



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

May 22, 2026

Licensee
Partridge Home
12423 Partridge Street Northwest
Coon Rapids, MN 55448

RE: Project Number(s) SL34925016

Dear Licensee:

On April 28, 2026, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on February 5, 2026. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the February 5, 2026 survey.

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.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on February 5, 2026, found not corrected at the time of the April 28, 2026, follow-up survey and/or subject to penalty assessment are as follows:

0810-Fire Protection And Physical Environment-144g.45 Subd. 2 (b-F) - \$500.00

The details of the violations noted at the time of this follow-up survey completed on April 28, 2026 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

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 outlined on the state form; however, plans of correction are not required to be submitted for approval.

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.

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.

We urge you to review these orders carefully. If you have questions, please contact Stephanie Jones de Palma at 651-201-4320.

You are encouraged to retain this document for your records. It is your responsibility to share the

information contained in the letter and/or state form with your organization's Governing Body.

Sincerely,

A handwritten signature in black ink, reading "Stephanie Jones de Palma". The signature is fluid and cursive, with a large, sweeping initial 'S'.

Stephanie Jones de Palma, Supervisor
State Evaluation Team
Email: stephanie.jones.de.palma@state.mn.us
Telephone: 651-201-4320 Fax: 1-866-890-9290

KKM

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34925	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 04/28/2026
NAME OF PROVIDER OR SUPPLIER WE CARE HOME HEALTH SERVICES		STREET ADDRESS, CITY, STATE, ZIP CODE 12423 PARTRIDGE STREET NW COON RAPIDS, MN 55448			
(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 FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS 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: SL34925016-1 On April 27, 2026, through April 30, 2026, the Minnesota Department of Health conducted a a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on February 5, 2026. At the time of the survey, there were five (5) residents; five (5) receiving services under the Assisted Living Facility license. As a result of the follow-up survey, the following order was reissued.	{0 000}			
{0 420} SS=F	144G.40 Subdivision 1 Responsibility for housing and services The facility is directly responsible to the resident for all housing and service-related matters provided, irrespective of a management contract. Housing and service-related matters include but are not limited to the handling of complaints, the provision of notices, and the initiation of any	{0 420}			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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{0 420}	Continued From page 1 adverse action against the resident involving housing or services provided by the facility. This MN Requirement is not met as evidenced by:	{0 420}	Not reviewed during this survey.		
{0 460} SS=D	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by:	{0 460}			
{0 470} SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at	{0 470}			

Minnesota Department of Health

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{0 470}	Continued From page 2 least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by:	{0 470}			
{0 480} SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents:	{0 480}	Not reviewed during this survey.		

Minnesota Department of Health

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{0 480}	Continued From page 3 (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 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	{0 480}			

Minnesota Department of Health
STATE FORM 6899 KXHK12 If continuation sheet 5 of 17

Minnesota Department of Health

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{0 680}	Continued From page 5 (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:	{0 680}	Not reviewed during this survey.		
{0 775} SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by:	{0 775}			

Minnesota Department of Health

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{0 775}	Continued From page 6	{0 775}	Not reviewed during this survey.		
{0 780} SS=E	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; This MN Requirement is not met as evidenced by:	{0 780}	Not reviewed during this survey.		

Minnesota Department of Health

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{0 790}	Continued From page 7	{0 790}			
{0 790} SS=E	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by:	{0 790}			
{0 800} SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by:	{0 800}	Not reviewed during this survey.		
			Not reviewed during this survey.		

Minnesota Department of Health

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{0 810}	Continued From page 8	{0 810}			
{0 810} SS=E	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, record review, and	{0 810}			

Minnesota Department of Health

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{0 810}	Continued From page 9 interview, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated April 30, 2026, for the specific violations related the physical environment under Minnesota Statute 144G.	{0 810}			
{01290} SS=D	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under	{01290}			

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{01290}	Continued From page 10 this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by:	{01290}	Not reviewed during this survey.		
{01640} SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date 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:	{01640}			

Minnesota Department of Health

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{01760}	Continued From page 11	{01760}			
{01760} SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by:	{01760}			
{01830} SS=F	144G.71 Subd. 14 Renewal of prescriptions Prescriptions must be renewed at least every 12 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter 152. This MN Requirement is not met as evidenced by:	{01830}	Not reviewed during this survey.		
{01850} SS=D	144G.71 Subd. 16 Written or electronic prescription When a written or electronic prescription is received, it must be communicated to the	{01850}			

Minnesota Department of Health

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{01850}	Continued From page 12 registered nurse in charge and recorded or placed in the resident's record. This MN Requirement is not met as evidenced by:	{01850}	Not reviewed during this survey.		
{01880} SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all 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:	{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 by:	{01890}			
{01920} SS=F	144G.71 Subd. 23 Loss or spillage (a) Assisted living facilities providing medication management must develop and implement procedures for loss or spillage of all controlled	{01920}			

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER WE CARE HOME HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 12423 PARTRIDGE STREET NW COON RAPIDS, MN 55448		
(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	
{01920}	Continued From page 13 substances defined in Minnesota Rules, part 6800.4220. These procedures must require that when a spillage of a controlled substance occurs, a notation must be made in the resident's record explaining the spillage and the actions taken. The notation must be signed by the person responsible for the spillage and include verification that any contaminated substance was disposed of according to state or federal regulations. (b) The procedures must require that the facility providing medication management investigate any known loss or unaccounted for prescription drugs and take appropriate action required under state or federal regulations and document the investigation in required records. This MN Requirement is not met as evidenced by:	{01920}	Not reviewed during this survey.		
{01940} SS=D	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 administration;	{01940}			

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{01940}	Continued From page 14 (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:	{01940}	Not reviewed during this survey.		
{01960} SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by:	{01960}			

Minnesota Department of Health

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{01970}	Continued From page 15	{01970}			
{01970} SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by:	{01970}			
{02290} SS=F	144G.91 Subd. 2 Legislative intent The rights established under this section for the benefit of residents do not limit any other rights available under law. No facility may request or require that any resident waive any of these rights at any time for any reason, including as a condition of admission to the facility. This MN Requirement is not met as evidenced by:	{02290}			
{02320} SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan.	{02320}			

Minnesota Department of Health

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{02320}	Continued From page 16 This MN Requirement is not met as evidenced by:	{02320}			

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL34925016-1	Date: APRIL 30, 2026
Facility Name: WE CARE HOME HEALTH SERVICES	
Facility Address: 12423 PARTRIDGE STREET NW, COON RAPIDS, MN 55448	

☒ TAG IDENTIFICATION: 0810

SCOPE/ SEVERITY: Level 2; Pattern

1. Each assisted living facility shall develop and maintain fire safety and evacuation plans that include employee actions to be taken in the event of a fire or similar emergency. [Minn. Stat. 144G.45 subd.2]

Comments:

The fire safety and evacuation plan (FSEP) inaccurately referenced an elevator.

The licensee failed to develop the fire safety and evacuation plan with accurate employee actions relative to the facility's building. The FSEP employee actions were still not compliant on the day of the follow-up survey.
2. Each assisted living facility shall develop and maintain fire safety and evacuation plans that include fire protection procedures necessary for residents. [Minn. Stat. 144G.45 subd.2]

Comments:

The fire safety and evacuation plan (FSEP) emergency instructions for residents inappropriately instructed to residents to wait for staff to help if unable to leave their room in a building with no life safety systems or fire resistant construction type. The plan failed to identify bedroom egress windows as a secondary means for escape. The FSEP resident procedures were still not compliant on the day of the follow-up survey.



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

March 9, 2026

Licensee

We Care Home Health Services
12423 Partridge Street Northwest
Coon Rapids, MN 55448

RE: Project Number(s) SL34925016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on February 5, 2026, 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 . . ."

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 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - \$500.00

St - 0 - 0810 - 144g.45 Subd. 2 (b-F) - Fire Protection And Physical Environment - \$1,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$1,500.00**. 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,

A handwritten signature in cursive script that reads "Kelly Thorson". The ink is dark and the signature is fluid.

