Electronically Delivered

November 4, 2025

Licensee
Humanity Care LLC
7245 Grand Ave South
Richfield, MN 55423

RE: Project Number(s) SL40483015

Dear Licensee:

On October 15, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on June 25, 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,

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

HHH

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September 25, 2025

Licensee
Humanity Care LLC
7245 Grand Ave South
Richfield, MN 55423

RE: Project Number(s) SL40483015

Dear Licensee:

This is your **official notice** that you have been **granted your assisted living facility license.** Your license effective and expiration dates remain the same as on your provisional license. Your updated status will be listed on the license certificate at renewal and **this letter serves as proof** in the meantime. If you have not received a letter from us with information regarding renewing your license within 60 days prior to your expiration date, please contact us at (651) 201-5273 or by email at Health.assistedliving@state.mn.us.

The Minnesota Department of Health completed an initial survey on June 25, 2025, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

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

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

Level 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

The total amount you are assessed is $500.00. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

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

To submit a hearing request, please visit:

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,

Renee L Anderson

Renee.L.Anderson@state.mn.us , Supervisor
State Evaluation Team
Email: Renee.L.Anderson@state.mn.us
Telephone: 651-201-5871 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40483	A. BUILDING: _____ B. WING _____	06/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUMANITY CARE LLC	7245 GRAND AVE SOUTH RICHFIELD, MN 55423

(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: SL40483015-0 On June 23, 2025, through June 25, 2025, the Minnesota Department of Health conducted a full survey at the above provider, and the following orders are issued. At the time of the survey, there were two residents, both receiving services under the Provisional 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.	
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness	0 680		

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0 680	Continued From page 1 (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. In addition, the licensee failed to ensure the missing resident policy was reviewed quarterly as required under section 4659.0110. This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a	0 680		

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0 680	Continued From page 2 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's undated EPP lacked the following required content: -consider hazards like care related emergencies, equipment/utility failures, interruptions in communications/cyber-attacks, loss of all or portion of a facility, interruption to normal supply of essential resources and medical supplies, -take an all-hazards approach, including emerging infectious diseases, as applicable, -develop strategies for addressing facility & community-based risks (i.e.: staffing surges/shortages, back-up plans): -consider duration of interruptions-procedures for tracking of staff and residents, -arrangements/contracts to re-establish utility services -policies and procedures (P/P) for, at minimum pharmaceutical supplies, alternate sources of energy, sewage/waste disposal. -EP included P/P comprehensive communication plan to include means to providing information about the facility's occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee, -EP included P/P in relation to an 1135 waiver, -EP included P/P included sheltering in place, -EP included P/P include handling medical	0 680		

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0 680	Continued From page 3 documents, -EP included P/P included handling and use of volunteers, -EP included P/P long term care family notifications, and -EP included documentation of two emergency preparedness exercises (an annual full-scale exercise or individual facility-based functional exercise and a second full-scale exercise that was either community-based, an individual facility based functional exercise, a mock disaster drill, or a table-top exercise). The licensee's missing resident policy, dated February 20, 2023, lacked evidence it was reviewed quarterly, as required. On June 25, 2025, at 4:00 p.m., licensed assistant living director and owner (LALD)-A stated the licensee met with residents quarterly and as needed, but did not document annual review. LALD-A stated this would be incorporated in the EPP plan going forward as well as having all required content included in the EPP. LALD-A stated, "It is much bigger than we thought." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code:	0 780		

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0 780	Continued From page 4 (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: Based on observation and interview, the licensee failed to provide interconnected smoke alarms throughout the facility. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	0 780		

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0 780	Continued From page 5 The findings include: On a facility tour on June 24, 2025, from 11:00 a.m. to 12:15 p.m., with licensed assisted living director and owner (LALD)-A, the surveyor observed the following: When tested, smoke alarms provided in resident room 4, resident room 5, basement common room, and laundry room were not interconnected such that activation of one alarm activates all alarms. Smoke alarms were tested by LALD-A by activating alarms resident room 3, resident room 4 and basement common room. All smoke alarms on the upper level of the facility were interconnected when tested, but smoke alarms in the basement level were not interconnected. When the smoke alarms in the basement common room and resident room 4 were tested, only those alarms sounded, and no other alarms were activated in the facility. Where multiple smoke alarms are required, these alarms must be interconnected so activation of one alarm activates all alarms within the facility. During the facility tour interview on June 24, 2025, LALD-A verified the above-listed fire protection and physical environment observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Two (2) days	0 780		
0 790 SS=F	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;	0 790		

