



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

February 12, 2026

Licensee
Direct Home Care Services LLC
19449 Rush Street Northwest
Elk River, MN 55330

RE: Project Number(s) SL38050016

Dear Licensee:

On January 27, 2026, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on August 15, 2025. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'Tim Hanna'.

Tim Hanna, Supervisor
State Engineering Services Section
Email: Tim.Hanna@state.mn.us
Telephone: 507-208-8982 Fax: 1-866-890-9290

CLN



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

October 2, 2025

Licensee

Direct Home Care Services LLC
19449 Rush Street Northwest
Elk River, MN 55330

RE: Project Number(s) SL38050016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 15, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement;

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

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

Level 4: a fine of \$3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

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

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

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38050	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/15/2025
NAME OF PROVIDER OR SUPPLIER DIRECT HOME CARE SERVICES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 19449 RUSH STREET NORTHWEST ELK RIVER, MN 55330			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL38050016-0 On August 11, 2025, through August 14, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there was one resident 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 License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements	0 470			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 470	Continued From page 1 (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; (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 observation, 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 and failed to post an accurate daily work	0 470			

Minnesota Department of Health

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0 470	Continued From page 2 schedule at the beginning of each work shift. 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: On August 11, 2025, at 10:50 a.m., the licensee's staff schedule was observed on a cork board in a common area of the facility. The schedule dated "March1st-31st" indicated one unlicensed personnel (ULP) was scheduled to work each of two shifts during the week. -morning/evening 7:00 a.m.- 7:00 p.m. -evening/overnight 7:00 p.m.-7:00 a.m. Owner (O)-A acknowledged the staffing schedule was not current and the staffing plan was not evaluated twice annually. The licensee's Staffing Plan policy, dated August 1, 2023, indicated the Clinical Nurse Supervisor will prepare and implement a 24-hour daily staffing plan that ensures adequate staffing to meet residents' needs at all times, including reasonably foreseeable needs. 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. Considerations include:	0 470			

Minnesota Department of Health

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0 470	Continued From page 3 -the staffing requirements to meet the scheduled and reasonably foreseeable unscheduled needs of the residents based on the assessment and service plan -the acuity level of the residents based on the nursing assessment -the facility's ability to respond promptly and effectively to residents -staff experience, training and competence -dementia care requirements -the physical layout of the residence 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 (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	0 480			

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0 480	Continued From page 4 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 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	0 480			

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0 480	Continued From page 5 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 August 11, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			
0 485 SS=C	144G.41 Subdivision 1.a (a) Minimum requirements; required food services (a) All assisted living facilities must offer to provide or make available at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a	0 485			

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0 485	Continued From page 6 food that is served. Residents must be informed in advance of menu changes. The facility must not require a resident to include and pay for meals in the resident's contract. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure weekly menus were made available to the residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on August 11, 2025, at 9:48 a.m. owner (O)-A stated the licensee provided three meals daily and the resident had input with the menu. On August 11, 2025, at 10:50 a.m., during a tour with O-A, O-A stated the menu was normally on the board by the entrance door. Surveyor observed the Weekly Food Menu dated April 5, 2025, through April 11, 2025. No further menus were posted after April 11, 2025. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 485			

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0 485	Continued From page 7 (21) days	0 485			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness plan (EPP) with all the required content and failed to post the EPP in a prominent location. This had the potential to affect all visitors, employees, and residents.	0 680			

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0 680	Continued From page 8 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: On August 11, 2025, at 10:50 a.m. owner (O)-A provided licensee's Emergency Disaster Plan that was located on the lower level behind a locked medication room door. O-A stated that the EPP is always located in the medication room behind a locked door. The licensee's EPP dated May 24, 2024, lacked the required content: -process of EPP collaboration -subsistence needs of staff and patients -arrangement with other facilities -roles under waiver declared by secretary -sharing information on occupancy/needs -annual review -quarterly review of missing resident plan On August 14, 2025, at 9:32 a.m., owner (O)-A acknowledge they were not up to date annually with review and they were not aware the missing resident plan required quarterly review. The licensee's undated Emergency Disaster Plan Orientation and training policy indicated emergency services and emergency preparedness plans and training will be provided	0 680			

Minnesota Department of Health

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0 680	Continued From page 9 to staff and residents in compliance annually. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680			
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the	0 730			

Minnesota Department of Health

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0 730	Continued From page 10 resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to complete a discharge summary for one of one discharged resident (R2). This practice resulted in a level two violation (a violation that did not harm a client'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: Owner (O)-A provided R2's medication disposition dated August 18, 2023.	0 730			

