Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

January 2, 2026

Licensee
Caringhands LLC
2901 West 90th Street
Bloomington, MN 55431

RE: Project Number(s) SL36779016

Dear Licensee:

On December 23, 2025, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on October 1, 2025. This follow-up survey determined your facility had corrected all of the state correction orders issued pursuant to the October 1, 2025 survey.

The Department of Health concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

Also, at the time of this follow-up survey completed on December 23, 2025, we identified the following violation(s):

0800 - Fire Protection And Physical Environment - 144g.45 Subd. 2 (a) (4)

The details of the violation(s) noted at the time of this follow-up survey are delineated on the attached State Form. Only the ID Prefix Tag in the left hand column without brackets will identify these state correction orders. It is not necessary to develop a plan of correction.

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

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

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

We urge you to review these orders carefully. If you have questions, please contact Tim Hanna at 507-208-8982.

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

Sincerely,

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

KKM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36779	A. BUILDING: _____ B. WING _____	R 12/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARINGHANDS LLC	2901 WEST 90TH STREET BLOOMINGTON, MN 55431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL36779016-1 On December 22, 2025, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on September 30, 2025. At the time of the survey, there were 2 residents; 2 receiving services under the Assisted Living with Dementia Care license. As a result of the follow-up survey, the following new correction orders have been issued.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
{0 480} SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	{0 480}		

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

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{0 480}	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by:	{0 480}	Not reviewed during this survey.	
{0 650} SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living	{0 650}		

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{0 650}	Continued From page 3 services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by:	{0 650}	Not reviewed during this survey.	
0 800 SS=D	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 maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. 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 an isolated scope (when one or a	0 800		

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0 800	Continued From page 4 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: During a facility tour on December 22, 2025, from 12:45 p.m. through 1:05 p.m. with licensed assisted living director/registered nurse (LALD/RN)-D the surveyor observed broken glass in a window by the front door. The window was broken all the way across and through the glass and created a sharp edge. Broken glass can fall out of the frame and create sharp, jagged edges. LALD/RN-D stated the glass recently broke when the windows were being cleaned. LALD/RN-D verified the findings while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800		
{01710} SS=D	144G.71 Subd. 3 Individualized medication monitoring and reas A registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. This MN Requirement is not met as evidenced by:	{01710}	Not reviewed during this survey.	

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{01890} SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by:	{01890}	Not reviewed during this survey.	

Electronically Delivered

October 30, 2025

Licensee
Caringhands LLC
2901 West 90th Street
Bloomington, MN 55431

RE: Project Number(s) SL36779016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on October 1, 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

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

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

The correction order documentation should include the following:

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

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

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

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

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

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

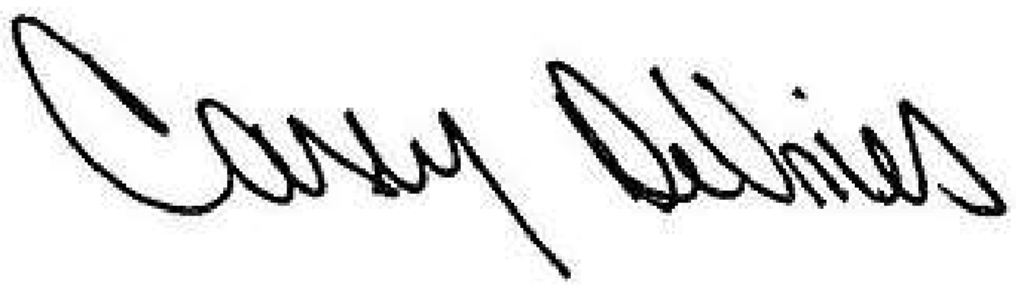
the website listed above.

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

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

If you have any questions, please contact me.

Sincerely,



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

CLN

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0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL36779016-0 On September 29, 2025, through October 1, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were two residents both received services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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

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0 480	Continued From page 2 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 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 September 30, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee	0 480		

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0 480	Continued From page 3 within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 650 SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records included all required content for two of two employees (unlicensed personnel (ULP)-B, and	0 650		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 650	Continued From page 4 clinical nurse supervisor (CNS)-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 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: ULP-B was hired on February 15, 2021, to provide assisted living services to residents. CNS-C was hired on March 6, 2020, to provide oversite and supervision of ULP and to provide assisted living services to residents after August 1, 2021. ULP-B and CNS-C's personnel files included Annual Training Checklist dated 2024 and 2025. The document listed the required annual training content, date completed, and credit amount. The document included the training of policies and procedures. Although the document indicated training was completed for policies and procedures for ULP-B on January 23, 2025, and CNS-C on February 3, 2025, the document lacked the following required content per Minnesota (MN) Rule 4659.0190 Subpart 6.: - facility location; - licensee number; - training methodology; - name and title of the instructor and the instructors signature; and - the staff person completing the training	0 650		

