



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

August 5, 2025

Licensee

Care Partners Homecare LLC
7517 Edgewood Avenue North
Brooklyn Park, MN 55428

RE: Project Number(s) SL39367016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 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.

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

IMPOSITION OF FINES

In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement;

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

Level 3: a fine of \$1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

Level 4: a fine of \$3,000 per incident, in addition to any enforcement mechanism authorized in

§ 144G.20;

Level 5: a fine of \$5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

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

St - 0 - 0780 - 144g.45 Subd. 2 (a) (1) - Fire Protection And Physical Environment - \$500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

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

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

To submit a hearing request, please visit:

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

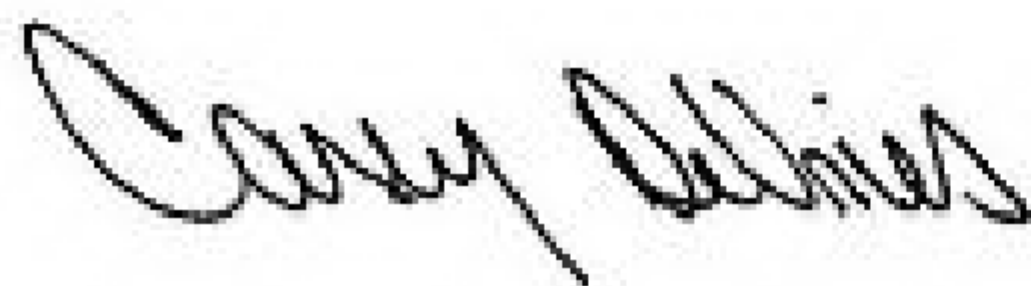
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **<https://forms.office.com/g/Bm5uQEPhVa>**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,



Casey DeVries, Supervisor

State Evaluation Team

Email: Casey.DeVries@state.mn.us

Telephone: 651-201-5917 Fax: 1-866-890-9290

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39367	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/04/2025
NAME OF PROVIDER OR SUPPLIER CARE PARTNERS HOMECARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 7517 EDGEWOOD AVENUE 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: SL39367016-0 On June 2, 2025, through June 4, 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 three residents all of whom received 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			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 480	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are	0 480			

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated June 2, 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	0 480			
0 680 SS=F	TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates. 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 by: Based on interview and record review, the licensee failed to maintain a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. This had the potential to affect all residents, staff, and visitors.	0 680			

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0 680	Continued From page 4 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 3, 2025, at 11:00 a.m., the surveyor reviewed the licensee's EPP dated May 10, 2023, stored among other files on a hanging shelf between the kitchen and the dining room and noted the following: - EPP was a 19-page document. First page included contact information for police department, sheriff, fire, Office of Health Facility Complaints (OHFC), and facility emergency contact persons. Pages 2-3 included the use of 911 and types of emergencies considered within the plan (fire, missing client, tornado, winter weather, high heat/humidity, flooding, water shortage, evacuation plan, and any other facility and location specific needs). Pages 4-6 included fire emergencies and use of fire extinguisher. Page 7 was for missing client (resident). Pages 8-10 included information about severe weather related (tornado, flooding). Page 11 was for loss of power. Pages 12-14 included heat exhaustion and heat stroke (symptoms, treatment, risk factors, procedure). Page 16 was for winter storm warning. Page 17 was evacuation plan (which indicated company owns four locations). Page 18 was additional emergency preparedness activities (which included lists for emergency item scavenger hunt, fire extinguisher practice, and	0 680			

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0 680	Continued From page 5 YouTube video). Page 19 was the signature page for the review and update of the EPP. Each of the sections missed the required information for EPP. On June 4, 2025, at 11:35 a.m., licensed assisted living director (LALD)-C provided the surveyor another EPP and stated it was their updated version and that it was in the computer. The EPP dated June 1, 2025, lacked the following required content: - risk assessment to consider hazards like care related emergencies; - categorize the various probable risks/hazards by likelihood of occurrence; - EPP program patient population; - development of EPP policies and procedures; - procedures for tracking of staff and patients; - policies and procedures including evacuation; - policies and procedures for sheltering; - policies and procedures for volunteers; - arrangement with other facilities; - development of communication plan; - names and contact information; - primary/alternate means for communication; - methods for sharing information; - sharing information on occupancy/needs; - LTC family notifications; - emergency prep training and testing; and - emergency prep training program. On June 14, 2025, at 12:06 p.m., LALD-C stated they had worked hard to upgrade their EPP and that they were still working on it until it mets the regulation requirement. The licensee's Emergency Preparedness Plan - Appendix Z Compliance policy dated August 1, 2021, indicated the licensee would have in place an effective and compliant Emergency Preparedness Plan, and the intent was the plan	0 680			