Kelly Thorson, Supervisor
State Evaluation Team
Email: Kelly.Thorson@state.mn.us
Telephone: 320-223-7336 Fax: 1-866-890-9290

CLN

Minnesota Department of Health

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0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL34925016-0 On February 2, 2026, through February 5, 2026, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were five (5) residents; five (5) 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.		
0 420 SS=F	144G.40 Subdivision 1 Responsibility for housing and services	0 420			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 420	Continued From page 1 The facility is directly responsible to the resident for all housing and service-related matters provided, irrespective of a management contract. Housing and service-related matters include but are not limited to the handling of complaints, the provision of notices, and the initiation of any adverse action against the resident involving housing or services provided by the facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide sufficient management, control, and operation of the housing and services provided by the facility. This had the potential to affect all 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 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: The licensee had an assisted living license, effective November 1, 2025. The licensee's renewal "Application for Assisted Living License", section titled "Official Verification of Owner or Authorized Agent", (page five and six of the application), identified, I certify I have read and understand the following: [an affirmative checkmark was placed before each of the following]: - I have read and fully understand Minn.	0 420			

Minnesota Department of Health

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0 420	Continued From page 2 [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17. - I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G. - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659. - Reporting of Maltreatment of Vulnerable Adults. - Electronic Monitoring in Certain Facilities. - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health	0 420			

Minnesota Department of Health

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0 420	Continued From page 3 protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license. - I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659, governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. - I have examined this application and all attachments, and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and belief, this information is true, correct and complete. I will notify MDH, in writing, of any changes to this information as required. - I attest to have all required policies and procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page six was electronically signed by the owner	0 420			

Minnesota Department of Health

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0 420	Continued From page 4 who is also the licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A on July 9, 2025. As a result of this survey, the following orders were issued under 0460, 0470, 0480, 0660, 0680, 0775, 0780, 0790, 0800, 0810, 1290, 1640, 1760, 1830, 1850, 1880, 1890, 1920, 1940, 1960, 1970, 2290, 2320 which indicated the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.01 to 144G.95. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 420			
0 460 SS=D	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit;	0 460			

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0 460	Continued From page 5 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide resident (R1) with a lockable door to his personal unit. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On February 4, 2026, at 1:40 p.m., the surveyor was notified that R1's bedroom door was unable to lock and documented the unlockable door with a photograph of R1's bedroom door. On February 4, 2026, at 1:45 p.m., R1 stated he wants to be able to lock his door, his door does not lock, it has not locked in a long time, and no one will fix his door. On February 4, 2026, at 2:30 p.m., supervisor/unlicensed personnel (S/ULP)-B stated the lock on R1's bedroom door is broken and not sure how long it has been like that. On February 4, 2026, at 2:30 p.m., unlicensed personnel (ULP)-D stated R1's door had been broken and fixed once before but is not sure how long it has been broken this time. On February 5, 2026, at 11:34 a.m., licensed assisted living director/clinical nurse supervisor	0 460			

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0 460	Continued From page 6 (LALD/CNS)-A stated she is aware resident's have the right to a lockable door and is not sure how long the lock has been broken but was aware the lock does not work and thinks the whole door needs to be replaced. She has already called to get this scheduled and completed. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 460			
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time;	0 470			

Minnesota Department of Health

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(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
0 470	Continued From page 7 (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the clinical nurse supervisor (CNS) developed and implemented a staffing plan to determine staffing levels to meet the needs of all residents, which included reviewing the staffing plan at least twice per year. 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 held an assisted living facility license and was licensed for a capacity of five (5) residents. The surveyor was given a binder labeled Survey Binder; the binder contained various facility specific information and contained two staffing plans. The first plan was titled Staffing Plan; the plan did not have evidence the clinical nurse supervisor had developed and implemented the staffing plan and did not indicate a date of review twice annually. The second plan was titled	0 470			

Minnesota Department of Health

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0 470	Continued From page 8 Staffing Plan 2022; the plan did not have evidence the clinical nurse supervisor had developed and implemented the staffing plan, the plan did not indicate staffing levels to meet the needs of the residents and did not indicate a date of review twice annually. On February 4, 2026, at 1:00 p.m., supervisor/unlicensed staff (S/ULP)-B verified the two staffing plans were in the binder and the first one did not include a signature or date, and the second one was from 2022. On February 5, 2026, at 10:40 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the staffing plan should be updated quarterly, and it has been updated but she did not pull the old staffing plan out of the survey binder and replace it with the updated one or it may have been missed. The licensee's Staffing policy dated August 1, 2021, indicated the staffing plan to determine the required staffing level is prepared by the clinical nurse supervisor. The plan considers the number of qualified direct-care staff to meet the residents' needs throughout the day and night. The staffing plan is based on an evaluation of the appropriateness of the staffing levels in the facility and is reviewed at least twice a year. No further information was provided. TIME PERIOD OF CORRECTION: Seven (7) days	0 470			
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34925	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/05/2026
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0 480	Continued From page 9 (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			

Minnesota Department of Health

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0 480	Continued From page 10 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 February 3, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.	0 480			

Minnesota Department of Health

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0 480	Continued From page 11	0 480			
	TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.				
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 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 establish and maintain a tuberculosis (TB) prevention and control program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) when the licensee failed to complete a facility TB risk assessment and failed to complete TB testing for two of two employees (unlicensed personnel (ULP-D and ULP-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	0 660			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34925	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/05/2026
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0 660	Continued From page 12 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: TB FACILITY RISK ASSESSMENT On February 2, 2026, at approximately 12:00 p.m., the surveyor reviewed the facility TB risk assessment that was dated January 10, 2025. On February 2, 2026, at 1:45 p.m., supervisor/unlicensed personnel (S/ULP)-B stated the TB risk assessment is the most current one they have. On February 5, 2026, at 10:30 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she thought she had updated the TB risk assessment but may have not updated it with the correct information. TB TESTING ULP-D ULP-D had a hire date of January 25, 2025. ULP-D's employee record included a chest x-ray dated January 24, 2025, which indicated no evidence of active TB disease. ULP-D's employee record lacked evidence of a positive TB skin test to indicate the need for a chest x-ray. ULP-E ULP-E had a hire date of January 7, 2025. ULP-E's employee record included a	0 660			

Minnesota Department of Health

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0 660	Continued From page 13 QuantiFERON TB blood test dated January 5, 2024. ULP-E's employee record lacked evidence that a TB test had been completed no more than 90 days prior to hire. On February 4, 2026, at 11:45 a.m., S/ULP-B stated she agreed the TB testing for ULP-D only contained a chest x-ray and the QuantiFERON blood test for ULP-E was more than 90 days prior to hire. On February 5, 2026, at 10:30 a.m., LALD/CNS-A stated the positive TB blood test was missed and they just sent ULP-D to get a chest x-ray, and she thinks ULP-E had a new TB blood test completed but the results were sent to her via email and she failed to print out the new results and put it in ULP-E's employee record. The licensee's Tuberculosis Screening/Prevention policy dated August 1, 2021, indicated the director is responsible for conducting the formal TB Risk Assessment and updating it annually. Baseline testing is completed on hire for all direct care providers and anyone who visits residents. The Minnesota Department of Health (MDH) Recourses and Frequently Asked Questions dated October 13, 2025, indicated the following questions and answers: How often should a provider perform a facility risk assessment? Each provider licensed by MDH is required to complete a TB risk assessment annually. How far back can a previous Tuberculin Skin Test (TST) or Interferon-Gamma Release Assays (IGRAs) be accepted? A test should be dated with 90 days of hiring is acceptable. If a health care worker	0 660			

Minnesota Department of Health

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0 660	Continued From page 14 received a Bacille Calmette-Guerin (BCG) vaccine in the past, but now tests positive for tuberculosis, is a chest x-ray acceptable documentation of vaccination? A chest x-ray alone is not acceptable documentation. You either need: - Documentation of a positive two-step TST or IGRA test, and - A chest x-ray with provider evaluation after that date or - Documentation of refusal of both the two-step TST and IGRA - Followed by a new chest x-ray and provider evaluation. If the health care worker had a prior positive TB test result, and they only have the chest x-ray but no other test documentation, then they need to take a new TB test. If the result is positive, a new chest x-ray needs to be completed. The chest x-ray needs to be done within 90 days of the positive test date or dated any time after the positive test date. 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	0 680			

Minnesota Department of Health

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0 680	Continued From page 15 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 post an emergency disaster plan prominently and develop a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all residents, employees, and visitors to the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 the residents). The findings include:	0 680			

