Electronically Delivered

December 18, 2025

Licensee
Carepoint Home Inc
2517 Hayward Avenue North
Oakdale, MN 55128

RE: Project Number(s) SL39820016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on December 4, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

The correction order documentation should include the following:

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

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

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

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

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

If you have any questions, please contact me.

Sincerely,

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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39820	A. BUILDING: _____ B. WING _____	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREPOINT HOME INC	2517 HAYWARD AVENUE NORTH OAKDALE, MN 55128

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments 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: SL39820016-0 On December 1, 2025, through December 4, 2024, the Minnesota Department of Health conducted a change of ownership (CHOW) survey at the above provider. At the time of the survey, there were two resident(s); two receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag."The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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0 480	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, 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 December 1, 2025, 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 TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content 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 on January 9, 2025, and began	0 630		

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0 630	Continued From page 4 receiving assisted living services. R2's Assessment dated October 3, 2025, which included the individual abuse prevention management plan, lacked the following required content: - resident's risk to abuse other vulnerable adults. On December 2, 2025, at 11:10 a.m., clinical nurse supervisor (CNS)-C stated the IAPP was completed at admission or with a change of condition. CNS-C stated they were aware the above information was to be assessed and it was an oversight for not including that information. The licensee's 6.05 Individual Abuse Prevention Plan policy dated April 8, 2025, indicated the abuse prevention plan would include an assessment of resident's risk to abuse other vulnerable adults. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
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	0 650		

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0 650	Continued From page 5 evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance 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 the employee record contained the required content for three of three employees (unlicensed personnel (ULP-A, ULP-B, ULP-F). 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-A ULP-A was hired on December 20, 2024, to provide direct care services. ULP-A's employee file lacked documentation for the following:	0 650		

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0 650	Continued From page 6 Training: - reports of changes in the resident's condition to the supervisor designated by the assisted living provider; - basic nutrition, meal preparation, food safety, and assistance with eating; - preparation of modified diets as ordered by a licensed health professional; - awareness of commonly used health technology equipment and assistive devices; - observation, reporting, and documenting of resident status; - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel, and; - recognizing physical, emotional, cognitive, and developmental needs of the resident. Competency evaluations for the following: - appropriate and safe techniques in personal hygiene and grooming including: hair care and bathing, care of teeth, gums, and oral prosthetic devices, care and use of hearing aids, and dressing and assisting with toileting; - standby assistance techniques and how to perform them; - reading and recording temperature, pulse, and respirations of the resident; - safe transfer techniques and ambulation, and; - range of motioning and positioning. ULP-B ULP-B was hired on December 20, 2024, to provide direct care services. ULP-B's employee file lacked documentation for the following:	0 650		

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0 650	Continued From page 7 Training: - reports of changes in the resident's condition to the supervisor designated by the assisted living provider; - basic nutrition, meal preparation, food safety, and assistance with eating; - preparation of modified diets as ordered by a licensed health professional; - awareness of commonly used health technology equipment and assistive devices; - observation, reporting, and documenting of resident status; - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel, and; - recognizing physical, emotional, cognitive, and developmental needs of the resident. Competency evaluations for the following: - appropriate and safe techniques in personal hygiene and grooming including: hair care and bathing, care of teeth, gums, and oral prosthetic devices, care and use of hearing aids, and dressing and assisting with toileting; - standby assistance techniques and how to perform them; - reading and recording temperature, pulse, and respirations of the resident; - safe transfer techniques and ambulation, and; - range of motioning and positioning. ULP-F ULP-F was hired on December 20, 2024, to provide direct care services. ULP-F's employee file lacked documentation for the following: Training:	0 650		

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0 650	Continued From page 8 - reports of changes in the resident's condition to the supervisor designated by the assisted living provider; - basic nutrition, meal preparation, food safety, and assistance with eating; - preparation of modified diets as ordered by a licensed health professional; - awareness of commonly used health technology equipment and assistive devices; - observation, reporting, and documenting of resident status; - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel, and; - recognizing physical, emotional, cognitive, and developmental needs of the resident. Competency evaluations for the following: -appropriate and safe techniques in personal hygiene and grooming including: hair care and bathing, care of teeth, gums, and oral prosthetic devices, care and use of hearing aids, and dressing and assisting with toileting; -standby assistance techniques and how to perform them; -reading and recording temperature, pulse, and respirations of the resident; -safe transfer techniques and ambulation, and; -range of motioning and positioning. On December 2, 2025, at 9:24 a.m., ULP-A stated they recalled receiving training from a registered nurse (RN) that included instruction on grooming, injections, glucose check, blood pressure, standby assist, and daily grooming including brushing teeth. On December 2, 2025, at 2:21 p.m., the surveyor called ULP-B and was only able to leave a	0 650		

