



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

September 16, 2026

Licensee

Total Home Health Services LLC

6949 Idaho Avenue North

Brooklyn Park, MN 55428

RE: Project Number(s) SL36648016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 13, 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 - 0510 - 144g.41 Subd. 3 - Infection Control Program - \$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,

A handwritten signature in black ink, appearing to read "Casey DeVries". The signature is written in a cursive, flowing style.

Casey DeVries, Supervisor

State Evaluation Team

Email: Casey.DeVries@state.mn.us

Telephone: 651-201-5917 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/13/2026
NAME OF PROVIDER OR SUPPLIER TOTAL HOME HEALTH SERVICES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 6949 IDAHO AVENUE NORTH BROOKLYN PARK, MN 55428		
(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: SL36648016-0 On August 10, 2026, through August 13, 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.		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 480	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, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated August 10, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.	0 480			

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0 480	Continued From page 3	0 480			
	TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.				
0 510 SS=F	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 interview and record review, the licensee failed to establish and maintain an infection control program that complied with accepted health care, medical, and nursing standards for infection control. The deficient practice had the potential to affect all residents, employees, 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).	0 510			

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0 510	Continued From page 4 The findings include: On August 10, 2026, at 12:40 p.m., the surveyor requested to review the licensee's infection prevention and control program. Clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A provided the surveyor with the licensee's infection control policy. The licensee lacked an infection control program with the following content: - demonstration of leadership support; - education and training; - resident, family, and visitor education; and - performance monitoring and feedback; - standard precautions; and - transmission-based precautions. On August 10, 2026, at 2:00 p.m., CNS/LALD-A stated they were unaware of the written infection control program requirement. The licensee's Infection Control policy dated February 3, 2023, indicated [licensee] will observe the recommended precautions for assisted living as identified by the Centers for Disease Control and Prevention (CDC). The precautions cover those residents with documented or suspected infection with highly transmissible or epidemiologically important pathogens that require additional precautions to prevent transmission. The practice of employees will conform with OSHA regulations, current law and currently accepted health care, medical and nursing standards of practice for infection control. The CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings dated April 12, 2024, indicated Core Practices should be implemented in all settings	0 510			

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0 510	Continued From page 5 where healthcare is delivered including: - leadership support; - education and training on infection prevention; - resident, family and visitor education; - performance monitoring and feedback; - standard precautions; and - transmission-based precautions. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 510			
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 information: (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.	0 650			

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0 650	Continued From page 6 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 three of three employees (unlicensed personnel (ULP)-B, ULP-C, and registered nurse (RN)-D). 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: ULP-B ULP-B started employment with the licensee on February 23, 2024, to provide assisted living services. ULP-C ULP-C started employment with the licensee on August 22, 2024, to provide assisted living services. ULP-B and ULP-C's employee record lacked annual performance reviews completed yearly. RN-D RN-D started employment with the licensee on January 23, 2023, to provide assisted living services. RN-D's employee record included an annual	0 650			

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0 650	Continued From page 7 performance review completed on July 18, 2024. RN-D's employee record lacked annual performance reviews completed yearly. On August 11, 2026, at 10:30 a.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-D stated they had not completed the performance reviews annually as required. CNS/LALD-D also stated it was their mistake as they had not scheduled the performance reviews with the employees. The licensee's Personnel Records policy dated February 3, 2023, indicated a record of each paid employee, regularly scheduled volunteer providing assisted living services, and each individual contractor providing assisted living services for [licensee] will be maintained. The policy lacked verbiage to include performance reviews. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650			
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,	0 660			

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0 660	Continued From page 8 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 observation, interview, and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included TB history and symptom screen, baseline screening, and TB training for two of three employees (unlicensed personnel (ULP)-C, registered nurse (RN)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: The facility TB risk assessment dated June 11, 2026, indicated the facility was at a low risk for TB transmission. ULP-C ULP-C started employment with the licensee on August 22, 2024, to provide assisted living services.	0 660			

