - Bathing Assistance - Shower or Bath;	01640			

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01640	Continued From page 35 - Dressing; - Grooming; - Meal Assistance; - Shopping Assistance (Monday, Wednesday, Friday); - Socialization; - Transportation Assistance; - Medication Setup (Monday, Wednesday, Friday); and - Medication Reminder. R1's service documentation charting did not include the following services required by the service plan: - Money management; - Delegated clinical monitoring; - Manage orientation issues; - Manage anxiety; - Manage repetitive behaviors; - Manage agitation; - Manage verbal aggression; and - Manage other cognitive mental health need. On June 10, 2025, at 11:07 a.m., unlicensed personnel/owner (ULP/O)-A stated they assisted R1 with bathing, medication reminders, laundry, appointment reminders, community activities, meal, housekeeping. ULP/O-A also stated R1 screams at staff, gets angry, and sometimes exhibits repetitive behaviors like walking back and forth repetitively. ULP/O-A stated they manage the behaviors by redirecting and reapproaching R1. ULP/O-A stated they did not help R1 with money management. On June 10, 2025, at 11:08 a.m., clinical nurse supervisor (CNS)-C stated they did not create nor review R1's service plan. On June 10, 2025, at 11:08 a.m., licensed assisted living director (LALD)-D stated the	01640			

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01640	Continued From page 36 service plan was created based on R1's waived services community support plan (CSP). LALD-D stated part of managing money, would be the resident asking staff to go through their bank statement, however the service was not entered into Rtask (electronic medical record software). On June 10, at 11:18 a.m., the surveyor inquired how would the ULPs know to provide the services listed above that were on the service plan but not entered into Rtask such as what behaviors to look for and how to manage them. CNS-C stated it should be on Rtask. R2 R2 was admitted to the licensee on May 21, 2025, and received assisted living services. R2's diagnosis included diabetic, bipolar disorder, hallucination, delusions, schizophrenia, anxiety, and depression. R2's record did not include a service plan. CNS-C provided the surveyor with a service plan generated on June 10, 2025, (during the survey). R2's unsigned and undated service plan generated during the survey with effective date of June 10, 2025, indicated R2 received services for medication administration, blood glucose, and blood pressure checks. R2's handwritten medication administration record (MAR) dated May 21, 2025, through May 31, 2025, indicated R2 started receiving medication administration services on May 21, 2025. On June 10, 2025, at 7:45 a.m., the surveyor observed ULP/O-B provide medication administration, blood pressure checks and blood	01640			

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01640	Continued From page 37 glucose check supervision to R2. R2's record lacked a service plan which was supposed to be finalized no later than 14-calander days after initiation of services. On June 10, 2024, at 10:32 a.m., licensed assisted living director (LALD)-D stated the actual service plan for R2 was not completed because they did not get the CSP form from the waived services case manager. LALD-D further stated they did not want to make assumptions on the dollar amount to complete the service plan and stated they were waiting for the CSP to get the exact dollar amount. On June 10, 2025, at 10:57a.m., CNS-C stated there was no temporary service plan or any other service plan completed for R2 other than the service plan generated during the survey. The licensee's Service Plan policy dated October 17, 2022, read, "1. Beginning with the date assisted living services are first provided, a service plan is developed for the resident based on an agreement with the resident/responsible party and on the assessed needs identified in the comprehensive assessment. 2. The service plan will be finalized no later than 14 days after the date home care services are first provided, if not already completed. 3. The service plan must be revised, if needed, based on resident review or reassessment. 4. The initial service plan and any revisions are signed by a representative from [the licensee's name], and the resident or resident's	01640			

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01640	Continued From page 38 representative, indicating agreement with the services to be provided. 5. [the licensee's name] will provide information to the resident about changes to the provider's fee for services and how to contact the Office of the Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. 6. The service plan and all revisions are entered into the resident's clinical record*, including notice of a change in a resident's fees when applicable. 7. [the licensee's name] will implement and provide all services required by the current service plan." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640			
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	01730			