Minnesota Department of Health

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0 680	Continued From page 16 The licensee's emergency preparedness plan (EPP), was brought to the facility from the office and lacked the required content: - maintenance of the EPP; - maintained annual updates; - a quarterly review of missing resident policy; - identification of program patient population; and - exercises to test the EPP at least twice per year, including unannounced drills using the EPP. On February 4, 2026, at 1:00 p.m., supervisor/unlicensed personnel (S/ULP-)-B stated the EPP showed the last review as 2022, she was not sure if the missing person policy had been reviewed quarterly, and she was not sure if drills of the EPP had been completed. On February 5, 2026, at 10:55 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the EPP and the missing person policy should be updated every six months, and they do drills of the EPP with the fire drills. The EPP was not at the facility because she had taken it to the office for updates and the updates should have been in the binder but the staff must have grabbed the incorrect binder. LALD/CNS-A stated she agreed the EPP the surveyor was given was not updated and missing some of the required items and no drills were documented. The licensee's Emergency Preparedness policy dated March 24, 2021, indicated the licensee will have an identified plan in place to assure the safety and well-being of clients and staff during periods of an emergency or disaster that disrupts services. A disaster drill is conducted at the residence at least annually. Results of the drill will be documented.	0 680			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34925	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/05/2026
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0 680	Continued From page 17 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			
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a 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:	0 775			

Minnesota Department of Health

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0 775	Continued From page 18 Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated February 4, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Two (2) days	0 775			
0 780 SS=E	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			

Minnesota Department of Health

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0 780	Continued From page 19 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated February 4, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780			
0 790 SS=E	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code,	0 790			

Minnesota Department of Health

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0 790	Continued From page 20 located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated February 4, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790			
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment	0 800			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34925	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/05/2026
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(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
0 800	Continued From page 21 (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to 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 February 4, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34925	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/05/2026
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0 810	Continued From page 22	0 810			
0 810 SS=I	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:	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34925	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/05/2026
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0 810	Continued From page 23 Based on observation, record review, and interview, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident), 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, Physical Environment Inspection Report (PEIR) dated February 4, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
01290 SS=D	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12.	01290			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34925	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/05/2026
NAME OF PROVIDER OR SUPPLIER WE CARE HOME HEALTH SERVICES		STREET ADDRESS, CITY, STATE, ZIP CODE 12423 PARTRIDGE STREET NW COON RAPIDS, MN 55448			
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01290	Continued From page 24 (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study was affiliated to the licensee's health facility identification number (HFID) as required for one of seventeen employees (unlicensed personnel (ULP)-C). 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 finding include: ULP-C was hired on April 27, 2025, and provided direct care services to the licensee's residents. ULP-C's employee record failed to include a background study affiliated with the licensee's HFID, however, ULP-C's record did include a background study clearance for another HFID the licensee operates. On February 2, 2026, at 1:45 p.m., supervisor/unlicensed personnel (S/ULP)-B stated ULP-C started on morning shift at the	01290			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34925	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/05/2026
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01290	Continued From page 25 other facility and decided they wanted night shift so they switched him to this facility and the affiliation of this HFID must have been missed. On February 5, 2026, at 10:40 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated ULP-C was missed for this HFID, he used to work at a different facility, and they must not have affiliated him with this HFID. The licensee's Recruitment and Hiring policy dated March 24, 2021, indicated the Criminal Background Check will be submitted to Minnesota Department of Human Services (DHS) following the step by step procedure established by DHS. - The administrator or designee is responsible for initiating the criminal background study for new employees; - NetStudy 2.0 (or current version) will be used for the background check; - The employee will be directed to locations established by DHS to obtain fingerprint scans; - Employees will be instructed that photographic identification will be required; - Employees/study subjects may enter their own background study demographic information using the facility identification code provided; and - Results of he background study will be maintained in the employee's personnel file. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290			
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to	01640			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34925	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/05/2026
NAME OF PROVIDER OR SUPPLIER WE CARE HOME HEALTH SERVICES		STREET ADDRESS, CITY, STATE, ZIP CODE 12423 PARTRIDGE STREET NW COON RAPIDS, MN 55448			
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01640	Continued From page 26 (a) No later than 14 calendar days after the date 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 observation, interview and record review, the licensee failed to ensure the service plan was revised based on change of service 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 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:	01640			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34925	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/05/2026
NAME OF PROVIDER OR SUPPLIER WE CARE HOME HEALTH SERVICES		STREET ADDRESS, CITY, STATE, ZIP CODE 12423 PARTRIDGE STREET NW COON RAPIDS, MN 55448			
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01640	Continued From page 27 R2 was admitted to the licensee on September 17, 2021, with diagnoses that included diabetes, schizophrenia, and anxiety. R2's service plan signed on January 27, 2026, indicated R2 received assistance with activity assistance, appointment reminders, bathing reminders, COVID-19 screening, dressing assistance/reminder, housekeeping, reminder, laundry, linen change, behavior management, meal assistance, medication administration, medication reconciliation, medication review/reorder/monitoring/set up, medication setup, nail care, blood glucose, vitals, registered nurse visit, safety check, skin care, symptom screen, verbal or visual medication reminders, and wound care. R2's Service Recap Summary for December 2025 and January 2026, indicated R2 received wound care daily and was signed completed by various ULP'S. R2's Service Recap Summary for January 2026, indicated on January 9, 2026, the wound care was declined, no wound on resident anymore. R2's most recent nursing assessment completed by licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A on January 14, 2026, indicated R2 had no wound present. On February 4, 2026, at 8:45 a.m., R2 stated he had a cyst removed from his chest a long time ago, but the area is completely healed and proceeded to lift his shirt to show the surveyor his incision scar on his chest that was clean, dry, and fully intact. R2 stated staff were checking the incision daily and covering it with a bandage right	01640			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34925	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/05/2026
NAME OF PROVIDER OR SUPPLIER WE CARE HOME HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 12423 PARTRIDGE STREET NW COON RAPIDS, MN 55448		
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01640	Continued From page 28 after the procedure was done until the stitches were removed, but the staff have not done any wound care for him in months. On February 4, 2026, at 2:05 p.m., supervisor/unlicensed personnel (S/ULP)-B stated she is unsure why the wound care for R2 is being charted as completed everyday but R2 has no wound. On February 5, 2026, at 11:30 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated service plans should be updated yearly or if anything changes with the services, within 24 hours. LALD/CNS-A stated she was responsible for the assessments of residents and addition and removal of services based on the assessments and she missed removing the wound care for R2 and did not update the service plan. The licensee's Service Plan policy dated August 1, 2021, indicated a service plan must be revised, if needed, based on resident review or reassessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640			
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34925	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/05/2026
NAME OF PROVIDER OR SUPPLIER WE CARE HOME HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 12423 PARTRIDGE STREET NW COON RAPIDS, MN 55448		
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01760	Continued From page 29 must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to document the reason why medication administration was not completed as prescribed and failed to document any follow-up procedures that were provided to meet the residents' needs when medication was not administered as prescribed 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 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On February 3, 2026, at 10:15 a.m., the surveyor observed unlicensed personnel (ULP)-D provide meal assistance for R2. R2 was admitted to the licensee on September 17, 2021, with diagnoses that included diabetes, schizophrenia, and anxiety.	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34925	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/05/2026
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01760	Continued From page 30 R2's service plan signed on January 27, 2026, indicated R2 received assistance with medication administration twice daily. R2's prescriber orders dated December 9, 2025, indicated R2 was prescribed the following medication: -lidocaine 5% topical patch, apply to intact skin to cover most painful area for max 12 hours per 24-hour period. R2's medication administration record (MAR) dated December 11, 2025, through December 31, 2025, for lidocaine 5% patch administration time of 9:00 a.m., lacked documentation that medication administration was completed on December 14, 19, 20, 21, 23, 24, 25, 27, 28, 31, and 31. The MAR indicated the reason the medication was not administered was declined or med out of stock-nurse notified. R2's MAR dated January 1, 2026, through January 31, 2026, for lidocaine 5% patch administration time of 9:00 a.m., lacked documentation that medication administration was completed on January 1, 2, 3, 4, 6, 7, 8, 11,13, 14, 15, 16, 17, 20, 21, 22, 25, 27, 28, 29, 30, and 31. The MAR indicated the reason the medication was not administered was not given or med out of stock-nurse notified. R2's MAR dated February 1, 2025, through February 2, 2026, for lidocaine 5% patch administration time of 9:00 a.m., indicated the patch was administered both days. On February 3, 2026, at 12:15 p.m., supervisor/unlicensed personnel (S/ULP)-B confirmed there were no lidocaine patches in the	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34925	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/05/2026
NAME OF PROVIDER OR SUPPLIER WE CARE HOME HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 12423 PARTRIDGE STREET NW COON RAPIDS, MN 55448		
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01760	Continued From page 31 medication cabinet and stated she is not sure why the patches were charted as given on those days but declined for most of December and January with the notation indicating the patch was not available. S/ULP-B stated she is not sure if there have ever been any patches for R1 at the facility. On February 5, 2026, at 11:00 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the nurse has not been notified about the Lidocaine patches being out of stock, the staff are putting notes in and not updating the nurse. LALD/CNS-A stated she reviews MAR's, R1 has been complaining of a lot of pain and she should have followed up with the provider to update them he had not been receiving the patch, but she did not call them and she is not sure why some staff are charting administered when the patch is unavailable. On February 18, 2026, at 9:50 a.m., the surveyor spoke with the pharmacy the licensee uses and spoke with pharmacist (P)-G, he stated the lidocaine patch required a prior authorization that was never approved, and no lidocaine patches had been delivered to the licensee from this pharmacy. The licensee's Medication Documentation policy dated August 1, 2021, indicated documentation will be complete, accurate and legible. If the administration of one or more medications was not completed, staff will document the following: - The reason why the medication was not administered; - Follow up procedures to meet the resident's needs in compliance with the medication management plan; - Appropriate notification to RN Supervisor or	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34925	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/05/2026
NAME OF PROVIDER OR SUPPLIER WE CARE HOME HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 12423 PARTRIDGE STREET NW COON RAPIDS, MN 55448		
(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
01760	Continued From page 32 other persons as instructed regarding missed dosages; and - Medication error report, if appropriate. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			
01830 SS=F	144G.71 Subd. 14 Renewal of prescriptions Prescriptions must be renewed at least every 12 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter 152. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure prescriptions were renewed at least every 12 months for two of two residents (R1 and 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 the residents). The findings include: R1 R1 admitted to the licensee on April 15, 2019, began receiving assisted living services on	01830			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34925	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/05/2026
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(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
01830	Continued From page 33 August 1, 2021. R1's service plan, signed January 27, 2026, indicated R1 received medication administration services four times daily. R1's medication administration record (MAR) dated February 2026, included the following scheduled medications: - Breo Ellipta 100-25 micrograms (mcg) inhaler, inhale once daily for chronic obstructive pulmonary disease (COPD) - cyclobenzaprine HCL 10 milligrams (mg), take one tablet three times daily for muscle spasms - daily-vit tab, take one tablet daily for nutritional deficiency - deep sea nasal spray 0.65%, use one spray in both nostrils three times daily for chronic sinusitis - Eliquis 5 mg, take one tablet two times a day for history of pulmonary embolism - escitalopram 10 mg, take one tablet once daily for anxiety disorder - gabapentinn 100 mg, take one capsule three times daily for schizoaffective disorder - loratadine 10 mg, take one tablet by mouth daily for allergies - lorazepam 0.5 mg, take one tablet twice daily for anxiety disorder - trihexyphenidyl HCL 5 mg, take one tablet twice daily for schizoaffective disorder - vitamin D3 2000 units, take 1 capsule (2000 u) daily for fatigue - Risperdal Consta 50 mg/2 milliliters (ml), inject 50 mg intramuscularly every two weeks for paranoid schizophrenia - lidocaine 5% patch, apply to intact skin for 12 hours per 24-hour period for lower back pain - atorvastatin 20 mg, take one tablet daily at bedtime for high cholesterol - divalproex sodium Er 500 mg, take three tablets	01830			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34925	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/05/2026
NAME OF PROVIDER OR SUPPLIER WE CARE HOME HEALTH SERVICES		STREET ADDRESS, CITY, STATE, ZIP CODE 12423 PARTRIDGE STREET NW COON RAPIDS, MN 55448			
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01830	Continued From page 34 at bedtime for schizoaffective disorder - olanzapine 10 mg, take one tablet at bedtime for schizoaffective disorder R1's record had expired annual provider orders dated May 24, 2022, to May 24, 2023, for the following medications: - Breo Ellipta 100-25 mcg inhaler, inhale once daily for COPD - daily-vit tab, take one tablet daily for nutritional deficiency - deep sea nasal spray 0.65%, use one spray in both nostrils three times daily for chronic sinusitis - Eliquis 5mg, take one tablet two times a day for history of pulmonary embolism - gabapentinn100 mg, take one capsule three times daily for schizoaffective disorder - loratadine 10 mg, take one tablet by mouth daily for allergies - lorazepam 0.5 mg, take one tablet twice daily for anxiety disorder - trihexyphenidyl HCL 5 mg, take one tablet twice daily for schizoaffective disorder - vitamin D3 2000 units, take 1 capsule (2000 u) daily for fatigue - Risperdal Consta 50 mg/2 ml, inject 50 mg intramuscularly every two weeks for paranoid schizophrenia - atorvastatin 20 mg, take one tablet daily at bedtime for high cholesterol - divalproex sodium Er 500 mg, take three tablets at bedtime for schizoaffective disorder R2 R2 was admitted to the licensee on September 17, 2021, with diagnoses that included diabetes, schizophrenia, and anxiety. R2's service plan signed on January 27, 2026, indicated R2 received assistance with medication	01830			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34925	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/05/2026
NAME OF PROVIDER OR SUPPLIER WE CARE HOME HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 12423 PARTRIDGE STREET NW COON RAPIDS, MN 55448		
(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
01830	Continued From page 35 administration twice daily. R2's medication administration record (MAR) dated February 2026, included the following scheduled medications: - amlodipine 5 mg, take one and a half tablets daily for high blood pressure - Atenolol 100 mg, take one tablet daily for high blood pressure - famotidine 20 mg, take one tablet twice daily for heartburn - fluoxetine HCL 20 mg, take one capsule by mouth daily for depression - glipizide Er 10 mg, take one tablet daily for type II diabetes - metformin HCL Er 500 mg, take two tablets twice daily for type II diabetes - oyster shell calcium 500 mg, take one tablet daily for calcium supplement - vitamin D3 2000 u, take one tablet daily for vitamin D deficiency - atorvastatin 20 mg, take one tablet daily for high cholesterol - clozapine 100 mg, take three tablets at bedtime for schizophrenia - divalproex sodium Er 500 mg, take three tablets at bedtime for schizophrenia - olanzapine 10 mg, take one tablet at bedtime for schizophrenia R2's record had expired annual provider orders dated May 24, 2022, to May 24, 2023, for the following medications: - amlodipine 5 mg, take one and a half tablets daily for high blood pressure - Atenolol 100 mg, take one tablet daily for high blood pressure - famotidine 20 mg, take one tablet twice daily for heartburn - fluoxetine HCL 20 mg, take one capsule by	01830			