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0 660	Continued From page 9 On August 11, 2026, at 10:45 a.m., the surveyor observed ULP-C assist R2 to prepare meal in the kitchen. ULP-C's TB record included a history and symptom screen completed on February 20, 2024, and a single TB skin test completed on August 21, 2024. ULP-C's record lacked a second TB skin test and TB training at hire. RN-D RN-D started employment with the licensee on January 23, 2023, to provide assisted living services. RN-D's TB record included a history and symptom screen completed on February 20, 2024, and chest Xray (CXR) completed on March 27, 2020. RN-D's record lacked a positive TB test before doing a CXR. On August 11, 2026, clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated they had worked on the employee TB records and did not expect to have any issues there. The licensee's Tuberculosis Screening/Prevention dated February 3, 2023, indicated [licensee] will observe the recommended precautions related to TB prevention as identified by the Centers for Disease Control and Prevention (CDC) and the Minnesota Department of Health (MDH). The precautions include the following elements:	0 660			

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0 660	Continued From page 10 - risk assessment - TB screening - staff education The Minnesota Department of Health's Assisted Living FAQs: Staff Requirements dated June 5, 2026, indicated baseline TB screening is required at the time of hire for all health care personnel in Minnesota. The FAQs indicated baseline TB screening includes assessing for current symptoms of active TB disease, assessing TB history, and testing for the presence of Mycobacterium tuberculosis by administering either a two-step tuberculin skin test (TST) or single TB blood test. The FAQs further indicated all Minnesota health care personnel should receive TB education annually, regardless of facility risk level classification. The FAQs also indicated A CXR alone is not acceptable documentation. You either need documentation of a positive two-step Tuberculin Skin Test (TST) or Interferon-Gamma Release Assay (IGRA) test, and a CXR with provider evaluation after that date or documentation of refusal of both the two-step TST and IGRA followed by a new CXR and provider evaluation, or documentation of refusal of both the two-step TST and IGRA followed by a new CXR and provider evaluation. 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:	0 680			

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0 680	Continued From page 11 (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to have a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all residents receiving services under the provisional assisted living license. 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	0 680			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/13/2026
NAME OF PROVIDER OR SUPPLIER TOTAL HOME HEALTH SERVICES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 6949 IDAHO AVENUE NORTH BROOKLYN PARK, MN 55428		
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0 680	Continued From page 12 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's EPP dated July 11, 2024, lacked the following required content: -develop and maintain the EPP; -maintain and annual EPP updates; -EPP resident population; -process for emergency preparedness collaboration; -policies and procedures for development of EPP; -policies and procedures for subsistence needs for staff and residents; -policies and procedures for tracking of staff and residents; -policies and procedures for medical documents; -policies and procedures for volunteers; -names and contact information; -methods for sharing information; -procedure for sharing information on occupancy and or needs; -long term care family notifications; -EPP training and testing; -EPP training program; and -emergency prep testing requirements; On August 10, 2026, at 1:10 p.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated the licensee was still working on updating their EPP to be compliant with state requirements. CNS/LALD-A also stated they needed time to go through their EPP to confirm the missing content. The licensee's Emergency Preparedness policy dated July 14, 2019, indicated the licensee will have an identified plan in place to assure the safety and well-being of clients and staff during	0 680			

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0 680	Continued From page 13 periods of an emergency or disaster that disrupts services. 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			
0 780 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	0 780			

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0 780	Continued From page 14 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 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 August 11, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7)	0 780			

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0 780	Continued From page 15 days	0 780			
0 790 SS=F	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation, 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	0 790			

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0 790	Continued From page 16 Environment Inspection Report (PEIR) dated August 11, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790			
0 800 SS=F	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, 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).	0 800			

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0 800	Continued From page 17 The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated August 11, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800			
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the 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	0 810			

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0 810	Continued From page 18 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 August 11, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 810			