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER DIRECT HOME CARE SERVICES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 19449 RUSH STREET NORTHWEST ELK RIVER, MN 55330			
(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
0 730	Continued From page 11 R2's record lacked a discharge summary. On August 14, 2025, at 9:37 a.m. O-A stated they were unable to locate R2's discharge summary. The licensee's undated Discharge Summary policy indicated a discharge policy would be completed for each resident discharged from the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730			
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except	0 780			

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0 780	Continued From page 12 that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that functioned and were interconnected so that the actuation of one alarm caused all alarms in the dwelling unit to actuate. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 August 13, 2025, from 12:30 p.m. to 1:30 p.m., the surveyor toured the facility with owner (O)-A. The surveyor asked O-A to initiate a test of the smoke alarms throughout the home. Upon testing, it was found that the smoke alarms in the facility were not interconnected. Bedroom 1 was not interconnected with the rest of the facility. The licensee had additional small battery-operated smoke alarms in the kitchen, lower level living room, and upper level hallway	0 780			

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0 780	Continued From page 13 that were not interconnected to the rest of the smoke alarms in those areas. Where more than one smoke alarm is required in an individual dwelling unit, all smoke alarms are required to be interconnected so activation of one alarm activates all alarms throughout the facility. These deficient conditions were visually verified at the time of discovery by O-A accompanying on the tour. On August 13, 2025, , at 1:30 p.m.,O-A stated they just never removed the extra smoke alarms in some areas after installing the interconnected system. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780			
0 800 SS=E	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee	0 800			

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0 800	Continued From page 14 failed to maintain the physical environment, in a continuous state of good repair and operation. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: On August 13, 2025, from 12:30 p.m. to 1:30 p.m., the surveyor toured the facility with owner (O)-A, The following was observed. - The egress window in bedroom 1 was difficult to open. O-A had to force it to open completely. - The carpet runner on the stairs to the lower level living room were frayed and gapping away from the stair structure at the step edges. This had the potential to create a tripping hazard for anyone using the stairs. - The med room had two large holes in the walls where it appeared utility work had been completed but not closed up. - The lower level basement had dark staining and fuzzy, raised growth on the ceiling tiles above the file storage area. - The backyard fence gate was loose on the hinges and did not open as designed. O-A had to lift it out of the grass to open it.	0 800			

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0 800	Continued From page 15 These deficient conditions were visually verified at the time of discovery by O-A accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800			
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	0 810			

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0 810	Continued From page 16 activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content, to provide the required training, and to conduct evacuation drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level 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: On August 13, 2025, from 12:30 p.m. to 1:30 p.m., the surveyor toured the facility with owner (O)-A. The fire evacuation diagrams incorrectly labeled the attached garage as an egress path. The attached garage is a higher hazard and is not an approved egress path. Exit plan diagrams must be correctly labeled to reduce confusion and potential obstructions to egress in a fire or similar emergency. The incorrect evacuation diagrams were posted on multiple levels. The lower level living room evacuation diagram was posted adjacent to the	0 810			

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0 810	Continued From page 17 main level kitchen patio door. On August 13, 2025, O-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP, Fire Safety, dated August 1, 2021, failed to include the following: The FSEP failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The provided FSEP was from a third-party provider and had not been updated to the specific facility. The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. On August 13, 2025, at 2:30 p.m., O-A stated they didn't understand that the third-party policy they were using was not correct. HM-C stated they would work on bringing them into compliance. The policy reviewed was an unedited policy from a third-party provider that was not specific to the facility. TRAINING: The licensee failed to provide evacuation training to residents at least once per year. O-A lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan.	0 810			

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0 810	Continued From page 18 The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. The licensee's training records, titled Emergency Preparedness In Assisted Living: Audit Tool, undated, indicated staff were trained upon hire. No other training documentation was provided. On August 13, 2025, at 2:30 p.m., O-A stated they understood the requirements for training residents and staff and would implement a training program that was compliant with statute requirements. DRILLS: The licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. Record review of licensee's evacuation drill log, titled Fire Drill Log, undated, indicated evacuation drills were conducted on August 20, 2023, January 15, 2024, July 16, 2024, December 20, 2024, January 20, 2025 and March 20, 2025. No other documentation was provided. On August 13, 2025, at 2:30 p.m., O-A stated there were no additional documented drills for the facility. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810			
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living	01440			

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01440	Continued From page 19 facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure direct supervision of staff performing delegated tasks was provided within 30 calendar days after the date on which the individual began working for the licensee for one of one employee (owner (O)-A). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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	01440			

