Electronically Delivered

April 22, 2025

Licensee
Care Partners Homecare LLC
6218 Unity Avenue North
Brooklyn Center, MN 55429

RE: Project Number(s) SL38680016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on March 27, 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.

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 . . ."

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 survey 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 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.

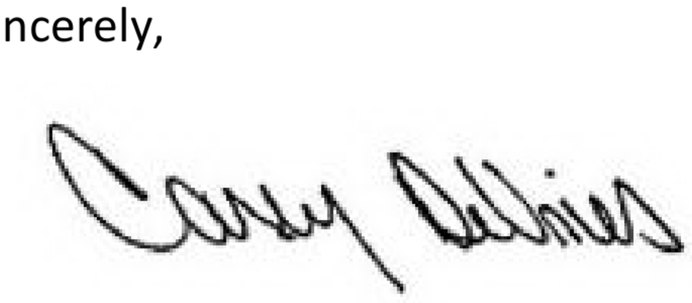
To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38680	A. BUILDING: _____ B. WING _____	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS HOMECARE LLC	6218 UNITY AVENUE NORTH BROOKLYN CENTER, MN 55429

(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 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: SL386880016-0 On March 24, 2025, through March 27, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were two residents; two receiving services under the Assisted Living Facility license. An immediate correction order was identified on March 24, 2025, and issued for SL386880016-0, tag identification 2310. During the survey, the licensee took action to mitigate the immediate risk. However, noncompliance remained, and the scope and level remain unchanged.	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: 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) 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: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated March 24, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		

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0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program to comply with accepted health care, medical, and nursing standards for infection control. 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 March 26, 2025, at 8:21 a.m., unlicensed personnel (ULP)-B stated they were going to administer medications to R2. Without performing hand hygiene, ULP-B placed a pair of gloves on,	0 510		

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0 510	Continued From page 4 placed medications from a pill box into a medication cup, and measured a liquid medication into a second medication cup. ULP-B removed the gloves, and without performing hand hygiene, placed another pair of gloves on, and administered the medications. On March 26, 2025, at 8:55 a.m., ULP-B stated they were trained to perform hand hygiene before placing gloves on and to perform hand hygiene between glove changes. ULP-B stated they forgot to perform hand hygiene. On March 26, 2025, at 9:02 a.m., clinical nurse supervisor (CNS)-C stated staff were trained to perform hand hygiene before putting gloves on and to perform hand hygiene between glove changes. CNS-C stated that was an oversight for not performing hand hygiene. The licensee's 8.09 Hand Washing policy dated August 1, 2021, indicated staff should perform hand hygiene before and after removing gloves. The Center for Disease Control Clinical Safety: Hand Hygiene for Healthcare Workers website dated February 27, 2025, recommended wearing gloves if staff anticipate they will come into contact with blood, infectious materials, mucous membranes, non-intact skin, or potentially contaminated skin, and to perform hand hygiene after glove removal. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		

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0 810	Continued From page 5	0 810		
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 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 interview, and record review, the licensee failed to develop the fire safety and	0 810		

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0 810	Continued From page 6 evacuation plan with the 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 March 24, 2025, licensed assisted living director/registered nurse supervisor (LALD/RNS)-D provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP, titled "4.8 Fire Emergency", undated, failed to include the following: The FSEP did not identify specific fire protection actions for residents. There was a section in the policy labeled "Resident Procedure" that was blank. LALD/RNS-D stated that they thought there was an updated policy that had the section labeled resident procedure filled in. LALD/RNS-D was not able to locate an update policy for review. The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to	0 810		

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0 810	Continued From page 7 evacuate residents but did not include any procedures for assisting residents during evacuation nor did it include instructions for staff to follow in case of relocation. The fire evacuation diagrams incorrectly labeled the attached garage as an egress path. The attached garage is a higher hazard and is not an approved egress path. Exit plan diagrams must be correctly labeled to reduce confusion and potential obstructions to egress in a fire or similar emergency. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 950 SS=A	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable."	0 950		

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0 950	Continued From page 8 (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to offer the resident the opportunity to identify a designated representative in writing with the required statutory language for one of two residents (R2). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at 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). R2 was admitted to the facility November 26, 2024, and began receiving assisted living services. R2's Assisted Living Contract lacked the required verbatim language for designating a representative. On March 26, 2025, at 12:15 a.m., licensed assisted living director (LALD)-D stated they would normally talk to the resident about designating a representative when they were admitted to the facility. LALD-D stated that was	0 950		

