Electronically Delivered

June 25, 2026

Licensee
Good Time Care LLC
17515 30th Avenue North
Plymouth, MN 55447

RE: Project Number(s) SL36029017

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on May 19, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement;
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;
Level 3: a fine of $1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

Level 4: a fine of $3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 5: a fine of $5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

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

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - 500.00
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 - 500.00

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.

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,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: Jess.Schoenecker@state.mn.us
Telephone: 651-201-3789 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
	36029	A. BUILDING: _____ B. WING _____	05/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD TIME CARE LLC	17515 30TH AVENUE NORTH PLYMOUTH, MN 55447

(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: SL36029017-0 On May 18, 2026, through May 19, 2026, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were two residents; two receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 110 SS=C	144G.10 Subdivision 1a Assisted living director license required	0 110		

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0 110	Continued From page 1 Each assisted living facility must employ an assisted living director who is licensed or permitted by the Board of Executives for Long Term Services and Supports and affiliated as the director of record with the board. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensed assisted living director (LALD) was listed as the Director of Record for the licensee through the Board of Executives for Long-Term Service and Supports (BELTSS) website. This had the potential to affect all the licensee's residents, staff, and visitors. This practice resulted in a level one violation (a violation that will cause only minimal impact on the residents 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 the potential to affect a large portion or all the residents). The findings include: On May 18, 2026, at 7:37 a.m., the BELTSS website indicated the health facility identification number (HFID) 36029 had a licensed assisted living director (LALD) indicated as the director of record but had ended on October 31, 2025. The website did not list another LALD as the director of record for the licensee's HFID. On May 18, 2026, at 2:01 p.m., the BELTSS website indicated LALD-C had an active assisted living director license with an expiration date of October 31, 2026; and a shared assisted living	0 110		

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0 110	Continued From page 2 director with an expiration date of October 31, 2026. LALD-C was not listed as the director of record for HFID 36029. LALD-C's email from BELTSS dated March 25, 2026, at 8:32 a.m., indicated LALD-C was listed as the director of record of more than one HFID licensed by the Minnesota Department of Health; and LALD-C must submit a secondary permit/license application online via the BELTSS online portal. On May 18, 2026, at 10:10 a.m., LALD-C stated they had applied to be the director of record for the licensee but for some reason they could not find the facility using the licensee's name and HFID when the change of ownership happened. LALD-C stated they were told by BELTSS they would be added as the director of record and BELTSS had emailed recommendations. LALD-C stated they had recently paid for the shadow license. On May 18, 2026, at 1:45 p.m., LALD-C acknowledged their email from BELTSS did not acknowledge the licensee's HFID; and BELTSS indicated in the email to LALD-C that they needed to complete an application for a shared license. LALD-C stated they called BELTTS as they could not locate the HFID for the license to be added as the director of records. On May 19, 2025, at 12:50 p.m., LALD-C stated they had called BELTSS on May 18, 2026, and left them a message. LALD-C stated they will need to submit some papers still according to the email they provided to the surveyor. The licensee's Assisted Living Director policy dated December 20, 2025, indicated the licensee	0 110		

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0 110	Continued From page 3 expected the LALD to comply with all requirements set forth by BELTSS. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
0 660 SS=E	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included baseline testing results for one of two employees (unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a	0 660		

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0 660	Continued From page 4 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: The licensee's Facility TB Risk Assessment dated December 22, 2025, identified the facility was at a low risk for TB transmission. ULP-B was hired on December 22, 2025, to provide direct care to residents. ULP-B's Baseline TB Screening Tool for Health Care Workers (HCWs) dated December 22, 2025, indicated ULP-B was assessed for current symptoms of active TB disease and a history of TB, which indicated no current symptoms and no previous history of TB. ULP-B's Baseline TB Screening Tool for HCWs was left blank under section TB blood test and tuberculin skin test (TST). ULP-B's record included negative testing results of a TST dated August 30, 2025. ULP-B's record lacked evidence of a second step TST. Also, the first step TST was completed 114 days prior to hire and was not completed within 90 days of hire. On May 19, 2026, at 1:27 p.m., licenses assisted living director (LALD)-C stated they must have misplaced the second TST results. LALD-C stated most employees would get the TB blood	0 660		