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01730	Continued From page 39 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 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 ensure the registered nurse (RN) completed an assessment prior to providing medication management services to determine what medication management services will be provided and how	01730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40327	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/13/2025
NAME OF PROVIDER OR SUPPLIER AGAPE HOME HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 7516 67TH AVEUE NORTH BROOKLYN PARK, MN 55428		
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01730	Continued From page 40 the services will be provided for one of two 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 May 21, 2025, and received assisted living services. R2's diagnosis included diabetic, bipolar disorder, hallucination, delusions, schizophrenia, anxiety, and depression. R2's record did not include a service plan. Clinical nurse supervisor (CNS)-C provided the surveyor with a service plan generated on June 10, 2025, (during the survey). R2's unsigned and undated service plan generated during the survey with effective date of June 10, 2025, indicated R2 received services for medication administration, blood glucose, and blood pressure checks. R2's handwritten medication administration record (MAR) dated May 21, 2025, through May 31, 2025, indicated R2 started receiving medication administration services on May 21, 2025. On June 10, 2025, at 7:45 a.m., the surveyor observed unlicensed personnel/owner (ULP/O)-B	01730			

Minnesota Department of Health

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01730	Continued From page 41 provide medication administration, blood pressure checks, and blood glucose check supervision to R2. R2's medication management plan, dated May 27, 2025, indicated R2 required full medication management and setup. R2's medication management plan was completed six days after medication management services were initiated. R2's electronic medication administration record (eMAR) for the month of June 2025, indicated R2 received the following medications: - meloxicam 50 milligrams (mg), take one tablet by mouth daily; - sertraline 50mg, take 1 tablet by mouth daily; - aspirin 81mg, take one tablet by mouth daily; - atorvastatin 20mg, take one tablet by mouth daily; - Jardiance 25mg, take one tablet by mouth daily; - metformin ER 500mg, take four tablets by mouth daily; - valsartan 320mg, take one tablet by mouth daily; - carvedilol 25mg, take one tablet by mouth twice daily; - nifedipine ER 90mg, take one tablet by mouth at bedtime; - risperidone 3mg, take one tablet by mouth daily at bedtime; - albuterol sulfate inhalation solution, 0.083% inhale 3ml (2.5mg) by nebulization route every 4 hours as needed for wheezing/shortness of breath; - acetaminophen (no dosage indicated) take three tablets two times daily as needed; - docusate sodium (no dosage indicated), take one capsule by mouth two times a day as needed; and - guaifenesin, take 10ml (200mg) by mouth every 4 hours as needed for cough.	01730			

Minnesota Department of Health

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01730	Continued From page 42 On June 11, 2025, at 11:05 a.m., CNS-C stated R2 started receiving medication administration services on the 21st of May 2025, at bedtime. CNS-C stated the first day they were able to sit down with the R2 and do a face-to-face assessment for medication management was on the 27th of May 2025. R2's record included Individualized medication management plan dated May 27, 2025. The licensee's Service Plan for Medication Management policy indicated the licensee will prepare and document a Medication Management Plan as part of the Service Plan for each resident receiving medication management services. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730			
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be	01790			

Minnesota Department of Health

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01790	Continued From page 43 labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and	01790			

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01790	Continued From page 44 (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) documented training and/or competencies for two of two staff (unlicensed personnel/owner (ULP/O)-A, ULP/O-B) who would provide medications for residents for unplanned time away from home when a licensed nurse was not available. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP/O-A ULP/O-A was hired on September 20, 2024, to provide direct care to residents. ULP/O-B ULP/O-B was hired on September 20, 2024, to provide direct care to residents. ULP/O-A and ULP/O-B's employee records lacked evidence of training and competency in preparing medications for unplanned times away	01790			

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01790	Continued From page 45 when the licensed nurse is not available. On June 11, 2025, at 10:55 a.m., clinical nurse supervisor (CNS)-C stated they would come in and prepare medications for a resident who was going on a leave. CNS-C stated if the leave was unplanned, they would give instruction to the ULPs on what to do, over the phone. CNS-C stated they had not trained any ULP on how to prepare medication for unplanned times away, as they just started providing medication management services recently. On June 11, 2025, at 10:58 a.m., ULP/O-A stated they were not trained on how to prepare medication for unplanned times away when the licensed nurse is not available. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days		01790		
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain current medication orders for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or		01820		

Minnesota Department of Health

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01820	Continued From page 46 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 of the residents). The findings include: R2 was admitted to the licensee on May 21, 2025, and received assisted living services. R2's diagnosis included diabetic, bipolar disorder, hallucination, delusions, schizophrenia, anxiety and depression. R2's unsigned and undated service plan indicated R2 received services for medication administration, blood glucose, and blood pressure checks. R2's record included admission assessment completed on May 27, 2025. The admission assessment completed on May 27, 2025, was late by six days. R2's electronic medication administration record (eMAR) for the month of June 2025, indicated R2 received the following medications: - meloxicam 50 milligrams (mg), take one tablet by mouth daily; - sertraline 50 mg, take 1 tablet by mouth daily; - aspirin 81mg, take one tablet by mouth daily; - atorvastatin 20mg, take one tablet by mouth daily; - Jardiance 25mg, take one tablet by mouth daily; - metformin ER 500mg, take four tablets by mouth daily; - valsartan 320mg, take one tablet by mouth daily; - carvedilol 25mg, take one tablet by mouth twice	01820			