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01440	Continued From page 20 situation has occurred only occasionally). The findings include: O-A was hired on August 1, 2021, to provide direct care services to residents of the facility. On August 11, 2025, at 11:00 a.m., the surveyor observed O-A assisting R1. O-A's employee record lacked documented evidence of a supervision of performing delegated tasks within 30 calendar days. On August 14, 2025, at 9:41 a.m., clinical nurse supervisor (CNS)-B stated they thought that O-A had the 30-day supervision completed as they were a certified nursing aide at a different agency. The licensee's undated Supervision of Unlicensed Personal policy indicated, the direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs delegated tasks for residents, and thereafter as needed based on performance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440			
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter;	01470			

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01470	Continued From page 21 (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss	01470			

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01470	Continued From page 22 and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of one employee owner (O)-A received orientation to assisted living facility licensing requirements and regulations before providing 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 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: O-A was hired on August 1, 2021, to provide direct care and services to the facility's residents.	01470			

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01470	Continued From page 23 O-A's employee record did not include the following required orientation content: -overview of Assisted Living statutes -handling of resident complaints, reporting of complaints, where to report -review of types of Assisted Living services the employee will provide and provider's scope of license -principles of person-centered planning/service delivery On August 14, 2025, at 9:42 a.m., O-A acknowledge the missing training in O-A's employee record. The licensee's undated Facility Employee Orientation policy indicated employees must complete the orientation to assisted living facility requirements before providing assisted living services to residents. The orientation must contain the following topics: -an overview of Minnesota's home care law (MN Statutes 144A.43 to 144.4798) -an introduction and review of all of facility's policies and procedures related to the provision of home care services -handling of emergencies and use of emergency services -reporting the maltreatment of vulnerable minors or adults under Minnesota Statutes 626.556 and 626.557. -assisted Living Bill of Rights -handling of residents' complaints and reporting of complaints to the Office of Health Facility Complaints -consumer advocacy services of the Ombudsman for Long-Term care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care	01470			

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01470	Continued From page 24 Ombudsman at the Department of Human Services, county managed care advocates and other relevant advocacy services -a review of the types of services the employee will be providing and the scope of the facility's services under the specific license -completion of the orientation training shall be documented in the employee's personnel file. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01470			
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve	01500			

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01500	Continued From page 25 when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received at least eight (8) hours of annual training for each 12 months of employment for one of one	01500			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38050	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/15/2025
NAME OF PROVIDER OR SUPPLIER DIRECT HOME CARE SERVICES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 19449 RUSH STREET NORTHWEST ELK RIVER, MN 55330			
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01500	Continued From page 26 employees (owner (O)-A). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: O-A was hired on August 1, 2021, to provide direct care and services to the facility's residents. On August 11, 2025, at 12:39 p.m. surveyor reviewed O-A's employee record lacked annual required training in the following topics: -mental illness and De-escalation Training: Met one (1) hour annually, effective July 1, 2025. On August 14, 2025, at 9:43 a.m., O-A stated they were unaware the requirement. The licensee's undated Annual Training Requirements policy indicated all staff that provide direct care services in assisted living must completed at least eight (8) hours of annual training for each 12 months of employment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500			
01530 SS=D	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De-	01530			

Minnesota Department of Health

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01530	Continued From page 27 (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter;	01530			

Minnesota Department of Health

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01530	Continued From page 28 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure direct care staff received the required 8 hours of dementia training within 160 hours of start date for one of one employee (owner (O)-A). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: O-A was hired on August 1, 2021, to provide direct care and services to the facility's residents. On August 11, 2025, at 12:39 p.m. surveyor reviewed O-A's employee record with five (5) hours of dementia training upon orientation. O-A-s employee record lacked the orientation training for the required eight (8) hours of dementia training within 160 hours. On August 14, 2025, at On August 14, 2025, at 9:43 a.m., O-A stated they were unaware of the missing education. The licensee's undated Dementia Care Training policy indicated, direct care employees must	01530			

Minnesota Department of Health

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01530	Continued From page 29 have completed at least eight hours of initial training on required topics in the 160 hours from employment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530			
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed	01620			

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01620	Continued From page 30 practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive reassessment not to exceed 90 calendar days from the last assessment, for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the	01620			