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0 650	Continued From page 9 voicemail. On December 2, 2025, at 2:13 p.m. ULP-F stated they provided direct care services to residents. ULP-F stated they remembered receiving training from the RN that included transfer techniques, range of motion, personal cares, and dressing. On December 2, 2025, at 11:17 a.m., clinical nurse supervisor (CNS)-C stated they were responsible for the training and competencies for staff. CNS-C stated the trainings were completed to ensure the safety of each resident, and the paperwork might have been misplaced. On December 4, 2025, at 9:50 a.m., the surveyor concluded the survey. The surveyor did not receive a return telephone call from ULP-B. The licensee's 5.02 Competency Training Evaluations policy dated August 1, 2021, indicated staff would receive training and competency evaluation in the above areas. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
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	0 680		

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0 680	Continued From page 10 emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a written emergency preparedness (EP) plan with all the required content as defined in Appendix Z. This had the potential to 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, 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 EP plan dated June 24, 2025,	0 680		

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0 680	Continued From page 11 lacked evidence of the following required content: - polices and procedures for subsistence needs for staff and patients; - policies and procedures for medical documentation; - policies and procedures for volunteers; - names and contact information names/contact information: staff, entities providing services under agreement, residents' physicians, other facilities, volunteers; - methods for sharing information; - long-term care (LTC) family notifications; - emergency preparation and testing requirements, and; - emergency prep training program. On December 3, 2025, at 9:48 a.m., assisted living director resident (ALDR)-D stated they were responsible for the EP plan. ALDR-D stated the EP plan would protect the safety of residents. ALDR-D stated they reviewed 144G statutes online and reviewed policies to ensure the EP plan was compliant when they made amendments to the EP plan from the previous owner, and it was an oversight for that information being missed. The licensee's Emergency Preparedness policy dated August 1, 2021, indicated the licensee would have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		

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0 800	Continued From page 12	0 800		
0 800 SS=A	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, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level one violation (a violation that will cause only minimal impact on the cresident and does not affect health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated December 3, 2025, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREPOINT HOME INC	2517 HAYWARD AVENUE NORTH OAKDALE, MN 55128

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	0 810		

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0 810	Continued From page 14 review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated December 3, 2025, for the specific violations related the physical environment under Minnesota Statute 144G. 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. (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	0 910		

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0 910	Continued From page 15 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 information for two of two residents (R1, R2). This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R1 R1 was admitted on June 1, 2025, and began received assisted living services. R1's signed Service Plan Addendum to Contract - Wavier dated November 24, 2025, indicated R1 received assistance with activity assistance, ambulation, appointment reminders, bathing assistance, bedmaking, dressing, grooming, housekeeping, laundry, behavior management, meal assistance, medication administration, safety checks, shopping assistance, and socialization. R1's contract lacked the following required content: - health facility identification number; - the licensee of the facility, and; - the authorized agent for the facility.	0 910		

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0 910	Continued From page 16 R2 R2 was admitted on January 9, 2025, and began receiving assisted living services. R2's signed Service Plan Addendum to Contract - Waiver dated November 24, 2025, indicated R2 received assistance with appointment reminders, bathing assistance, bedmaking, dressing, finance management, housekeeping, incontinence care, laundry, behavior management, medication administration, blood glucose, blood pressure, shopping assistance, socialization, and transportation assistance. R2's contract lacked the following required content: - health facility identification number; - the licensee of the facility, and; - the authorized agent for the facility. On December 3, 2025, at 9:48 a.m., assisted living director resident (ALDR)-D stated they reviewed the assisted living contract at the time of the change of ownership. ALDR-D stated they did not make any adjustments, updates or changes to the contract, and it was an oversight for not updating the contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 910		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or	0 970		