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0 790	Continued From page 6 (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: Based on observation and interview, the licensee failed to maintain the portable fire extinguishers. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On June 24, 2025, from approximately 11:00 a.m. to 12:15 p.m., the surveyor toured the facility with licensed assisted living director and owner (LALD)-A. During the tour, the surveyor observed the following deficient conditions: The fire extinguisher in the basement common area and upper level near kitchen did not have current annual service tags. Both extinguishers indicated they were manufactured in 2021. No	0 790		

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0 790	Continued From page 7 annual service tags were present on the extinguishers, nor were records of such service available. All fire extinguishers should have current annual service tags from a licensed professional to ensure proper function and maintenance. Fire extinguishers should also have monthly maintenance checks by facility staff to confirm visible condition. During the tour LALD-A verified the annual testing had not been conducted on the fire extinguishers. LALD-A indicated that testing would be scheduled. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
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 failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors.	0 800		

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0 800	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) 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 a facility tour on June 24, 2025, from 11:00 a.m. to 12:15 p.m., with licensed assisted living director and owner (LALD)-A, the surveyor observed the following: A supplied carbon monoxide alarm was not functional when tested in the basement common area. Supplied carbon monoxide alarm should be maintained in proper working order or removed if adequate carbon monoxide protection is otherwise met. The basement shower was discolored and had grout that appeared sullied. The shower should be maintained in sanitary and clean condition. The ventilation in the basement bathroom did not operate when activated. Bathroom ventilation should be maintained in proper functional working order to mitigate moisture buildup. Paint was peeling and flaking from the ceiling in the basement bathroom. The exterior screen door located off of the stairs near the kitchen was disconnected from the	0 800		

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0 800	Continued From page 9 self-closing arm, which appeared broken and was hanging loosely in front of the frame. The screen door and hardware should be maintained and not left hanging which may block the doorway. During the facility tour interview on June 24, 2025, LALD-A verified the above listed physical environment observations while accompanying on the tour. LALD-A indicated that the noted deficiencies would be corrected. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the	0 810		

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0 810	Continued From page 10 proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop the fire safety and evacuation plan with required content. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On June 24, 2025, at approximately 12:00 p.m., licensed assisted living director and owner (LALD)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility.	0 810		

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0 810	Continued From page 11 The licensee FSEP failed to include the following: The FSEP failed to identify specific fire protection actions for residents. There was no section in the provided documents that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. LALD-A stated residnet procedures for evacuation will be developed. The FSEP did not include location and number of resident rooms and no floor plans were included in emergency binders. Record review indicated the licensee failed to provide and document adequate training to employees on the FSEP upon hire and at least twice per year. Staff was unable to provide documentation showing adequate trainings were provided for employee training on the fire safety and evacuation plan. LALD-A stated that employees were trained only upon hire. Employees should be provided training upon hire and at least twice a year thereafter and trainings should be specific to the facility and FSEP plans. Record review indicated that the licensee failed to provide and document adequate training with residents on the FSEP. Residents should be offred training on proper actions during an evacuation at least once per year. During an interview on June 24, 2025, at approximately 12:10 p.m., the surveyor explained the requirements for employee trainings, resident trainings, and FSEP documentation. LALD-A stated they understood the requirements. TIME PERIOD FOR CORRECTION: Twenty-one	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40483	A. BUILDING: _____ B. WING _____	06/25/2025

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0 810	Continued From page 12 (21) days	0 810		
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; (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	01470		

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01470	Continued From page 13 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 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 observation, interview, and record review, the licensee failed to provide orientation to assisted living licensing requirements and regulations prior to providing services for one of two 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	01470		