Minnesota Department of Health

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01830	Continued From page 36 mouth daily for depression - glipizide Er 10 mg, take one tablet daily for type II diabetes - metformin HCL Er 500 mg, take two tablets twice daily for type II diabetes - oyster shell calcium 500 mg, take one tablet daily for calcium supplement - vitamin D3 2000 u, take one tablet daily for vitamin D deficiency - atorvastatin 20 mg, take one tablet daily for high cholesterol - clozapine 100 mg, take three tablets at bedtime for schizophrenia - divalproex sodium Er 500 mg, take three tablets at bedtime for schizophrenia - olanzapine 10 mg, take one tablet at bedtime for schizophrenia On February 3, 2025, at 10:10 a.m., supervisor/unlicensed personnel (S/ULP)-F stated the annual orders for all of the residents have been sent to the providers offices, but they have not been signed or sent back, so all we have is the old annual orders and the electronic prescriptions from the pharmacy that are also outdated. On February 5, 2026, at 11:17 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated when she does not get the orders back from the provider she will call the pharmacy and get the electronic prescriptions, she thought the electronic prescriptions from the pharmacy should be up to date and if they are not they must have been missed. The licensee's Medication Orders policy dated August 1, 2021, indicated [the facility] will maintain a current written or electronically recorded prescription for all prescribed	01830			

Minnesota Department of Health

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01830	Continued From page 37 medications managed for the resident. Medication orders will be renewed at least every 12 months or as required by the physician, the RN assessment and/or regulation. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01830			
01850 SS=D	144G.71 Subd. 16 Written or electronic prescription When a written or electronic prescription is received, it must be communicated to the registered nurse in charge and recorded or placed in the resident's record. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure written or electronically recorded prescriptions were communicated to the registered nurse (RN) for one of two residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: On February 3, 2026, at 8:10 a.m., the surveyor observed the medication refrigerator with	01850			