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0 680	Continued From page 6 would be aligned with the Centers for Medicare and Medicaid Services State Operation Manual Appendix Z: "State Operations Manual Appendix Z - Emergency Preparedness for All Provides and Certified Supplier Types: Interpretive Guidance." 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 that newly introduced smoke alarms in existing buildings may be battery operated;	0 780			

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0 780	Continued From page 7 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 3, 2025, from 11:00 a.m. to 12:30 p.m., the surveyor toured the facility with clinical nurse supervisor (CNS)-A. The surveyor asked CNS-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 all interconnected. The smoke alarms in the upstairs hallway, entry way, and basement staff office were hardwired (receiving power from the building electrical system) and were not interconnected with the battery-operated smoke alarms in the facility. At the time of discovery, CNS-A stated they did not know what the alarms in the upstairs hallway and	0 780			

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0 780	Continued From page 8 entry way were and that they had always been in the house. 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. On June 3, 2025, at 1:30 p.m. licensed assisted living director (LALD)-C stated the smoke alarms in the upstairs hallway and entry way were hardwired. No further information was provided. 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, 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.	0 810			

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0 810	Continued From page 9 (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 and to provide the required training. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On June 4, 2024, licensed assisted living director (LALD)-C and clinical nurse supervisor (CNS)-A provided documents on the fire safety and	0 810			

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0 810	Continued From page 10 evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP, 4.8 Fire Emergency - 4.8a. Internal Fire, dated January 5, 2025, failed to include the following: The FSEP failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included the identification of residents that needed assistance in a fire or evacuation, but did not include any resident-specific procedures to staff for assisting residents during evacuation, nor did it include instructions for staff to follow in case of relocation. On June 4, 2025, at 1:30 p.m., LALD-C stated they had documentation for which residents need assistance in a fire or evacuation, but did not have staff procedures developed or documented for those residents. TRAINING: The licensee failed to provide evacuation training to residents at least once per year. LALD-C and CNS-A lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan. On June 4, 2025, at 1:30 p.m., LALD-C stated they provided the fire safety training to residents on intake, but were not documenting it. LALD-C stated they would develop a way to document the resident training going forward.	0 810			

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER CARE PARTNERS HOMECARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 7517 EDGEWOOD AVENUE 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
0 810	Continued From page 11 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) 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. (e) 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 resident moves in, whichever is earlier. 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) conducted a resident	01620			

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01620	Continued From page 12 reassessment to include all the required parts of the uniform assessment tool 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 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 for assisted living services on October 23, 2021. R2's diagnoses included traumatic brain injury (TBI), depression, anxiety, and bi-polar disorder. R2's Service Plan dated September 1, 2024, indicated R2 received the following services: monitoring, review and assessments, medication management, wheeling, dressing, and meal assistance. On June 3, 2025, at 8:37 a.m., after breakfast the surveyor observed R2 wheel themselves from the dining table. R2 headed toward the kitchen but was unable to go over the floor trim between the dining room and kitchen floors. R2's 90-day assessment dated March 28, 2025, lacked assessment for R2's risk for falls including mobility status pertaining to the wheelchair use and risk for falling down the open staircase in the licensee's living room, evacuation status in case of an emergency, and elopement risk.	01620			

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01620	Continued From page 13 On June 4, 2025, at 12:30 p.m., clinical nurse supervisor (CNS)-A stated their documentation system missed the three assessment topics above. CNS-A also stated they completed the assessments manually and included them in the individual abuse prevention plan (IAPP). However, the assessment content noted above was missing in both R2's 90-day assessment and IAPP. The licensee's Comprehensive Assessment Schedule dated July 2021, indicated assessments would be completed within 14 days after initiation of services and at least every 90 days thereafter. The policy did not include all the required content for the uniform assessment tool. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620			
01940 SS=F	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy	01940			

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01940	Continued From page 14 administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a current individual treatment or therapy management plan to include all required content for one of one resident (R1) with blood glucose monitoring. 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: R1 was admitted to the licensee for assisted living services on May 15, 2023.	01940			

Minnesota Department of Health

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01940	Continued From page 15 R1's diagnoses included schizophrenia, type 2 diabetes mellitus without complications, psychotic disorder with hallucinations due to known physiological condition, and morbid obesity due to excess calories. On June 3, 2025, at 9:35 a.m., the surveyor observed unlicensed personnel (ULP)-D complete a blood glucose check for R1. R1's Service Plan dated August 31, 2024, indicated R1 received the following services: medication management, stand by assist with shower, grooming, dressing reminders, laundry, housekeeping, food preparation, and nursing assessments. The service plan did not include blood glucose as a service R1 received. R1's Comprehensive Health Assessment dated May 23, 2025, indicated R1 received daily blood glucose checks. The assessment also indicated R1's last average amount of sugar in the blood over the past 2 - 3 months (glycated hemoglobin (A1C)) completed on July 18, 2024, was 6.8. R1's blood glucose record dated between May 1, 2025, and May 31, 2025, indicated R1's blood glucose ranged between 77 milligrams per deciliter (mg/dL) and 168 mg/dl. R1's individual treatment or therapy management plan lacked the following content: - a statement of the type of services that will be provided; and - documentation of specific resident instructions relating to the treatments or therapy administration. On June 4, 2025, at 12:20 p.m., clinical nurse supervisor (CNS)-A stated they had forgotten to	01940			