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01470	Continued From page 14 situation has occurred only occasionally). The findings include: ULP-C was hired on September 28, 2024, to provide direct care and services to residents of the facility. ULP-C's record lacked documentation of orientation to assisted living regulations as follows: - Overview of Assisted Living statutes - Review of provider's policies and procedures - Handling emergencies and using emergency services - Reporting maltreatment of vulnerable adults or minors - Assisted Living bill of rights - Handing of resident complaints, reporting of complaints, where to report - Consumer advocacy services - Review of types of Assisted Living services the employee will provide and provider's scope of license - Orientation to each specific resident and services provided - Dementia training required for all direct care staff and supervisors On June 24, 2025, at 1:30 p.m., licensed assisted living director and owner (LALD)-A stated they had placed a call to Edu-Care (online training platform) requesting any additional education transcripts or training for ULP-C. LALD-A stated Edu-Care did not respond. LALD-A explained ULP-C was educated either though Edu-Care or by the licensee's registered nurses.	01470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01470	Continued From page 15 On June 24, 2025, at 2:36 p.m., Edu-Care chief training officer (ETO)-D stated ULP-C had two separate accounts in the Edu-Care system, but neither had completed modules. ETO-D also stated a new account was added that day with two courses in progress. On June 25, 2025, at 4:00 p.m., LALD-A stated employees were expected to complete all orientation training prior to providing direct care to residents. LALD-A explained this may have been overlooked because ULP-C was employed by another facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01530 SS=D	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics	01530		

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01530	Continued From page 16 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; This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to ensure employees completed dementia care training (at least eight hours within 160 working hours of the employment start date) for one of two 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	01530		

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01530	Continued From page 17 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: ULP-C was hired on September 28, 2024, to provide direct care and services to residents of the facility. ULP-C's employee record included documentation of 5.5 hours dementia training completed within 160 hours of working. ULP-C's record lacked a total of 8 hours of dementia care training in the required topics. On June 24, 2025, at 1:30 p.m., licensed assisted living director and owner (LALD)-A stated they had placed a call to Edu-Care (an online training platform) requesting any additional education transcripts or training for ULP-C. LALD-A stated Edu-Care did not respond. LALD-A explained ULP-C was educated either though Edu-Care or by the licensee's registered nurses. On June 24, 2025, at 2:36 p.m., Edu-Care chief training officer, (ETO)-D stated ULP-C had two separate accounts in the Edu-Care system, but neither had completed modules also, a new account was added today with two courses in progress. On June 25, 2025, at 4:00 p.m., LALD-A stated ULP-C's record lacked the required dementia training. LALD-A stated employees were expected to complete dementia training prior to providing direct care to residents in the regulated	01530		

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01530	Continued From page 18 time-frame. LALD-A explained this may have been overlooked because ULP-C was employed by another facility and possibly the records were mis placed. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		

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

Food & Beverage Inspection Report

Establishment Info

Humanity Care LLC
7245 Grand Avenue South
Richfield, MN 55423
Hennepin County
Parcel:

Phone:

License Info

License: HFID 0483

Risk:
License:
Expires on:
CFPM: Kedija Shamoro
CFPM #: 58397; Exp: 12/9/2027

Inspection Info

Report Number: F7963251012
Inspection Type: Full - Single
Date: 6/24/2025 Time: 3:19:53 PM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

No orders were issued for this inspection report.

Food & Beverage General Comment

MET WITH MDH NURSE SURVEYOR MARY BRUESS AND ESTABLISHMENT REPRESENTATIVE SHUMITA DIKALE.
DISCUSSED THE FOLLOWING-
-EMPLOYEE ILLNESS POLICY AND LOG
-SUSCEPTIBLE POPULATION RESTRICTIONS
-SAME DAY SERVICE DEFINITION
-TESTING OF DISHWASHER
-VOMIT/FECAL CLEAN-UP POLICY

THIS IS A RESIDENTIAL KITCHEN USING A DISHWASHER FOR WAREWASHING.
THE FLOOR IS LINOLEUM, WOOD CABINETS, PAINTED WALLS AND SMOOTH, PAINTED CEILING AND LAMINATE COUNTERTOPS.

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 F7963251012 from 6/24/2025

Shumita Dikale

Peggy Spadafore,
Public Health Sanitarian Supervisor
651-201-3979
peggy.spadafore@state.mn.us

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

Temperature Observations/Recordings

Establishment Info

Humanity Care LLC
Richfield
County/Group: Hennepin County

Inspection Info

Report Number: F7963251012
Inspection Type: Full
Date: 6/24/2025
Time: 3:19:53 PM

Food Temperature: Product/Item/Unit: TUNA SALAD**; Temperature Process:**
Location: Refrigerator at 38 Degrees F.
Comment:
Violation Issued?: No

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

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

Sanitizer Observations/Recordings

Establishment Info

Humanity Care LLC
Richfield
County/Group: Hennepin County

Inspection Info

Report Number: F7963251012
Inspection Type: Full
Date: 6/24/2025
Time: 3:19:53 PM

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