Minnesota Department of Health

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01850	Continued From page 38 unlicensed personnel (ULP)-D and observed several bottles of latanoprost eye drops prescribed for R1. R1 admitted to the licensee on April 15, 2019, began receiving assisted living services on August 1, 2021. R1's service plan, signed January 27, 2026, indicated R1 received medication administration services four times daily. R1's record contained an electronic prescription dated April 29, 2025, for latanoprost 0.005% eye drops (a medication for glaucoma). Place one drop into both eyes at bedtime. R1's medication administration record (MAR) for December 2025, indicated the medication was administered December 1, 2025, through December 16, 2026, and then is blacked out for the remainder of the month. R1's MAR for January 2026 and February 2026, lacked latanoprost order. R1's resident notes dated December 1, 2025, through February 2, 2026, entered by unlicensed personnel (ULP)-E on December 17, 2025, indicated that R1 had an eye appointment that was successful. R1's resident notes dated December 1, 2025, through February 2, 2026, lacked any nursing notes regarding any medication changes from the eye appointment. On February 3, 2026, at 12:20 a.m., supervisor/unlicensed personnel (S/ULP)-B verified the eye drop was not listed on R1's MAR	01850			

Minnesota Department of Health

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01850	Continued From page 39 for January or February. On February 5, 2026, at 11:22 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she thinks the eye drop order was discontinued and the medication had not been disposed of but she will need to call the pharmacy to figure out the current order or if it has been discontinued. LALD/CNS-A stated she agreed she does not currently have a discontinue order for R1's eye drops in the record, and she did not document any notes in R1's record. The licensee's Medication Orders policy dated August 1, 2021, indicated the licensee will maintain a current written or electronically recorded prescription for all prescribed medications managed for the resident. Verbal prescription orders from an authorized prescriber will be received by a nurse or pharmacist. When a written or Electronic Prescription is received, it must be communicated to the registered nurse in charge and recorded or placed into the residence clinical record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01850			
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all 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	01880			

Minnesota Department of Health

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01880	Continued From page 40 by: Based on observation, interview, and record review, the licensee failed to ensure prescription medications were stored in securely locked and substantially constructed compartments permitting only authorized personnel to have access. This had the potential to affect all residents receiving medication management services. 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: On February 2, 2026, during the entrance conference at 11:45 a.m., supervisor/unlicensed personnel (S/ULP)-B stated they provide medication administration to all residents of the facility, all medications are kept in the locked medication cabinet and narcotic medications are in the locked medication cabinet in a separate lock box. On February 3, 2026, at 8:50 a.m., the surveyor observed unlicensed personnel (ULP)-D provide medication administration to R3. ULP-D opened the locked medication cabinet and retrieved R3's medications which included an as needed (PRN) narcotic medication lorazepam. The lorazepam was not in a separate lock box. ULP-D stated R3 always asks for his PRN so this is why she got it out to administer with his scheduled morning	01880			

Minnesota Department of Health

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01880	Continued From page 41 medications but she did not realize this was a narcotic medication and is not sure why it is not in a separate lock box. During the medication administration, ULP-D charted medications on the computer that sat on top of a desk in the living room, she reached into the top drawer of the left side of the desk to get a pen and the surveyor observed a bottle of medication in the drawer. On February 3, 2026, at 9:20 a.m., the surveyor verified the medication in the desk drawer with ULP-D, the medication was sertraline HCL 50 mg tablets, and the bottle contained a label which indicated the medication was for R3. ULP-D stated she is unsure why the bottle of medication is in the desk drawer and will need to ask someone about it. On February 3, 2026, at 9:30 a.m., S/ULP-B stated she is unsure why the bottle of medication was in the desk drawer and agreed it should be in the locked medication cabinet. S/ULP-B stated the lorazepam medication should be locked in a separate lock box per their policy. On February 5, 2026, at 11:10 am, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the staff must have put the bottle of medication into the desk in error and are aware all medications should be in the locked cabinet. LALD/CNS-A also stated it was a staff error that the narcotic medication was not in a separate lock box and she was not aware this was not being stored properly. The licensee's Storage/Control of Medications policy dated August 1, 2021, indicated When licensee is providing storage of medications outside of their residence private living space, all prescription drugs are securely locked in	01880			

Minnesota Department of Health

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01880	Continued From page 42 substantially constructed compartments according to the manufacturer's directions. Only authorized personnel have access to the stored medications. When controlled substances are being managed, stored, and secured by licensee, the registered nurse will provide for security and accountability for the overall management, control, and disposition of those substances in compliance with state and federal regulations. Controlled substances are stored in a separately locked compartment. 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 by: Based on observation, interview, and record review, the licensee failed to ensure medications were maintained bearing the original prescription and failed to include the opened or expiration date for time sensitive medications being stored by the licensee. 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	01890			

Minnesota Department of Health

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01890	Continued From page 43 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On February 3, 2026, at 9:50 a.m., the surveyor observed the medication cart with supervisor/unlicensed personnel (S/ULP)-B. S/ULP-B confirmed the Breo Ellipta inhaler did not have an open date indicated on it and she was not aware the inhaler needed an open date. The manufacturer's patient information dated May 2023, for Breo Ellipta inhaler indicated safely throw away Breo Ellipta in the trash six weeks after you open the tray or when the counter reads zero, whichever comes first. Write the date you open the tray on the label on the inhaler. On February 5, 2026, at 11:15 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the first person to open the inhaler failed to put the date on the inhaler. The licensee's Storage/Control of Medications policy dated August 1, 2021, indicated the licensed nurse is responsible for dating time-sensitive medications when opened. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			

Minnesota Department of Health

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01920	Continued From page 44	01920			
01920 SS=F	144G.71 Subd. 23 Loss or spillage (a) Assisted living facilities providing medication management must develop and implement procedures for loss or spillage of all controlled substances defined in Minnesota Rules, part 6800.4220. These procedures must require that when a spillage of a controlled substance occurs, a notation must be made in the resident's record explaining the spillage and the actions taken. The notation must be signed by the person responsible for the spillage and include verification that any contaminated substance was disposed of according to state or federal regulations. (b) The procedures must require that the facility providing medication management investigate any known loss or unaccounted for prescription drugs and take appropriate action required under state or federal regulations and document the investigation in required records. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop and implement procedures for loss and spillage of all controlled substances defined in Minnesota Rules part 6800.4220. In addition, the licensee failed to investigate when discrepancies were noted with narcotic counts for one of one resident (R3). This had the potential to affect all residents requiring the licensee to store and manage their medications. 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	01920			

Minnesota Department of Health

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01920	Continued From page 45 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: During entrance conference on February 2, 2026, at 11:45 a.m., supervisor/unlicensed personnel (S/ULP)-B stated they provide medication management services, including storage of controlled medications. S/ULP-B stated the medications are stored in a locked cabinet and narcotic medications are in a separate lock box within the cabinet. S/ULP-B stated they keep a narcotic count of all controlled medications in the electronic charting system. On February 3, 2026, at 8:50 a.m., the surveyor observed unlicensed personnel (ULP)-D administer medications to R3. ULP-D gathered morning medications for R3 out of the locked medication cabinet along with a punch pack (a medication card that included separate bubbles with individual doses of the medication) for as needed (PRN) narcotic medication lorazepam that R3 requested. The punch pack for the narcotic medication lorazepam was not in a separate lock box. ULP-D verified the morning medications with the electronic medication administration record (MAR) and administered the morning medications and charted they were administered in the MAR. ULP-D then verified the narcotic PRN medication with the MAR and took the punch pack of the lorazepam over to R3, who was sitting on a stool at the kitchen bar, and punch a dose of the lorazepam from the punch pack into R3's hand but the medication fell onto the floor under the stool R3 was sitting on. ULP-D proceeded to punch another dose of the	01920			

Minnesota Department of Health

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01920	Continued From page 46 lorazepam from the punch pack into R3's hand and R3 took the medication. ULP-D left the dropped tablet of lorazepam on the floor and went back to the medication cabinet and retrieved a second punch pack that also contained lorazepam and proceeded to the computer to chart the administered PRN lorazepam. ULP-D and the surveyor counted both punch packs of lorazepam and the remaining count was 50. ULP-D added the narcotic count into the computer and received an error message that indicated the count was incorrect. The electronic charting system showed the previous medication count for the PRN lorazepam as 27 tablets remaining. On February 3, 2026, at 9:10 a.m., ULP-D stated a new card of the medication must have come from the pharmacy, but the nurse has not added the count on the new card, which must be why the counts do not match up. ULP-D stated she did not realize that lorazepam was a narcotic medication and is not sure why it is not in a separate lock box. ULP-D failed to pick up the dropped lorazepam tablet and failed to notify anyone about the narcotic count discrepancy. On February 3, 2026, at 9:20 a.m., the surveyor asked ULP-D if she should pick the dropped medication off the floor and when prompted ULP-D retrieved the dropped medication and proceeded to throw it in the kitchen garbage. On February 3, 2026, at 9:50 a.m., S/ULP-B stated narcotic medications should be placed in an envelope and given to the nurse for destruction and if the narcotic medication count was off a supervisor should be notified.	01920			