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0 660	Continued From page 5 test. LALD-C stated a two-step TST was when the employee had their first-step TST by having tuberculin administered under the skin, then got the results read after 48 hours, and then they would complete the process again for the second step TST within 72 hours later. The licensee's Tuberculosis Screening policy dated December 24, 2025, indicated the licensee would establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the CDC. The policy indicated new staff would have an IGRA blood test (TB blood test) or a two-step Mantoux conducted with results documented on the Baseline TB screening Tool for HCWs. Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, indicated on page 11, an employee may begin work with patients after a negative TST or IGRA dated within 90 days before hire. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an	0 680		

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0 680	Continued From page 6 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 develop a written emergency preparedness (EP) plan with all the required content as defined in Appendix Z. 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 the potential to affect a large portion or all of the residents). The findings include: The licensee's Hazard Vulnerability Assessment	0 680		

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0 680	Continued From page 7 dated June 15, 2025, included the following events but was left blank on the assessment for determination of risk to the facility for probability, level of vulnerability/degree of disruption, and preparedness: flooding, bomb threat/explosion, hazardous material/chemical accident, civil disturbance, mass casualty event, terrorist attack, water failure, wastewater treatment loss, structural damage, transportation interruption, and environmental or air quality pollution. The Hazard Vulnerability Assessment did not consider all hazards relevant to the licensee or facility. The licensee's undated EP lacked evidence of the following required content: - develop and maintain the EP; - substance needs for staff and patients; - procedures for tracking staff and patients; - policies and procedures for volunteers; and - methods for sharing information. On May 19, 2026, at 11:26 a.m., licensed assisted living director (LALD)-C agreed the licensee's Hazard Vulnerability Assessment could be re-assessed to consider all hazards for the licensee or facility. LALD-C acknowledged the licensee did not have policies and procedures in place to address minimum food, water, and pharmaceutical supplies; alternate sources of energy; or sewage/waste disposal. LALD-C verified the licensee did not have back-up emergency supplies at the facility. LALD-C acknowledged the licensee did not have a policy and procedure for the use of volunteers during an emergency; and asked the surveyor if the licensee was able to allow volunteers without a background during an emergency. The surveyor referred LALD-C to the State Operations Manual for Appendix Z Emergency Preparedness for all Provider and Certified Supplier Types Interpretive	0 680		

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0 680	Continued From page 8 Guidance for review. The licensee's Emergency Preparedness policy dated December 24, 2025, indicated the licensee's intent would be to have a plan that would be aligned with the Centers for Medicare and Medicaid Services State Operation Manual Appendix Z: State Operations Manual Appendix Z Emergency Preparedness for All Provides and Certified Supplier Types Interpretive Guidance. Minnesota Administrative Rule 4659.0100 dated August 11, 2021, indicated assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.72, or successor requirements. This part referenced documents, specifications, methods, and standards in "State Operations Manual Appendix Z - Emergency Preparedness for All Provider and Certified Supplier Types: Interpretive Guidance." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 690 SS=F	144G.43 Subdivision 1 Resident record (a) Assisted living facilities must maintain records for each resident for whom it is providing services. Entries in the resident records must be current, legible, permanently recorded, dated, and authenticated with the name and title of the person making the entry. This MN Requirement is not met as evidenced by:	0 690		

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0 690	Continued From page 9 Based on observation, interview, and record review, the licensee failed to ensure entries in resident records were current, permanently recorded, and authenticated with the name and title of the person making the entry for the task performed for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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: R2 was admitted on November 17, 2025. R2's Addendum to Contract - Waiver - MN dated January 10, 2026, indicated R2 received medication setup one day a week. R2's Med Setup/Review Summary - Month dated May 1, 2026, to May 31, 2026, indicated the following: - unlicensed personnel (ULP)-B had completed the following medication setup: - May 1, 2026, for propranolol; - May 2, 2026, for divalproex sodium, haloperidol, and trazodone; and - May 3, 2026, for divalproex sodium, haloperidol, and trazodone. - clinical nurse supervisor (CNS)-D had completed the following medication setup: - May 1, 2026, for divalproex sodium, haloperidol, and trazodone (dated as being completed on May 4, 2026, which was after May	0 690		