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	36779	A. BUILDING: _____ B. WING _____	10/01/2025

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0 650	Continued From page 5 signature with statement attesting that the staff person successfully completed the training as described in the training documents. On September 30, 2025, at 9:41 a.m., CNS-C stated they used the document titled Annual Training Checklist to document annual trainings completed for all employees including policies and procedures. CNS-C stated they were unaware the training documents needed staff signatures to attest they received the trainings. CNS-C stated training on the licensee's policies and procedures were conducted at an in-person training and all other items on the Annual Training Checklist were completed via EduCare (a training software). Minnesota Administrative Rule 4659.0190 Subpart 6. Training records and Documentation, dated August 11, 2021, read, "A. The facility must maintain a record of staff training and competency required under this part and Minnesota Statutes, chapter 144G, that documents the following information for each competency evaluation, training, retraining, and orientation topic: (1) facility name, location, and license number; (2) name of the training topic or training program, and the training methodology, such as classroom style, web-based training, video, or one-to-one training; (3) date of the training and competency evaluation, and the total amount of time of the training and competency evaluation; (4) name and title of the instructor and the instructor's signature, and the name and title of the competency evaluator, if different from the instructor, and the evaluator's signature with a statement attesting that the employee	0 650		

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0 650	Continued From page 6 successfully completed the training and competency evaluation; and (5) name and title of the staff person completing the training, and the staff person's signature with a statement attesting that the staff person successfully completed the training as described in the training documentation. B. Documentation of the completed competency evaluation, training, retraining, or orientation must be provided to the employee at the time the evaluation or training is completed." The licensee's Personnel Records policy dated August 1, 2021, indicated a record of each paid employee of the licensee would be maintained and would include records of annual training. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 775 SS=E	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the current Minnesota Fire Code Provisions. 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	0 775		

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0 775	Continued From page 7 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: During facility tour on September 30, 2025, from 3:45 p.m. through 4:25 p.m. with licensed assisted living director/registered nurse (LALD/RN)-D and clinical nurse supervisor (CNS)-C, it was observed that compliant emergency escape and rescue openings were not provided in resident sleeping rooms four and five. CNS-C and the surveyor entered unoccupied resident room five and CNS-C opened the window for measurement. Emergency escape and rescue clear window opening measurements were 18 inches wide, 35 inches in height and 630 square inches in openable area. The window was measured with CNS-C, and the surveyor. The window did not meet the minimum requirements for clear opening width or clear opening area. CNS-C and the surveyor entered unoccupied resident room four. CNS-C stated that the window was broken and would not open. CNS-C stated that they had already placed a work order to have the window replaced. CNS-C could not open the window for measurement. State Fire Code in Minnesota Rules, chapter 7511 requires at least one compliant and operable emergency escape and rescue opening within each resident sleeping room. Existing emergency escape and rescue openings are	0 775		

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0 775	Continued From page 8 required to meet a minimum clear opening area of 648 square inches and have a minimum dimension of 20 inches in height and a minimum dimension of 20 inches in width. Windowsill height shall not be more than 48 inches from the floor to the clear opening. CNS-C and LALD/RN-D visually verified the deficient condition while accompanying on the tour and stated they understood the requirement. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 775		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing	0 780		

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0 780	Continued From page 9 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 are interconnected so that the actuation of one alarm causes all alarms in the dwelling unit to actuate. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During facility tour on September 30, 2025, from 3:45 p.m. through 4:25 p.m. with licensed assisted living director/registered nurse (LALD/RN)-D and clinical nurse supervisor (CNS)-C, the surveyor observed smoke alarms inside all bedrooms and outside in the immediate vicinity of all bedrooms. CNS-C tested the alarms. All alarms functioned when tested individually but they failed to be interconnected so that actuation of any one alarm will activate all alarms. CNS-C and LALD/RN-D stated the	0 780		

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0 780	Continued From page 10 alarms were connected wirelessly and attempted to reprogram the alarms. After several attempts to reprogram CNS-C and LALD/RN-D stated that the alarms were connected and worked properly earlier in the day, and they were not sure what happened. All dwelling units required to have multiple smoke alarms are required to have interconnected alarms so activation of one alarm activates all alarms within the dwelling unit. LALD/RN-D and CNS-C verified the above findings while accompanying on the tour and stated they understood the requirements. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
01710 SS=D	144G.71 Subd. 3 Individualized medication monitoring and reas A registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure the registered nurse (RN) conducted an accurate medication assessment for one of two residents (R1).	01710		