Minnesota Department of Health

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01620	Continued From page 31 situation has occurred only occasionally). The findings include: R1's diagnoses cerebral infarction (lack of blood supply to the brain) and hypertension (high blood pressure). R1's Service Plan dated August 11, 2021, indicated R1 received services including manage agitation, medication administration, bath assist, hygiene, and grooming, dressing, laundry, housekeeping, and food preparation. R1's last three assessments were requested. Assessments dated June 10, 2025, March 8, 2025; and November 20, 2024, were provided. 94 days had passed between the June 10, 2025 and March 8, 2025, assessments (4 days late); 108 days had passed between the March 8, 2025 and November 20, 2024, assessments (18 days late). On August 14, 2025, at 9:48 a.m., clinical nurse supervisor (CNS)-B stated that she had missed the 90-day time frame and will schedule the timing of assessments to prevent missing the 90-day requirement. The licensee's undated Comprehensive Resident Assessment policy indicated, ongoing resident reassessment cannot exceed 90 calendar days form the last date of the assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620			

Minnesota Department of Health

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01730	Continued From page 32	01730			
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, a registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions.	01730			

Minnesota Department of Health

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01730	Continued From page 33 (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to develop an individualized medication management plan with all required content for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R1's diagnoses cerebral infarction (lack of blood supply to the brain) and hypertension (high blood pressure). R1's Service Plan dated August 11, 2021, indicated R1 received services including manage agitation, medication administration, bath assist, hygiene, and grooming, dressing, laundry, housekeeping, and food preparation. R1's record included lacked a individualized	01730			

Minnesota Department of Health

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01730	Continued From page 34 medication management plan that followed the required content per [144G.71, Subd. 5]: -medication management services provided by nurse and unlicensed personnel (ULP) (included PRN); -type of medication storage system, based on resident's needs; -specific written instructions for resident's medication administration; -person responsible for monitoring medication supplies and refills; -medication management tasks that may be delegated to ULPs; -procedures for staff to notify an RN when problems arose; -any resident-specific requirements (i.e., parameters: blood sugar, blood pressure, pulse, etc.); and -medication Reconciliation was completed by nurse, licensed health professional, or authorized prescriber. On August 14, 2025, at 9:50 a.m. clinical nurse supervisor (CNS)-B stated they were unaware the medication management plans lacked required content. The licensee's undated Medication Management Services policy indicated, the registered nurse (RN) will develop an individualized medication management plan for each resident receiving any type of medication management services, consistent with current practice standards and guidelines and will develop specific procedures for medication management services that staff will provide. No further information was provided.	01730			

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01730	Continued From page 35 TIME PERIOD FOR CORRECTION: Seven (7) days	01730			



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

Food & Beverage Inspection Report

Page: 1

Establishment Info

DIRECT HOME CARE SERVICES LLC
19449 RUSH STREET NW
Elk River, MN 55330
Sherburne County
Parcel:

Phone:

License Info

License: HFID 38050

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

Inspection Info

Report Number: F1051251080
Inspection Type: Full - Single
Date: 8/11/2025 Time: 11:45:00 AM
Duration: 30 minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 1
Delivery: Emailed

New Order: 2-100 Supervision

2-102.12AMN Priority Level: Priority 3 CFP#: 2

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

COMMENT:

AT THE TIME OF INSPECTION, THERE IS NO CERTIFIED FOOD PROTECTION MANAGER. SEND A FULL TIME EMPLOYEE TO TAKE AN APPROVED TRAINING CLASS. ONCE THEY HAVE PASSED THE CLASS, SUBMIT THE RESULTS TO THE STATE'S ONLINE CERTIFIED FOOD PROTECTION MANAGER APPLICATION. LINKS WILL BE PROVIDED WITH THE REPORT VIA EMAIL.

Comply By: 8/31/2025 Originally Issued On: 8/11/2025

Food & Beverage General Comment

MET WITH THE NURSE EVALUATOR, JESSICA DETERS.

DISCUSSED THE FOLLOWING WITH THE OWNER, SAM:

EMPLOYEE ILLNESS LOG (SENT WITH REPORT VIA EMAIL)
VOMIT CLEAN-UP PROCEDURES
HANDWASHING & GLOVE USE/DISPOSAL
CERTIFIED FOOD PROTECTION MANAGER

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

I acknowledge receipt of the St Cloud District Office inspection report number F1051251080 from 8/11/2025

Sam
Owner

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



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

Temperature Observations/Recordings

Page: 1

Establishment Info

DIRECT HOME CARE SERVICES LLC
Elk River
County/Group: Sherburne County

Inspection Info

Report Number: F1051251080
Inspection Type: Full
Date: 8/11/2025
Time: 11:45:00 AM

Equipment Temperature: Product/Item/Unit: AMBIENT; Temperature Process: Ambient Air

Location: Upright Cooler at 37 Degrees F.

Comment:

Violation Issued?: No