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0 950	Continued From page 9 missed for R2 and was and oversight. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 950		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensed failed to ensure to permit only authorized personnel to have access to medications for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On March 26, 2025, at 8:21 a.m., on the main level of the assisted living facility (ALF), the surveyor observed a combined kitchen and dining area and a common area that was divided by a wall. In the dining area next to the dividing wall	01880		

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01880	Continued From page 10 was a medication cabinet. Unlicensed personnel (ULP)-B unlocked the medication cabinet and administered medications to R1. ULP-B placed the keys onto a hook on a cabinet located in the kitchen. With no other staff members present, and the medication cabinet left unlocked, ULP-B pushed R1 in their wheelchair to the middle of the common area. ULP-B left the medication keys unsecured and the medication cabinet was unlocked. On March 26, 2025, at 8:56 a.m., ULP-B stated they were trained to lock the medication cabinet and to place the keys on the hook if they were in the kitchen area. ULP-B stated they were trained to take the keys with them if they left the kitchen area. ULP-B stated they forgot to lock the cabinet and forgot to take the keys with them. On March 26, 2025, at 9:04 a.m., clinical nurse supervisor (CNS)-C stated staff were trained to lock the medication cabinet and place them on the hook in the kitchen area. CNS-C stated if staff were leaving the kitchen area, they should take the keys with them. CNS-C stated the medication cabinet should not have been left unlocked and with the keys in the designated area with no staff present. CNS-C stated that must have been oversight. The licensee's 7.11 Medication Storage policy dated August 1, 2021, indicated medications will be kept locked and stored and only authorized staff will have access to stored medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		

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02310	Continued From page 11	02310		
02310 SS=F	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical or nursing standards for one of two residents (R1) with hospital bed rails. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1's diagnoses included anemia, hypothyroidism (under acting thyroid can disrupt heart rate, and all aspects of metabolism), morbid obesity, hypercholesterolemia (high cholesterol), hyponatremia (low sodium), unspecified dementia, unspecified psychosis (health condition characterized by loss of contact with reality), major depressive disorder, hypertension (high blood pressure), chronic kidney disease (impaired kidney function), shortness of breath,	02310		

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	38680	A. BUILDING: _____ B. WING _____	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS HOMECARE LLC	6218 UNITY AVENUE NORTH BROOKLYN CENTER, MN 55429

(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
02310	Continued From page 12 restlessness and agitation, and a history of falling. R1's signed Service Plan dated June 1, 2023, indicated R1 received assistance with medication, transferring, positioning, bathing, personal hygiene, dressing, toileting, daily checks, laundry, activities, light housekeeping, food preparation, transportation setup, and behavior management. On March 24, 2025, at 10:31 a.m., during a facility tour, the surveyor observed R1's bedroom that had a hospital bed with a single bed rail attached to the right-hand side. There were no identifying names or serial numbers on the bed rail. There were three sections to the bed rail. From left to right, the first section consisted of three vertical spaces that each measured 11" length by 3" in height. The next section was 5 horizontal spaces that each measured 3" length by 20" in height. The last section had three vertical spaces that each measured. 11" length by 3" in height. The total length of the bed rail was 37". The bed rail was securely attached to the hospital bed. R1's record included a document titled [licensee] Side Rails Assessment dated May 1, 2024. The document indicated R1 was using a quarter side rail. There were no further side rail assessments for R1 in their record. R1's previous two 90-day assessments dated October 14, 2024, and January 10, 2025, lacked assessment of the bed rail. In addition, R1's bed rail assessment dated May 1, 2024, lacked the following information: - the resident's preferences.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38680	A. BUILDING: _____ B. WING _____	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS HOMECARE LLC	6218 UNITY AVENUE NORTH BROOKLYN CENTER, MN 55429