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0 690	Continued From page 10 1, 2026); and - May 3, 2026, for propranolol (dated as being completed on May 4, 2026, which was after May 3, 2026). On May 18, 2026, at 3:09 p.m., CNS-D acknowledged the documentation on R2's Med Setup/Review Summary indicated ULP-B documented as if they had performed medication setup. CNS-D stated ULPs were not setting up medications for the residents. CNS-D stated sometimes their documentation does not lock if they don't hit a button "setup or review". CNS-D stated they needed to double check that they pushed the button when they set up medications. On May 19, 2026, at 1:29 p.m., CNS-D stated they planned to go back and change the documentation to make sure everything correlated correctly. CNS-D stated it would be the same for other residents. The licensee's Resident Record - Documentation policy dated December 20, 2025, indicated all documentation must include the signature and title of the person who performed the service. The licensee's Resident Record - Information and Content policy dated December 20, 2025, indicated all entries in the resident record must be current and permanently recorded. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 690		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment	0 775		

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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
0 775	Continued From page 11 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, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated May 19, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. 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	0 780		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36029	A. BUILDING: _____ B. WING _____	05/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD TIME CARE LLC	17515 30TH AVENUE NORTH PLYMOUTH, MN 55447

(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
0 780	Continued From page 12 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and	0 780		

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0 780	Continued From page 13 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated May 19, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in	0 810		

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0 810	Continued From page 14 their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated May 19, 2026, for the specific violations related the physical environment under Minnesota Statute 144G.	0 810		

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0 810	Continued From page 15 TIME PERIOD FOR CORRECTION: Twenty one (21) days.	0 810		
01770 SS=F	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure documentation of medication setup included all the required content for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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 May 19, 2026, at 1:29 p.m., clinical nurse supervisor (CNS)-D stated when the pharmacy delivered their monthly medications in packets that were setup by the pharmacist for each resident's dosage time to be administered later, the nurse checked those for accuracy and would hit a button in the licensee's electronic medical record to indicate all medications were reviewed	01770		

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01770	Continued From page 16 and medications were setup, but it would document for the whole month. CNS-D stated they also wrote a progress note for when they performed the medication setup. CNS-D stated they needed to change the documentation process to make sure everything correlated together correctly. CNS-D stated they did not think they documented consistently for the medication setup to include the dates of the medication setup in the progress notes. CNS-D stated it would be the same for other residents. R2 was admitted on November 17, 2025. R2's Addendum to Contract - Waiver - MN dated January 10, 2026, indicated R2 received medication setup one day a week. R2's Med Setup/Review Summary - Month dated May 1, 2026, to May 31, 2026, indicated the following: - unlicensed personnel (ULP)-B had completed the following medication setup: - May 1, 2026, for propranolol; - May 2, 2026, for divalproex sodium, haloperidol, and trazodone; and - May 3, 2026, for divalproex sodium, haloperidol, and trazodone. - CNS-D had completed the following medication setup: - May 1, 2026, for divalproex sodium, haloperidol, and trazodone (dated as being completed on May 4, 2026, which was after May 1, 2026); - May 3, 2026, for propranolol (dated as being completed on May 4, 2026, which was after May 3, 2026); and - May 4, 2026, through May 31, 2026, all medications were documented as being setup on May 4, 2026.	01770		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01770	Continued From page 17 - No documentation of medication setup for propranolol on May 2, 2026. R2's progress note dated May 3, 2026, at 4:54 p.m., by CNS-D read, "This RN [registered nurse] reconciled medications against current orders and completed weekly medication setup for a 7-day supply." The progress note lacked documentation of the dates of medication setup, name of medications, quantities of dose, time to be administered, and routes of administration. R2's progress note dated May 10, 2026, at 1:15 p.m., by CNS-D read, "RN completed medication review and prepared a 7-day medication setup for [R2] according to current physician orders and medication administration records." The progress note lacked documentation of the dates of medication setup, name of medications, quantities of dose, time to be administered, and routes of administration. R2's progress note dated May 17, 2026, at 1:02 p.m., by CNS-D read, "This RN reviewed current medication orders and completed setup of a 7-day medication supply as ordered." The progress note lacked documentation of the dates of medication setup, name of medications, quantities of dose, time to be administered, and routes of administration. R2's record indicated conflicting information for the documentation of medication setup. The licensee's Medication Management - Administration & Setup policy dated December 29, 2025, indicated a licensed nurse would setup medications in dosage boxes for the resident, usually on a weekly basis. The policy did not indicate documentation requirements for	01770		