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01940	Continued From page 16 update R1's individual treatment or therapy management plan after they transitioned from paper documentation to Therap (documentation system). The licensee's Treatment & Therapy Management Plan policy dated August 1, 2021, indicated for each resident receiving management of ordered or prescribed treatments or therapy services, the facility will prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The policy also included all the missing content above. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940			



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

Page: 1

Establishment Info

Care Partners Homecare LLC
7517 Edgewood Avenue North
Brooklyn Park, MN 55428
Hennepin County
Parcel:

Phone:

License Info

License: HFID 39367

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

Inspection Info

Report Number: F1039251023
Inspection Type: Full - Single
Date: 6/2/2025 Time: 10:30:00
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 1
Total Priority 2 Orders: 1
Total Priority 3 Orders: 0
Delivery: Emailed

New Order: 4-300 Equipment Numbers and Capacities

4-302.14 *Priority Level: Priority 2 CFP#: 48*

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

COMMENT: PERSON-IN-CHARGE STATES BLEACH USED AS SURFACE SANITIZER. NO TEST STRIPS ON-HAND FOR MEASURING CHLORINE BLEACH CONCENTRATION. PROVIDE TEST STRIPS AND USE TO CONFIRM 50-200 PPM CHLORINE (PREPARE BY MIXING APPROXIMATELY 1 TEASPOON BLEACH CONCENTRATE PER SPRAY BOTTLE).

Comply By: 6/9/2025 Originally Issued On: 6/2/2025

! New Order: 4-700 Sanitizing Equipment and Utensils

4-703.11B *Priority Level: Priority 1 CFP#: 16*

MN Rule 4626.0905B Sanitize food contact surfaces of equipment and utensils after cleaning by using mechanical hot water operations that achieve a utensil surface temperature of 160 degrees F (71 degrees C) and are set up and maintained in accordance with the specifications of NSF International and the manufacturer's data plate.

COMMENT: TEST OF DISHWASHING MACHINE WITH THERMO STICKER SHOWED RINSE TEMPERATURE DID NOT EXCEED 150 DEGREES F. REPAIR OR REPLACE MACHINE WITH ONE WHICH COMPLIES WITH ABOVE RULE. USE ALTERNATE SANITIZING MEANS (50-200 PPM CHLORINE BLEACH) IN MEANTIME.

Comply By: 6/2/2025 Originally Issued On: 6/2/2025

Food & Beverage General Comment

The inspection was completed with the person in charge and reviewed with MDH nurse evaluator Benard Nyangena.

The kitchen is of residential build and should serve food for same-day service only.

The kitchen has wood cabinets with hollow base and faux-stone countertops with a decorative tile backsplash, laminate wood floor, painted walls and ceiling. These kitchen finishes and surfaces are clean and well maintained.

The kitchen refrigerator/freezer are of residential grade.

A chest freezer and 2 large reach-in freezers are in-use in garage.

A 2-compartment sink is present in kitchen. 1 compartment is designated for handwashing only.

A residential dishwashing machine is present in the kitchen. During inspection, a run of the dish machine was started with a color-change thermos test strip. Results of the run were shared by person-in-charge via email showing a rinse

temperature did not exceed 150 degrees F.

A supply of single-use gloves is present in kitchen. A probe thermometer is present in kitchen.

Discussed the following with the person-in-charge: minimum cook temps for animal proteins, food source, foodborne illness symptoms and exclusion of ill employees, avoiding bare hand contact with ready to eat foods, handwashing, cleaning and sanitizing, all orders on this report.

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 F1039251023 from 6/2/2025



Tabitha Briggs
person-in-charge

Aron Goodner,
Public Health Sanitarian 1
651-201-4910
aron.goodner@state.mn.us



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

Temperature Observations/Recordings

Page: 1

Establishment Info

Care Partners Homecare LLC
Brooklyn Park
County/Group: Hennepin County

Inspection Info

Report Number: F1039251023
Inspection Type: Full
Date: 6/2/2025
Time: 10:30:00

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

Location: REFRIGERATOR at 39 Degrees F.

Comment:

Violation Issued?: No

FREEZER X 4: **Product/Item/Unit:** ; **Temperature Process:**

Location: at Degrees F.

Comment: FROZEN

Violation Issued?: No