(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
02310	Continued From page 13 On March 24, 2025, at 1:05 p.m., clinical nurse supervisor (CNS)-C stated they and licensed assisted living director/registered nurse supervisor (LALD/RNS)-D were responsible for the bed rail assessments for R1. CNS-C stated the bed rail had not changed since the assessment completed on May 1, 2024. CNS-C stated they checked the stability of the bed rail once per month and would only document if there was an issue with the stability of the bed rail. CNS-C stated they were unaware the bed rail assessment was required to be completed every 90 days. On March 24, 2025, at 1:08 p.m., LALD/RNS-D stated they believed the bed rail assessment was required to be completed annually or with a change in condition. LALD/RNS-D stated they were unaware the bed rail assessment was required to be completed every 90 days. The licensee's 6.28 Side Rail policy dated August 1, 2021, indicated when side rails are in use, an RN must conduct an assessment to identify the intended purpose of the side rail and the risks regarding the use of the side rail. The policy did not address the frequency of the assessment. The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) also indicated, "Per FDA recommendations, the need for bed rails must be assessed on a "frequent, regular basis." At a minimum this would include assessment of the bed rail upon initial installation, with each 90-day assessment, or with a change of condition." The Minnesota Department of Health (MDH) website, Assisted Living Resources &	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38680	A. BUILDING: _____ B. WING _____	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS HOMECARE LLC	6218 UNITY AVENUE NORTH BROOKLYN CENTER, MN 55429

(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
02310	Continued From page 14 Frequently-Asked Questions (FAQs) read, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, Documentation about a resident's hospital-style bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Measurements; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	02310		
02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38680	A. BUILDING: _____ B. WING _____	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS HOMECARE LLC	6218 UNITY AVENUE NORTH BROOKLYN CENTER, MN 55429

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02320	Continued From page 15 sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of one employee (unlicensed personnel (ULP)-B) followed appropriate medication administration procedures. 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 March 26, 2025, at 8:21 a.m., the surveyor observed ULP-B in the dining area where the medication cabinet was located. ULP-B removed a pill pack containing medications for R2. ULP-B opened the pill pack bubble section labeled, "[R2] Wed 3/26" and placed the medications into a medication cup. Without verifying the medications with R2's medication administration record (MAR), ULP-B administered the medications to R2. On March 26, 2025, at 8:47 a.m., ULP-B stated they were trained to compare the number of medications to the MAR prior to administrating the medications. ULP-B stated they forgot to open the MAR prior to administering the	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38680	A. BUILDING: _____ B. WING _____	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02320	Continued From page 16 medications. On March 26, 2025, at 9:00 a.m., clinical nurse supervisor (CNS)-C stated staff were trained to compare the medications to the MAR and count the number of medications prior to administering the medications. CNS-C stated that was oversight for not verifying the medications prior to administration. The licensee's Medication Management - Administration and Setup policy dated August 1, 2021 indicated staff will verify medications before administrating medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		

Minnesota Department of Health

3333 Division St #212
St. Cloud
320 223-7300

Type: Full
Date: *03/24/25*
Time: 11:30:00
Report: 1051251079

Food and Beverage Establishment Inspection Report

Location:
Care Partners Homecare LLC
6218 Unity Avenue N
Brooklyn Center, MN55429
Hennepin County, 27

Establishment Info:
ID #: 0041263
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/23

Operator:

Phone #:
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

The following orders were issued during this inspection.

4-300 Equipment Numbers and Capacities

4-302.12B ***** Priority 2 *****

MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.

AT TIME OF INSPECTION, THERE IS NO THIN-TIPPED THERMOMETER ON-SITE.
Comply By: 03/28/25

6-300 Physical Facility Numbers and Capacities

6-301.14A

MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands

AT TIME OF INSPECTION, THERE IS NO HANDWASH SIGN FOR THE EMPLOYEE RESTROOM IN THE LOWER FLOOR.
Comply By: 03/24/25

Food and Equipment Temperatures

Process/Item: Upright Cooler
Temperature: 39 Degrees Fahrenheit - Location: MILK
Violation Issued: No

Type: Full
Date: *03/24/25*
Time: 11:30:00
Report: 1051251079
Care Partners Homecare LLC

Food and Beverage Establishment Inspection Report

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	0	1	1

MET WITH NURSE EVALUATOR, KEITH LANGLEY.

DISCUSSED THE FOLLOWING WITH THE MANAGER, VICKIE

EMPLOYEE ILLNESS LOG
VOMIT CLEAN-UP PROCEDURE
HANDWASHING & GLOVE USE

THE KITCHEN HAS A HIGH TEMPERATURE DISHWASHER, LAMINATE COUNTERTOPS WITH HOLLOW BASES, MDF WOODEN CABINETS, AND A SMOOTH TEXTURE CEILING.

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 1051251079 of 03/24/25.

Certified Food Protection Manager: Tabitha V. Briggs

Certification Number: FM13885 Expires: 11/10/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
Vickie Briggs
Manager

Signed: Kai Yang
Kai Yang
Public Health Sanitarian 1
St. Cloud
320 640-3532
Kai.Yang@state.mn.us