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0 970	Continued From page 17 should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety, or personal property of a resident for two of two residents (R1, R2). This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R1 R1 was admitted on June 1, 2025, and began receiving assisted living services. R2 R2 was admitted on January 9, 2025, and began receiving assisted living services. R1 and R2's signed contract included the following language, "We are not responsible for any damage or injury suffered by you, your property, your guests or their property that was not caused by us." On December 3, 2025, at 10:00 a.m., assisted	0 970		

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0 970	Continued From page 18 living director resident (ALDR)-D stated they were responsible for resident contracts. ALDR-D stated the contact should not contain a liability clause and it was an oversight for including that wording. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01530 SS=F	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one 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	01530		

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01530	Continued From page 19 to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure direct-care staff completed an initial two hours of mental illness and de-escalation training with 80 working hours for three of three employees (unlicensed personnel (ULP)A, ULP-B, ULP-F). 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-A ULP-A was hired on December 20, 2024, to provide direct care services.	01530		

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01530	Continued From page 20 ULP-A's employee file contained a transcript which indicated ULP-A had completed the following courses in Educare (an online computer program for training): - mental illness 1 - overview and depression 0.75 hours, and; - mental illness 3 - personality disorders, substance abuse and de-escalation 0.50 hours. ULP-B ULP-B was hired on December 20, 2024, to provide direct care services. ULP-B's employee file contained a transcript which indicated ULP-B had completed the following courses in Educare: - mental illness 1 - overview and depression 0.75 hours, and; - mental illness 3 - personality disorders, substance abuse and de-escalation 0.50 hours. ULP-F ULP-F was hired on December 20, 2024, to provide direct care services. ULP-F's employee file contained a transcript which indicated ULP-F had completed the following courses in Educare: - mental illness 1 - overview and depression 0.75 hours, and; - mental illness 3 - personality disorders, substance abuse and de-escalation 0.50 hours. On December 3, 2025, at 10:13 a.m., clinical nurse supervisor (CNS)-C stated they were responsible for the training of staff. CNS-C stated they assigned classes through Educare for staff to complete, however, they did not check to ensure the assigned classes met the statutory requirements of 2 hours. CNS-C stated that was	01530		

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01530	Continued From page 21 an oversight. The licensee's undated Notice of Dementia and Mental Illness Training policy indicated staff would complete two hours of mental illness training. 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 personnel;	01730		

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01730	Continued From page 22 (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 develop and maintain a current individualized medication management record for each resident to include all the required content 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:	01730		

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01730	Continued From page 23 R2 was admitted on January 9, 2025, and began receiving assisted living services. R2 had diagnoses of depression (persistent feeling of sadness and loss of interest) and anxiety (feeling of fear). R2's signed Service Plan Addendum to Contract - Waiver dated November 24, 2025, indicated R2 received assistance with medication administration. On December 2, 2025, at 7:25 a.m., the surveyor observed unlicensed personnel (ULP)-A administer a medication to R2. R2's Assessment dated October 3, 2025, which included the medication management plan, lacked the following required content: - identification of medication management tasks that may be delegated to unlicensed personnel. On December 2, 2025, at 11:33 a.m., clinical nurse supervisor (CNS)-C stated they were responsible for the medication management plans for residents. CNS-C stated they were aware they had to specify what tasks could be delegated to staff. CNS-C stated that information should be included and was an oversight for not including that information. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all	01880		

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01880	Continued From page 24 prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure prescription medications were stored according to the manufacturer's directions for two of two residents (R1, 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 potential to affect a large portion or all of the residents). The findings include: On December 1, 2025, at 10:41 a.m., during a facility tour, the surveyor observed a refrigerator that contained the following medications: 13 full Mounjaro injection pens, 3 full Lantus injection pens, and 1 Lantus injection pen that contained 180 units (u). There was no thermometer inside the refrigerator. On December 1, 2025, at 10:41 a.m., clinical nurse supervisor (CNS)-C stated the refrigerator temperature was not being recorded or documented, and there was no thermometer or temperature sensor to do so. CNS-C stated they were required to store medications according to the manufacturer's guidelines and staff should not	01880		