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01770	Continued From page 18 medication setups. MN Statue 144G.08 Subd 41, Medication Setup, reads, "Medication setup" means arranging medications by a nurse, pharmacy, or authorized prescriber for later administration by the resident or by facility staff. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770		

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

GOOD TIME CARE LLC
17515 30TH AVENUE NORTH
Plymouth, MN 55447
Hennepin County
Parcel:

Phone:

License Info

License: HFID 36029

Risk:
License:
Expires on:
CFPM: MUSTAFE FARAH MOHAMOUD
CFPM #: 6851; Exp: 2/10/2028

Inspection Info

Report Number: F8058261137
Inspection Type: Full - Single
Date: 5/18/2026 Time: 1:11:48 PM
Duration: minutes
Announced Inspection: No
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

HRD INSPECTOR RHAWNIE QUIMEHAN

RESIDENTIAL HOME WITH NON COMMERCIAL APPLIANCES AND FINISHES, LAMINATE FLOOR AND COUNTER, WOOD CABINETS, PAINTED SHEETROCK

38 APPLE COOLER
41 CHEESE COOLER

170 DISH MACHINE

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 F8058261137 from 5/18/2026

MUSTAFE FARAH MOHAMOUD
LALD

Aaron Gertz,
Public Health Sanitarian 3
651-201-4516
aaron.gertz@state.mn.us

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ASSISTED LIVING | ASSISTED LIVING WITH DEMENTIA CARE

Project No: SL36029017-0	**Date:** 5/19/2026
Facility Name: GOOD TIME CARE LLC	
Facility Address: 17515 30th Ave N, Minneapolis, Minnesota 55447	

☒ **TAG IDENTIFICATION: 0775**

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

1. Each assisted living facility must comply with the provisions of the Minnesota State Fire Code (MSFC) in Minnesota Rules chapter 7511. [Minn. Stat. 144G.45 subd. 2]

2. A means of egress shall be free from obstructions that would prevent its use, including the accumulation of snow and ice. Means of egress shall remain free of any material or matter where its presence would obstruct or render the means of egress hazardous. No combustible material storage is allowed in the corridors or exit stairs. [Minn. Stat. 144G.45 subd. 2; MSFC 1031.3]

   Comments: The door leading from the basement of the assisted living into the garage was marked with an exit sign leading occupants through the garage as an exit. The door leading from the assisted living to the garage shall not be marked as an exit and lead occupants through the garage as an exit as the garage is a higher hazard area than the assisted living area.

3. Clothes dryers and their exhaust systems shall be cleaned as necessary to keep lint traps, exhaust ducts, and mechanical and heating components free from excessive lint accumulation. [Minn. Stat. 144G.45 subd. 2; MSFC 304.4]

   Comments: The dryer exhaust vent was detached from the dryer and there was excessive lint/debris accumulation behind the machine posing a fire hazard.

4. Listed single and multiple-station smoke alarms complying with UL 217 shall be installed. [Minn. Stat. 144G.45 subd. 2; MSFC 907.2.10]

   Comments: The smoke alarm devices provided throughout the facility did not display any indication that they were listed to underwriter laboratories (UL) standards to comply with requirements.

☒ **TAG IDENTIFICATION: 0780**

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

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

   Comments: Licensed assisted living director (LALD)-C tested the smoke alarms for interconnection. The alarms located in the basement and the upstairs hallway failed to activate when tested.

2. Smoke Alarm power supply complies with MN State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated. [Minn. Stat. 144G.45 subd.2]

   Comments: The hardwired smoke alarm in the upstairs hallway was not interconnected with the battery-operated alarms in the rest of the facility. Licensed assisted living director (LALD)-C stated they replaced the old smoke alarms with new battery-operated smoke alarms.

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Twenty One (21) days

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

   Comments: Licensee's FSEP failed to include site-specific employee actions relative to the facility's building layout, evacuation routes, and ways to remove residents. Staff responsibilities and evacuation procedures were not clearly defined.