Minnesota Department of Health

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01920	Continued From page 47 On February 3, 2026, at 10:00 a.m., ULP-D stated she did drop the lorazepam on the floor and was going to pick it up but picked it up after the surveyor asked about it. ULP-D stated she did throw the dropped medication into the kitchen trashcan and did not notify the nurse or supervisor about this incident or the incorrect narcotic medication count being in the computer system. On February 5, 2026, at 11:28 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the narcotic medication should have been picked up immediately, the nurse should have been notified, and the medication should have been put back in the medication cabinet for the nurse to destroy and document. LALD/CNS-A stated the staff should always notify the nurse of any narcotic count discrepancy. The licensee's Disposition and Disposal of Medications policy dated August 1, 2021, indicated when A loss or spillage of a schedule 2 controlled substance occurs, an explanatory note is made in the clinical record explaining the spillage and actions taken the notation is signed by the person responsible for the loss or spillage and includes verification that any contaminated substance was disposed of according to state/federal regulation and by one witness who must also observe the destruction of any remaining contaminated drug by mixture with an undesirable substance such as coffee grounds or wiping up the spill. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	01920			

Minnesota Department of Health

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01920	Continued From page 48 days	01920			
01940 SS=D	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 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 interview and record review, the	01940			

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER WE CARE HOME HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 12423 PARTRIDGE STREET NW COON RAPIDS, MN 55448		
(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
01940	Continued From page 49 licensee failed to develop individual treatment management plans with all required content for one of one resident (R2) who received ordered treatments. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On February 2, 2026, during the entrance conference at 11:45 a.m., supervisor/unlicensed personnel (S/ULP)-B stated they have one resident (R2) with a treatment of blood glucose monitoring. R2 was admitted to the licensee on September 17, 2021, with diagnoses that included diabetes, schizophrenia, and anxiety. R2's service plan signed on January 27, 2026, indicated R2 received assistance with blood glucose monitoring twice daily and wound care once daily. R2's Service Recap Summary for December 2025 and January 2026, indicated R2 received blood glucose monitoring twice daily and wound care once daily. R2's record lacked an Individualized Treatment and Therapy Plan for blood glucose monitoring and wound care that included the required	01940			

Minnesota Department of Health

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01940	Continued From page 50 information - a statement of the type of services that will be provided; - documentation of specific resident instructions relating to the treatments or therapy administration; - identification of treatment or therapy tasks that will be delegated to unlicensed personnel; - procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and - 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. On February 4, 2026, at 2:20 p.m., S/ULP-B stated R2 does not have a treatment plan for blood glucose monitoring or wound care. On February 5, 2026, at 11:32 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she missed creating a treatment plan for blood glucose monitoring and the wound care. The licensee's Treatment and Therapy Management policy dated August 1, 2021, indicated The RN or licensed professional will prepare an individualized treatment or therapy management plan for each resident receiving ordered or prescribed treatments or therapy services, which addresses: - type of service to be provided - procedures for documenting treatments or therapies - procedures for monitoring treatments or	01940			

Minnesota Department of Health

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01940	Continued From page 51 therapies to prevent possible complications or adverse reactions - identification of treatment or therapy task delegated to unlicensed personnel - procedures for notifying the RN or licensed health professional when a problem arises related to the treatment or therapy service. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940			
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure treatment or therapies were administered as prescribed, or to document the reason they were not provided 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 safety but had the potential to have harmed a	01960			

Minnesota Department of Health

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01960	Continued From page 52 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On February 2, 2026, during the entrance conference at 11:45 a.m., supervisor/unlicensed personnel (S/ULP)-B stated they have one resident (R2) with a treatment of blood glucose monitoring. R2 was admitted to the licensee on September 17, 2021, with diagnoses that included diabetes, schizophrenia, and anxiety. R2's service plan signed on January 27, 2026, indicated R2 received assistance with blood glucose monitoring twice daily. R2's Service Recap Summary for December 2025 and January 2026, indicated R2 should have blood glucose monitoring twice daily at 8:00 a.m., and 6:00 p.m. R2's blood glucose monitoring was declined for the 8:00 a.m., scheduled service on December 2, 3, 4, 5, 9, 10, 11, 12, 13, 14, 18, 19, 22, 23, 24, 25, 26, 27, 28, 30, and 31. R2's blood glucose monitoring was declined for the 6:00 p.m., scheduled service on December 2, 3, 4, 5, 8, 9, 10, 11, 12, 13, 14, 16, 18, 19, 22, 24, 25, 26, 27, 28, 29, 30, and 31. The reason cited for declined service was out of finger strips (test strips). R2's blood glucose monitoring was declined for the 8:00 a.m., scheduled service on January 1, 2,	01960			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34925	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/05/2026
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01960	Continued From page 53 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, and 30. R2's blood glucose monitoring was declined for the 6:00 p.m., scheduled service on January 1, 2, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, and 30. The reason cited for declined service was out of finger strips. On February 4, 2026, at 2:00 p.m., S/ULP-B stated R2's insurance is not covering the test strips for the blood glucose monitoring, sometimes staff will use another resident's strips to spot check R2 and this must be why it is only charted as completed occasionally. On February 5, 2026, at 11:35 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the blood glucose strips are not covered by insurance and she has followed up so much that she does not document her follow up anymore. The licensee's Treatment and Therapy Management policy dated August 1, 2021, indicated if the RNs or licensed professional delegates treatments or therapies, the professional will monitor and evaluate its effectiveness on a regular basis as specified in the service plan. When a treatment or therapy is not administered as ordered or prescribed, staff will document the reason why it was not administered and any follow up procedures provided to meet the residents needs as documented in the care plan or treatment plan or as ordered by the authorized prescriber. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960			

Minnesota Department of Health

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01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure up-to-date written or electronic treatment orders were maintained for one of one resident (R2) who had treatments. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On February 2, 2026, during the entrance conference at 11:45 a.m., supervisor/unlicensed personnel (S/ULP)-B stated they have one resident (R2) with a treatment of blood glucose monitoring. R2 was admitted to the licensee on September 17, 2021, with diagnoses that included diabetes, schizophrenia, and anxiety.	01970			

Minnesota Department of Health

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01970	Continued From page 55 R2's service plan signed on January 27, 2026, indicated R2 received assistance with blood glucose monitoring twice daily and wound care once daily. R2's Service Recap Summary for December 2025 and January 2026, indicated R2 received blood glucose monitoring twice daily and wound care once daily. R2's record lacked signed provider treatment orders for the blood glucose monitoring and wound care. On February 4, 2026, at 2:40 p.m., S/ULP-B stated the provider orders sent out have not been received yet and they do not have current orders for the treatments. On February 5, 2026, at 11:30 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated they did have an order from the emergency room for the wound care, but it must have been scanned incorrectly and missed putting it in the record. LALD/CNS-A stated the blood glucose order is very old and should be somewhere in the record and is not sure why it is not in the resident's record. The licensee's Treatment and Therapy Management policy dated August 1, 2021, indicated the RN or licensed health professional will obtain orders or prescriptions for all treatments and therapies. The order will include the following elements: - resident name - description of the treatment or therapy to be provided - frequency	01970			

Minnesota Department of Health

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01970	Continued From page 56 - other pertinent information. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970			
02290 SS=F	144G.91 Subd. 2 Legislative intent The rights established under this section for the benefit of residents do not limit any other rights available under law. No facility may request or require that any resident waive any of these rights at any time for any reason, including as a condition of admission to the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee limited the rights of residents when the licensee required all residents who resided in the facility to follow certain house rules. 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: On February 3, 2026, at 10:30 a.m., the surveyor observed a document in R1's record that was titled resident responsibilities/house rules and signed on November 27, 2020.	02290			

Minnesota Department of Health

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02290	Continued From page 57 The document indicated the following: - alcoholic drinks are not allowed anywhere within the premises of the agency - residents are expected to be at home by 10 pm. [sic] - the use of foul language when interacting with anyone is not allowed - meals should be consumed at the dining table On February 4, 2026, at 2:30 p.m., supervisor/unlicensed personnel (S/ULP)-B stated at the last survey at another facility it was pointed out that you can not have rules that prohibit alcohol and have a set curfew, an addendum was completed at the other facility but she was not sure if the same thing was done at this facility. On February 5, 2026, at 11:30 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the house rules should have been removed from the resident records, she was aware of the rules not being allowed from a previous survey and the rules did not get removed from the resident records. The licensee's Minnesota Assisted Living Bill of Rights indicated residents have the right to enter and leave the facility as they choose. This right may only be restricted only as allowed by other law and consistent with a resident's service plan. Residents have the right to individual autonomy, initiative, and independence in making life choices, including establishing a daily schedule and choosing with whom to interact. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02290			