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01710	Continued From page 11 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: R1 admitted to the licensee on July 1, 2023, and began receiving assisted living services. R1's Service Plan (Waiver)- Addendum to Contract signed September 15, 2025, indicated R1 received assistance with bathing reminders, grooming, housekeeping, laundry, behavior management, meal reminder, medication administration, and blood glucose supervision. On September 30, 2025, at approximately 8:55 a.m., the surveyor observed unlicensed personnel (ULP)-B prepare Lantus SoloStar pen to 17 units (u), hand the pen to R1, and R1 administered Lantus 17 u into their right abdomen. Then UPL-B prepared NovoLog Flex pen to 3 u, handed the pen to R1, R1 administered NovoLog into their left abdomen. R1's ongoing assessments dated January 21, 2025, April 23, 2025, and July 22, 2025, indicated the following: - staff administered R1's medications; - a face-to-face assessment/review of medication services was completed by the RN, including review of services and medication, side effects,	01710		

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01710	Continued From page 12 contraindications, allergic or adverse reactions, and actions to address the issues; - RN was responsible for reordering of medications; - all medications were kept in a closed storage cabinet; - medication management tasks that may be delegated to a ULP included eye drops, ear drops, nasal, and oral; - staff were able to call the on call nurse 24 hrs/7 days a week if questions or concerns arise with medications; - current list of medication reviewed with R1 upon admission; and - self-administration of medication: "Med Self-Admin is not applicable", R1 required the assistance of staff to administer medications as prescribed. R1's Medication Administration Summary- Actual-Month September 2025 included a NovoLog FlexPen sliding scale scheduled three times per day subcutaneously (SQ) and a Lantus SoloStar pen to administer 17 units SQ twice per day. Both orders included additional instructions to discard the pen 28 days after fist use, do not refrigerate after first use. The additional instructions did not include R1 to self-administer the insulins after setup. On September 30, 2025, at 12:35 p.m., the surveyor inquired where the licensee documented R1 self-administration of insulin after setting up. Licensed assisted living director/registered nurse (LALD/RN)-D showed the surveyor a progress note they were unable to print that indicated on April 7, 2025, R1 preferred to self-administer insulin, R1 medical provider was updated, R1 was educated on infection	01710		

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01710	Continued From page 13 control, and ULP would supervise R1 during the insulin administration. On September 30, 2025, at 12:40 p.m., clinical nurse supervisor (CNS)-C stated R1's medication management plan did not reflect ULP being delegated SQ injections because initially R1 did not receive SQ injections. On October 1, 2025, at 8:58 a.m., CNS-C stated R1 had a change of condition on January 21, 2025, and was started on insulin. CNS-C stated a new medication assessment was conducted that indicated R1 needed assistance with insulin administration. CNS-C stated on April 7, 2025, after R1 became comfortable with insulin administration, R1 told them they wanted to self-administer their insulins. CNS-C stated staff were responsible for dialing the insulin pens to the correct dose and R1 was responsible for administering the insulins. The surveyor inquired why the medication management plan was not updated. CNS-C stated they had already completed the new medication assessment when insulins were started, staff were already trained on insulin administration, and "that was a fail on our part to update the med management plan." LALD/RN-D stated that was why they put a progress note in R1's medical record so all staff were aware of the change in how the insulins were administered. LALD/RN-D stated they understood the assessment needed to reflect the changes and how it should not be just written in a progress note. Although the CNS-C stated a new medication assessment was completed upon R1 change of condition January 21, 2025, the April 23, 2025, and July 22, 2025, medication assessment and	01710		

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01710	Continued From page 14 self-administration assessment did not accurately reflect R1's ability to self-administer insulin after setup when the change occurred on April 7, 2025. Due to an inaccurate medication assessment, it led to inaccurate or missing information in the medication management plan. The following items were inaccurate in R1's medication management plan: - statement describing the medication management services that would be provided; and - identification of medication management tasks that may be delegated to the ULP. In addition, the following items were missing from R1's medication management plan: - documentation of specific resident instructions related to the administration of medication. The licensee's Assessment of Medications policy dated August 1, 2021, indicated the medication assessment included any difficulties with taking the medication and residents preferences in how to take the medications. In addition, based on the results of the assessment, the RN would document an individualized medication management plan and would update the medication management plan with changes in medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01710		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed	01890		

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01890	Continued From page 15 by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to label prescription medications with the original prescription label and failed to ensure time-sensitive medications were labeled with the date opened for one of two residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On September 29, 2025, at 12:27 p.m., the surveyor observed the licensee's medication cabinet. The medication cabinet contained a tote containing blood glucose equipment, one Lantus SoloStar Pen with an expiration date of July 31, 2027, and one NovoLog FlexPen with an expiration date of October 21, 2026. The surveyor observed both pens were previously used and did not contain the following: - a date when the insulin pens were opened; - a prescription label; and - a name of who the medication belonged to. Licensed assisted living director/registered nurse	01890		