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01820	Continued From page 47 daily; - nifedipine ER 90mg, take one tablet by mouth at bedtime; - risperidone 3mg, take one tablet by mouth daily at bedtime; - albuterol sulfate inhalation solution, 0.083% Inhale 3ml (2.5mg) by nebulization route every 4 hours as needed for wheezing/shortness of breath; - acetaminophen (no dosage indicated) take three tablets two times daily as needed - docusate sodium (no dosage indicated), take one capsule by mouth two times a day as needed; and - guaifenesin, take 10ml (200mg) by mouth every 4 hours as needed for cough. R2's records lacked signed physician's orders for medications. On June 10, 2025, at 11:37 a.m., clinical nurse supervisor (CNS)-C stated they did not have physician's orders for R2's medication because R2 did not have primary care provider. CNS-C stated they contacted R2's clinic to get the orders but the clinic did not send the orders yet. CNS-C stated they used the labels on R2's medication bottles to enter the medication orders listed above into the eMAR. The licensee's Prescriber's Orders policy dated October 17, 2022, indicated written orders from an authorized prescriber will be obtained for all medications and treatments with which the assisted living facility assists residents, including over the counter medications. Verbal orders may be accepted by a nurse who records and signs the order and then forwards it to the prescriber for signature no later than seven days after receipt of the verbal order. Medication orders will include	01820			

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01820	Continued From page 48 the name of the medication, dosage, and directions for use. The Registered Nurse is responsible for implementing medication and treatment orders or for delegating the orders to the appropriate paraprofessional. Medication and treatment orders will be renewed at least every year or when changes occur. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820			



St Cloud District Office
Minnesota Department of Health
4140 Thielman Lane, Suite 101
St Cloud, MN 56301
Phone: 651-201-4500

Food & Beverage Inspection Report

Page: 1

Establishment Info

AGAPE Home Health Care LLC
7516 67th Avenue North
Brooklyn Park, MN 55428
Hennepin County
Parcel:

Phone:

License Info

License: HFID 40327

Risk:
License:
Expires on:
CFPM: Agnes S. Baysahwala
CFPM #: 3018; Exp: 07/15/2026

Inspection Info

Report Number: F1051251035
Inspection Type: Full - Single
Date: 6/9/2025 Time: 12:35:00 PM
Duration: 30 minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 1
Total Priority 3 Orders: 0
Delivery: Emailed

New Order: 4-300 Equipment Numbers and Capacities

4-302.12B *Priority Level: Priority 2 CFP#: 36*

MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.

COMMENT:

AT THE TIME OF THE INSPECTION, THERE IS NO THIN-TIPPED THERMOMETER.

Comply By: 6/13/2025 Originally Issued On: 6/9/2025

Food & Beverage General Comment

MET WITH NURSE EVALUATOR, DEE MOSISSA.

DISCUSSED THE FOLLOWING WITH THE PERSON IN CHARGE, AGNES:

EMPLOYEE ILLNESS LOG

VOMIT CLEAN-UP PROCEDURE

HANDWASHING & GLOVE USE/DISPOSAL

THE KITCHEN HAS A NSF 184 DISHWASHER, STONE COUNTERTOPS WITH HOLLOW BASES, LAMINATE CABINETS, A SMOOTH TEXTURE CEILING, AND TILE FLOORS.

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 St Cloud District Office inspection report number F1051251035 from 6/9/2025

Agnes


Kai Yang,
Public Health Sanitarian 1
320-640-3532
kai.yang@state.mn.us



St Cloud District Office
Minnesota Department of Health
4140 Thielman Lane, Suite 101
St Cloud, MN 56301

Temperature Observations/Recordings

Page: 1

Establishment Info

AGAPE Home Health Care LLC
Brooklyn Park
County/Group: Hennepin County

Inspection Info

Report Number: F1051251035
Inspection Type: Full
Date: 6/9/2025
Time: 12:35:00 PM

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

Location: Upright Cooler at 40 Degrees F.

Comment:

Violation Issued?: No