Minnesota Department of Health

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02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the steps of the medication administration process were followed for two of two employees (unlicensed personnel (ULP)-D and ULP-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On February 3, 2026, at 8:20 a.m., the surveyor observed ULP-D login to the computer and R1's medication administration record (MAR) was open, ULP-D checked all medications as administered and then checked complete. ULP-D stated she had given the oral medications to R1, and the other staff ULP-E had given other non-oral medications, he had just finished so she charted them all.	02320			

Minnesota Department of Health

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02320	Continued From page 59 On February 3, 2026, at 8:30 a.m., the surveyor observed ULP-E ask ULP-D for the medication cabinet keys; ULP-E carried R1's Breo Elipta inhaler and deep sea nasal spray. ULP-D ULP-D was hired on January 25, 2025, to provide direct care services to residents. ULP-E ULP-E was hired on January 7, 2025, to provide direct care services to residents. ULP-D and ULP-E's employee records both contained medication administration all route procedures training and competency sign off by a registered nurse. On February 3, 2026, at 9:50 a.m., supervisor/unlicensed personnel (S/ULP)-B stated the staff should not chart any medications that were not administered by themselves. On February 3, 2026, at 10:00 a.m., ULP-D stated she verified all the medications, ULP-E administered the medications, and she charted them once ULP-E had completed the medication pass. ULP-D stated she did not witness R1 take the medications, and she did not know if ULP-E took any of the medications for himself, she would not think ULP-E would take any of the medications but she could not say because she did not witness the medication administration. On February 5, 2026, at 11:24 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated staff should not be administering medications for another staff member this is not how they are trained.	02320			

Minnesota Department of Health

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02320	Continued From page 60 The licensee's Medication Documentation policy dated August 1, 2021, indicated each medication administered by the licensee staff will be documented in the resident's clinical record. Documentation will be complete, accurate and legible. Complete documentation medication administration includes the following: - residents name - medication name - medication dosage - date and time of administration - method/route of administration - signature and title of staff administering the medication. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320			



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

We Care Home Health Services
12423 Partridge Street NW
Coon Rapids, MN 55448
Anoka County
Parcel:

Phone:

License Info

License: HFID 34925

Risk:
License:
Expires on:
CFPM: Matilda Agyapong
CFPM #: 13660; Exp: 3/21/2029

Inspection Info

Report Number: F7963261028
Inspection Type: Full - Single
Date: 2/3/2026 Time: 1:51:19 PM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 2
Total Priority 2 Orders: 1
Total Priority 3 Orders: 3
Delivery: Emailed

! New Order: 3-300B Protection from Contamination: cross-contamination, eggs

3-302.11A(1) *Priority Level: Priority 1 CFP#: 15*

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

COMMENT: RAW SHELL EGGS STORED ABOVE READY TO EAT FOOD IN REFRIGERATOR. MOVE TO LOWEST SHELF OR PLACE IN A CONTAINER TO PREVENT CONTAMINATION.

Comply By: 2/3/2026 Originally Issued On: 2/3/2026

New Order: 4-200 Equipment Design and Construction

4-204.112A *Priority Level: Priority 3 CFP#: 36*

MN Rule 4626.0620A Provide a temperature measuring device located in the warmest part of mechanically refrigerated units and coolest part of hot food storage units that are capable of measuring air temperature or a simulated product temperature.

COMMENT: NO THERMOMETER IN REFRIGERATOR FOR MONITORING REFRIGERATOR TEMPERATURE. OBTAIN AND USE.

Comply By: 2/3/2026 Originally Issued On: 2/3/2026

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: NO THIN PROBE FOOD THERMOMETER AVAILABLE FOR TAKING FOOD TEMPERATURES. OBTAIN AND USE.

Comply By: 2/3/2026 Originally Issued On: 2/3/2026

! 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: ESTABLISHMENT IS UNABLE TO SHOW DOCUMENTATION REGARDING IF DISHWASHER IS SANITIZING DISHES AND UTENSILS ACCORDING TO THE ABOVE RULE. USE AN ALTERNATIVE METHOD TEMPORARILY UNTIL DISHWASHER IS REPAIRED OR REPLACED. FACT SHEET SENT WITH REPORT.

Comply By: 2/3/2026 Originally Issued On: 2/3/2026

New Order: 6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.11 *Priority Level: Priority 3 CFP#: 55*

MN Rule 4626.1515 Maintain the physical facilities in good repair.

COMMENT: WOOD KITCHEN CABINETS ARE IN POOR REPAIR. DAMAGED HINGES AND PROTECTIVE VARNISH HAS WORN OFF LEAVING EXPOSED WOOD. REPAIR/REFINISH OR REPLACE.

Comply By: 8/3/2026 Originally Issued On: 2/3/2026

New Order: 6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.12A *Priority Level: Priority 3 CFP#: 55*

MN Rule 4626.1520A Clean and maintain all physical facilities clean.

COMMENT: KITCHEN NEED A THOROUGH CLEANING INCLUDING FLOORING (ESPECIALLY UNDER EQUIPMENT AND AROUND CABINET EDGES), WALLS AND CABINETS (INSIDE AND OUT).

Comply By: 2/10/2026 Originally Issued On: 2/3/2026

Food & Beverage General Comment

MET WITH ESTABLISHMENT REPRESENTATIVE TOYIN ADESANYA AND MDH NURSE SURVEYOR SARABETH REMKER. DISCUSSED THE FOLLOWING-

- EMPLOYEE ILLNESS POLICY AND LOG
- REPORTABLE DISEASES
- HIGHLY SUSCEPTIBLE POPULATION RESTRICTIONS
- SAME DAY FOOD SERVICE
- CLEANING AND SANITIZING

THIS IS A RESIDENTIAL KITCHEN THAT USES A DISHWASHER TO WASH AND SANITIZE DISHES AND UTENSILS. THEY ALSO USE SAME DAY FOOD SERVICE

KITCHEN HAS LINOLEUM FLOORING, WOOD CABINETS, LAMINATE COUNTERTOP AND POPCORN CEILING.

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 F7963261028 from 2/3/2026

Toyin Adesanya
PIC



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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	Inspection Info
We Care Home Health Services	Report Number: F7963261028
Coon Rapids	Inspection Type: Full
County/Group: Anoka County	Date: 2/3/2026
	Time: 1:51:19 PM

Food Temperature: **Product/Item/Unit:** BALOGNA; **Temperature Process:**

Location: REFRIGERATOR at 40 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: **Product/Item/Unit:** CREAM CHEESE; **Temperature Process:**

Location: REFRIGERATOR at 41 Degrees F.

Comment:

Violation Issued?: No

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL34925016-0	Date: FEBRUARY 4, 2026
Facility Name: WE CARE HOME HEALTH SERVICES	
Facility Address: 12423 PARTRIDGE STREET NW, COON RAPIDS, MN 55448	

☒ TAG IDENTIFICATION: 0775

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Two (2) days

1. Each assisted living facility must comply with the provisions of the Minnesota State Fire Code (MSFC) in Minnesota Rules chapter 7511. [Minn. Stat. 144G.45 subd. 2]
2. The means of egress shall be maintained free of obstructions or impediments to full instant use in case of fire or other emergency. [Minn. Stat. 144G.45 subd. 2; MSFC 1031.2]

Comments:

- An exit sign was posted at the basement door leading to the exterior of the building. Additionally, this door was labeled as an exit on the emergency evacuation floor plans. A clear continuous egress path from this door to the public right of way was not maintained free of snow.
- In occupied resident bedroom two, access to the egress window was obstructed by the storage of personal items in front of the window. Improper storage in front of an egress window could delay exiting in the event of an emergency.
- The posted floor plans labeled the deck enclosed by railings inappropriately as an exit.

3. Lighted matches, cigarettes, cigars or other burning objects shall not be discarded in such a manner that could cause ignition of other combustible material. [Minn. Stat. 144G.45 subd. 2; MSFC 310.7]

Comments:

- In occupied resident bedroom four, one burnt cigarette and ashes were disposed of on the wall shelf.
 - Several burnt cigarettes had been discarded on the top surface of the wood deck and on the ground under a bench on the back patio.
 - In the designated smoking area on the back deck, an uncovered plastic bucket containing trash was used for smoking material disposal.
- Improper smoking material disposal creates a fire hazard.