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01880	Continued From page 25 give medications if they were not stored properly. CNS-C stated that was an oversight for not tracking the refrigerator temperatures. The licensee's 7.11 Medication and Treatment policy dated April 8, 2025, indicated licensee would only follow manufacturer's storage instruction. The manufacturer's guidelines for the Mounjaro injection pen dated November 2025 recommended the medication pen should be storage in the refrigerator at 36 degrees to 46 degrees Fahrenheit. The manufacturer's guidelines for the Lantus injection pen dated May 2025 recommended the medication pen should be storage in the refrigerator at 36 degrees to 46 degrees Fahrenheit. Additionally, Lantus injections should be discarded 28 days after being removed from the refrigerator. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
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	01890		

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01890	Continued From page 26 by: Based on observation, interview, and record review, licensee failed to ensure time sensitive medications were labeled with the date opened, and the name of the resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 on January 9, 2025, and began receiving assisted living services. R2's signed Service Plan Addendum to Contract - Waiver dated November 24, 2025, indicated R2 received assistance with medication administration. On December 1, 2025, at 10:41 a.m., during a facility tour, the surveyor observed a medication refrigerator that contained the following medications: 3 full Lantus injection pens, and 1 Lantus injection pen that contained 180 units (u). There were no open dates or identifying markings on the pens. On December 1, 2025, at 2:31 p.m., unlicensed personnel (ULP)-A they were not trained to write the open date onto the insulin pen. On December 1, 2025, at 11:47 a.m., clinical nurse supervisor (CNS)-C stated staff were	01890		

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CAREPOINT HOME INC	2517 HAYWARD AVENUE NORTH OAKDALE, MN 55128

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01890	Continued From page 27 trained to write the open date on the Lantus injection pen. CNS-C stated without writing the open date on the injection pen, staff could not verify they were following the manufacturer's guidelines. CNS-C stated it was an oversight for not including the open date on the insulin pen and for not storing the injection pen in a manner that would clearly identify the correct resident. The licensee's Medication and Treatment policy dated April 8, 2025, indicated licensee would follow all manufacturer's recommendations for the storage all medications. The manufacturer's guidelines for the Lantus injection pen dated May 2025 recommended the medication pen should be storage in the refrigerator at 36 degrees to 46 degrees Fahrenheit. Additionally, Lantus injections should be discarded 28 days after being removed from the refrigerator. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

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

Food & Beverage Inspection Report

Establishment Info

Carepoint Home Inc
2517 Hayward Ave N
Oakdale, MN 55128
Washington County
Parcel:

Phone: 7024265892

License Info

License: 0043391

Risk:
License: -1
Expires on: 12/31/2024
CFPM: Nashad Mahamoud
CFPM #: 58118; Exp: 1/23/2028

Inspection Info

Report Number: F1031251200
Inspection Type: Full - Single
Date: 12/1/2025 Time: 11am
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 1
Total Priority 2 Orders: 3
Total Priority 3 Orders: 1
Delivery: Emailed

New Order: 4-100 Equipment Construction Materials
4-101.11BCDE *Priority Level: Priority 3 CFP#: 47*
MN Rule 4626.0450BCDE Remove all multi-use equipment, utensils, and food storage containers that are not durable, corrosion-resistant, nonabsorbent, smooth, easily cleanable, resistant to pitting, chipping, scratching or not able to withstand repeated warewashing.
COMMENT:
CUTTING BOARD IS CRACKED/DAMAGED ON BOTH SIDES.
DISCONTINUE USE OF CUTTING BOARD AND PURCHASE NEW.
Comply By: 12/4/2025 Originally Issued On: 12/1/2025

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:
ESTABLISHMENT DOES NOT HAVE A THIN PROBE THERMOMETER.

Comply By: 12/4/2025 Originally Issued On: 12/1/2025

New Order: 4-300 Equipment Numbers and Capacities
4-302.13B *Priority Level: Priority 2 CFP#: 48*
MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.
COMMENT:
IRREVERSIBLE MEASURING DEVICE IS ON SITE, BUT DOES NOT WORK.
PROVIDE NEW IRREVERSIBLE MEASURING AND MEASURE UTENSIL TEMPERATURE (160F REQUIRED) AT REGULAR INTERVALS.
Comply By: 12/11/2025 Originally Issued On: 12/1/2025

New Order: 6-300 Physical Facility Numbers and Capacities
6-301.12 *Priority Level: Priority 2 CFP#: 10*
MN Rule 4626.1445 Provide and maintain a supply of individual disposable towels, a continuous towel system, a heated-air hand drying device, or an approved ambient air temperature hand drying device at each handwashing sink or group of adjacent handwashing sinks.
COMMENT:
BATHROOM HANDWASH STATION MISSING PAPER TOWELS.
HAD STAFF RESTOCK PAPER TOWELS.
RECOMMEND INSTALLING PAPER TOWEL MOUNT.
Comply By: Complied On Site Originally Issued On: 12/1/2025

! **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:
CHLORINE SANI SPRAY MEASURED > 200PPM.
SANI SPRAY WAS REMEADE TO = 200PPM.
DISCUSSED IMPORTANCE OF MAKING SANI SPRAY AT REQUIRED CONCENTRATION.