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01890	Continued From page 16 (LALD/RN)-D stated insulin pens should be marked with the date they are first used. LALD/RN-D stated the insulin pens belonged to R1 and no other resident used insulin in the facility. LALD/RN-D stated they first used R1's insulin pens on Saturday September 27, 2025, and they forgot to label the insulin pens with the date opened. LALD/RN-D then labeled the insulin pens with the date they were first used. On September 30, 2025, at 12:49 p.m., the surveyor observed both insulin pens listed above and observed both pens had a handwritten prescription label on them. Clinical nurse supervisor (CNS)-C stated they contacted pharmacy to request prescription labels for the insulin pens and they labeled both insulin pens with the prescription information until the new labels were delivered to the facility. The manufactures instructions for NovoLog FlexPen dated September 10, 2025, indicated if a NovoLog FlexPen was in use, it should be stored at room temperature and discarded 28 days after opening. The manufactures instruction for Lantus SoloStar pen dated November 2018, indicated if Lantus SoloStar pen was in use, it should be stored at room temperature and should be discarded 28 days after opening. The licensee's Storage/Control of Medication policy dated August 1, 2021, indicated prescription drugs, prior to being set up for immediate or later administration, must be kept in the original container in which they were dispensed by the pharmacy bearing the original prescription label with legible information. The	01890		

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01890	Continued From page 17 medication is label should include the prescription number and name of medication, strength and quantity, expiration date for time-dated drugs, directions for use, resident name, prescriber's name, date issued, and name and address of licensed pharmacy issuing the medication. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

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

Food & Beverage Inspection Report

Establishment Info

CARINGHANDS LLC
2901 WEST 90TH STREET
Bloomington, MN 55431
Hennepin County
Parcel:

Phone:

License Info

License: HFID 36779

Risk:
License:
Expires on:
CFPM: Adarus Ali
CFPM #: FM86852; Exp: 4/27/2026

Inspection Info

Report Number: F1043251210
Inspection Type: Full - Single
Date: 9/30/2025 Time: 2:50:22 PM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 1
Total Priority 3 Orders: 1
Delivery:

New Order: 6-300 Physical Facility Numbers and Capacities
6-301.12 *Priority Level: Priority 2 CFP#: 10*
MN Rule 4626.1445 Provide and maintain a supply of individual disposable towels, a continuous towel system, a heated-air hand drying device, or an approved ambient air temperature hand drying device at each handwashing sink or group of adjacent handwashing sinks.
COMMENT: NO PAPER TOWELS AVAILABLE IN UPSTAIRS RESTROOM. ADVISED STAFF TO PROVIDE AND MAINTAIN. PER STAFF, RESTROOM WAS RECENTLY REMODELED. COMPLY WITH ABOVE RULE.
Comply By: 9/30/2025 Originally Issued On: 9/30/2025

New Order: 6-300 Physical Facility Numbers and Capacities
6-301.14A *Priority Level: Priority 3 CFP#: 10*
MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands.
COMMENT: NO REMINDER SIGN IN UPSTAIRS RESTROOM. ADVISED STAFF TO POST AND MAINTAIN. PER STAFF, RESTROOM WAS RECENTLY REMODELED. FACILITY CORRECTED PRIOR TO RECEIVING REPORT.
Comply By: 9/30/2025 Originally Issued On: 9/30/2025

Food & Beverage General Comment

Inspection was completed with Ashley Crews as the lead Health Regulation Division Nurse Evaluator completing the site survey.

FOOD TEMPERATURE (F)
WHITE FRIDGE: MILK 41, CHEESE 41
LG FRIDGE: MILK 41

UTENSIL SURFACE TEMPERATURE (F)
DISH MACHINE: 160

Discussed highly susceptible populations, date marking, illness policy, sanitizer use, ware washing, temperature control, same day service, cleaning, pest control, vomit/fecal procedures, test kits, food storage, and food handling procedures.

Foods cooked in house must be fully cooked (exception for pasteurized eggs) and must only be available for same day service for highly susceptible populations, discontinue any cooling and reservice of cooked food. Per staff, leftovers are discarded after every meal.

This facility has a residential kitchen with residential equipment, wooden cabinetry, linoleum flooring, and textured ceilings. GE residential dish machine with a sani rinse option. Equipment and physical facility will be monitored at future inspections.

Contact Health Regulation Division for plan review approval when facility/kitchen undergoes remodeling, major equipment additions, or changes of equipment due to a menu change.

***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.

If any customer complains of illness, establishment is required to notify the Minnesota Department of Health and provide the foodborne illness hotline phone number to the customer: 1-877-366-3455

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 F1043251210 from 9/30/2025

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PIC

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