4. Extension cords and flexible cords shall not be a substitute for permanent wiring. [Minn. Stat. 144G.45 subd. 2; MSFC 604.5]

Comments:

- A multi plug outlet adapter was plugged into an extension cord and used to provide power to a television and fan in occupied resident bedroom two.
- A power strip was plugged into an extension cord to supply power to a television and printer in the main floor living room.

Improper use of extension cords and flexible cords creates a fire hazard.

5. Single- and multiple-station smoke alarms shall be replaced when they fail to respond to operability tests or exceed ten years from the date of manufacture. Smoke alarms shall be replaced with smoke alarms having the same type of power supply. [Minn. Stat. 144G.45 subd. 2; MSFC 1103.8.1]

Comments:

- The battery operated smoke alarm in the basement laundry room did not work when tested by unlicensed personnel (ULP)-E.
- The condition of the smoke alarm installed in occupied resident room three indicated it was more than ten years from the date of manufacture. Supervisor/unlicensed personnel (S/ULP)-B and unlicensed personnel (ULP)-E stated they did not know when this smoke alarm was installed or if it had been replaced since the home was constructed in 1997.

6. Single or multiple-station smoke alarms shall be maintained. [Minn. Stat. 144G.45 subd. 2; MSFC 907.2.10.2]

Comments: The backup battery was missing for the hardwired smoke alarm in bedroom one and the smoke alarms were chirping in occupied resident bedrooms one and two, indicating these alarms were not properly maintained.

7. Escape window openings shall have a maximum height from the floor to the windowsill opening shall not exceed 48 inches. Escape windows with openings up to 52 inches off of the floor may meet the height requirement for existing buildings by securing a step, platform or bed to the wall directly underneath the window. This step, platform or bed shall be no more than 44 inches below the opening and must be strong enough to support the weight of the person. The minimum acceptable width shall be the same as the window opening. The minimum acceptable depth away from the wall shall be 18 inches. [Minn. Stat. 144G.45 subd. 2; MSFC 1104.26.3, 1104.26.6.1]

Comments: The sill height for the egress window measured 48.5 inches from the floor in occupied resident bedroom five. The bed was not located directly underneath the window, and a step or platform was not installed.

☒ **TAG IDENTIFICATION: 0780**

SCOPE/ SEVERITY: Level 2; Pattern

TIME PERIOD OF CORRECTION: Seven (7) days

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1. Smoke alarms interconnected so that actuation of one alarm causes all alarms in the individual dwelling or sleeping unit to operate where more than one smoke alarm is required within an individual dwelling or sleeping unit. [Minn. Stat. 144G.45 subd.2]

Comments: When unlicensed personnel (ULP)-E tested the smoke alarms on the main floor, the smoke alarms in occupied basement bedrooms four and five were not actuated. When ULP-E tested the smoke alarm in bedroom four, none of the other dwelling unit smoke alarms were actuated. When ULP-E tested the smoke alarm in bedroom five, none of the other dwelling unit smoke alarms were actuated. All dwelling unit smoke alarms were not interconnected.

☒ **TAG IDENTIFICATION: 0790**

SCOPE/ SEVERITY: Level 2; Pattern

TIME PERIOD OF CORRECTION: Seven (7) days

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

Comments:

- *Tags or labels were not attached to the portable fire extinguishers indicating annual maintenance had been performed by certified service personnel. The bottom of the fire extinguishers were date stamped 2023. All portable fire extinguishers shall be maintained to ensure the extinguisher is operable in the event of an emergency.*
- *The tags attached to the portable fire extinguishers indicated monthly inspections had not been completed in 2025 and 2026. Supervisor/unlicensed personnel (S/ULP)-B stated the licensee had switched to electronic inspection records. The surveyor requested these inspection records from S/ULP-B, but these records were not provided. Fire extinguisher inspections must be conducted and documented every month to ensure each installed extinguisher is in its designated place, it has not been tampered with, and there is no obvious physical damage or condition that would interfere with its use or operation.*

☒ **TAG IDENTIFICATION: 0800**

SCOPE/ SEVERITY: Level 2; Widespread**TIME PERIOD OF CORRECTION:** Seven (7) days

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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:

- There was a hole in the wall behind the door, two floor tiles were chipped at the door transition, and one piece of base trim was missing by the walk-in-shower in the basement bathroom.
- A knob or handle was not installed for the closet and part of the floor transition between the bathroom and hallway was missing in the main floor bathroom.
- In occupied resident bedroom four, the door was damaged near the knob and the lock was broken.
- In occupied resident bedroom three, there were several holes in the door.
- In occupied resident bedroom one, there was a large hole in the door, the knobs were missing from the closet doors, there were several holes in the walls, and the window screen was loose.
- The ceiling surface was peeling above the stairs and one seat cushion on the couch was torn in the main floor living room.
- The wall mounted battery operated carbon monoxide alarm on the main floor did not work when tested.

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 3; Widespread**TIME PERIOD OF CORRECTION:** Twenty One (21) days

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1. Each assisted living facility shall develop and maintain fire safety and evacuation plans that include the location and number of resident rooms. [Minn. Stat. 144G.45 subd.2]

Comments:

- The numbers posted at the bedroom doors did not match the number labels on the emergency evacuation floor plans.
 - A room identifier was not posted at the door for resident bedroom one.
 - The laundry/mechanical room was inaccurately identified as a resident bedroom.
 - One of the emergency evacuation floor plans included in the fire emergency binder was for a building with a different layout and address.
- The emergency evacuation floor plans did not accurately identify the resident bedroom locations. The numbers posted at the resident bedroom doors need to correspond with the floor plan to provide efficient communication for exiting in the event of a fire or similar emergency.

2. Each assisted living facility shall develop and maintain fire safety and evacuation plans that include employee actions to be taken in the event of a fire or similar emergency. [Minn. Stat. 144G.45 subd.2]

Comments:

- Employees were directed to exit the building through the attached garage. An exit sign was posted at the door leading into the attached garage and both garage doors were labeled as exits on emergency evacuation floor plans. Emergency exits are required to lead directly to the exterior of the building and not through a higher-hazard room.
 - Employees were directed to a first floor portable fire extinguisher stored on top of a cabinet. This fire extinguisher location was not accurate.
 - Fire safety and evacuation plan (FSEP) documents were from a third party. Pull fire alarms, fire doors, smoke compartments, and smoke partitions, were inaccurately referenced.
 - Employees were inappropriately instructed to use horizontal evacuation procedures and in a large scale, to wait until the local fire the fire department orders evacuation of the facility in a building with no life safety systems or fire resistant construction.
 - The property information inaccurately identified the location of all five resident bedrooms as being on the main floor. Bedrooms four and five were in the basement.
- The licensee failed to develop and maintain the fire safety and evacuation plan with site specific employee actions relative to the facility's building layout and environmental risks.*

3. Each assisted living facility shall develop and maintain fire safety and evacuation plans that include fire protection procedures necessary for residents. [Minn. Stat. 144G.45 subd.2]

Comments: The fire safety and evacuation plan (FSEP) resident procedures were limited to stoop or crawl to avoid smoke. The licensee failed to develop the FSEP with site specific fire safety and evacuation instructions for residents.

4. Each assisted living facility shall develop and maintain fire safety and evacuation plans that include procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. [Minn. Stat. 144G.45 subd.2]

Comments:

- One resident was identified with an evacuation level status two, requiring moderate staff assistance in the event of an evacuation. Emergency evacuation procedures were not included in the fire safety and evacuation plan for this resident.
 - There were five residents living at the facility and personalized evacuation plans for two residents were not included with the fire safety and evacuation plan.
- Individualized evacuation procedures for all residents shall be included with the fire safety and evacuation plan.*

5. 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: The surveyor requested records for employee training on the fire safety and evacuation plan completed between February 2025 and February 2026, from the licensee. Supervisor/unlicensed personnel (S/ULP)-B stated fire safety and evacuation plan training records were not available as the owner was out of the country.

6. 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: The surveyor requested records for resident training on fire safety and evacuation completed between February 2025 and February 2026, from the licensee. One resident training record was provided dated January 24, 2024. Supervisor/unlicensed personnel (S/ULP)-B stated additional fire safety and evacuation training records were not available as the owner was out of the country.

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

Comments: The surveyor requested records for evacuation drills completed between February 2025 and February 2026, from the licensee. Four fire drill reports were provided for 2025, indicating fire drills were completed in March, June, September, and December. These four drills were all completed during the day shift. Evacuation drill reports from 2026 were not provided. The licensee failed to meet the evacuation drill frequency as required by statute.