Comply By: Complied On Site Originally Issued On: 12/1/2025

Food & Beverage General Comment

Nurse Evaluator on site: Keith Langley

All violations discussed with PIC during the inspection.

NOTES:

- Establishment has a residential kitchen (4626.0506(G)(2)) Same-day service only. No saving and reheating of foods or preparation of foods the day prior to eating. Any remaining food from meals to be removed/discarded at end of day.

- Staff must prepare sanitizer bucket or squirt bottle. Check concentration with test strips (50-200ppm Chlorine) when preparing solution.

- Establishment does not have pasteurized eggs and does not prepare eggs for consumption under 145F. Purchase pasteurized eggs if intending to serve eggs undercooked.

- Make sure to datemark any prepared cold items that are kept in refrigerator.

- Employee food needs to be labeled and separated from residents' food.

- Cutting boards should be utilized as food contact surfaces and not counters or plates.

- Establishment needs to check dish washer utensil temperature weekly (160F required). If utensil temp not reaching 160F, use washer to wash/rinse and sink basin with sanitizer solution to sanitize dishes then air dry, as discussed during inspection.

- 2-Comp sink has left basin designated for handwashing and the right basin for product washing/prep sink.

- When cooking/preparing food, make sure to use a thin-probe thermometer to check temperatures.

NOTE: Downstairs kitchen is not used by staff. Contact inspector prior to using kitchen.

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

I acknowledge receipt of the Metro District Office inspection report number F1031251200 from 12/1/2025

Nashad Mahamoud
Kitchen Manager

Chris Foster, REHS/RS
Public Health Sanitarian 3
651-201-4728
chris.j.foster@state.mn.us

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

Temperature Observations/Recordings

Establishment Info

Carepoint Home Inc
Oakdale
County/Group: Washington County

Inspection Info

Report Number: F1031251200
Inspection Type: Full
Date: 12/1/2025
Time: 11am

Food Temperature: Product/Item/Unit: Strawberries**; Temperature Process:** Cold-Holding
Location: Refrigerator at 37 Degrees F.
Comment:
Violation Issued?: No

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

Sanitizer Observations/Recordings

Establishment Info

Carepoint Home Inc
Oakdale
County/Group: Washington County

Inspection Info

Report Number: F1031251200
Inspection Type: Full
Date: 12/1/2025
Time: 11am

Sanitizing Chemical: **Product:** Chlorine**; Sanitizing Process:** Spray Bottle
Location: Kitchen **Greater Than** 200 PPM
Comment:
Violation Issued?: Yes

Sanitizing Chemical: **Product:** Chlorine**; Sanitizing Process:** Spray Bottle
Location: Kitchen **Equal To** 200 PPM
Comment:
Violation Issued?: No

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

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL39820016	**Date:** 12/3/2025
Facility Name: Carepoint Home Inc.	
Facility Address: 2517 Hayward Ave N	

☒ **TAG IDENTIFICATION: 0800**

SCOPE/ SEVERITY: Level 1; Isolated **TIME PERIOD OF CORRECTION:** Seven (7) days

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

   Comments: A metal rod or wire was protruding from the driveway. The assisted living director in residency stated that the metal object had appeared recently after the driveway was plowed and that staff has been unable to remove it.

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Twenty One (21) days

1. Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. [Minn. Stat. 144G.45 subd.2]

   Comments: No record of employee trainings were provided and could not be located in the fire safety plan during record review. Assisted living director in training indicated that staff trainings are not recorded.

2. 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. [Minn. Stat. 144G.45 subd.2]

Comments: No record of resident trainings were provided and could not be located in the fire safety plan during record review. Assisted living director in training indicated that resident trainings are not recorded.