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0 970	Continued From page 19	0 970			
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property of a resident. This had the potential to affect all residents living within the assisted living facility. This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted to the licensee on February 20, 2024, for assisted living services. R1's Assisted Living Contract was signed and dated February 20, 2024. R2	0 970			

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0 970	Continued From page 20 R2 was admitted to the licensee on February 20, 2024, for assisted living services. R2's Assisted Living Contract was signed and dated February 20, 2024. R1 and R2's Assisted Living Contract included the following section which contained language waving the licensee's liability for health, safety, or personal property of a resident: - Miscellaneous Provisions: "The resident agrees that resident shall be responsible for any personal injury or property damage (including, without limitation, damage to, or loss or theft of, automobiles or personal property of resident) suffered by the resident or the resident's agents, guests or invitees, unless and to the extent that the injury or damage is caused by the negligence of [licensee] or its employees or agents." On August 11, 2026, at 2:40 p.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated they were not aware of the waiver in their contract. CNS/LALD-A also stated they had used the same contract since August 1, 2021, and that they had not been cited for the waiver. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970			
01500 SS=E	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another	01500			

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01500	Continued From page 21 source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss	01500			

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01500	Continued From page 22 and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment for two of three employees (unlicensed personnel (ULP)-B, ULP-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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: ULP-B ULP-B started employment with the licensee on February 23, 2024, to provide assisted living services.	01500			

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01500	Continued From page 23 ULP-B's Education Tracking Tool dated February 17, 2026, indicated ULP-B had completed the following annual training topics for a total of 4.5 hours of the eight hours required for every 12 months of employment. - infection control - 0.5 hours; - Bill of Rights - 0.5 hours; - vulnerable adults/minors - 1 hour; - policies and procedures - 1 hour; and - dementia training - 2 hours. ULP-B's record lacked the following annual training topics: - effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; - principles of person-centered planning/service delivery; and - mental illness and de-escalation training. ULP-C ULP-C started employment with the licensee on August 22, 2024, to provide assisted living services. ULP-C's record lacked annual training in the following topics: - reporting maltreatment of vulnerable adults or minors; - Assisted Living Bill of Rights; - infection control techniques; - effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; - review of provider's policies and procedures; - principles of person-centered planning/service	01500			

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01500	Continued From page 24 delivery; - hearing loss training (optional); - dementia training; and - mental illness and de-escalation training. On August 11, 2026, at 2:40 p.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated they were not aware of the 8-hour requirement. CNS/LALD-A also stated ULP-C was assigned their annual training topics, however, ULP-C had not completed their training. The licensee's Personal Records policy dated February 3, 2023, indicated a record of each paid employee, regularly scheduled volunteer providing assisted living services, and each individual contractor providing assisted living services will be maintained. The policy lacked verbiage to include annual training requirement for employees. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500			
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff	01650			

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01650	Continued From page 25 providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plan included all required content 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 the potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted to the licensee on February 20,	01650			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/13/2026
NAME OF PROVIDER OR SUPPLIER TOTAL HOME HEALTH SERVICES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 6949 IDAHO AVENUE NORTH BROOKLYN PARK, MN 55428		
(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
01650	Continued From page 26 2024, for assisted living services. R1's Service Plan dated February 20, 2024, indicated R1 received medication management and resident review/reassessment. R1's unlicensed personnel Home Health Aide Care Plan dated January 12, 2025, indicated R1 received the following services: assistance with dressing, grooming, meals, medications, vital signs, clean kitchen, remove garbage, shopping, and behavior monitoring. R2 R2 was admitted to the licensee on February 20, 2024, for assisted living services. R2's Service Plan dated February 20, 2024, indicated R2 received medication management and resident review/reassessment. R2's unlicensed personnel Home Health Aide Care Plan dated February 20, 2024, indicated R2 received the following services: assistance to clean kitchen, remove garbage, wash dishes, monitor food freshness, shopping, clean bathroom, laundry, and vacuum/sweep/dust. R1 and R2's service plan lacked the following required content: - the frequency of each service, according to the resident's current assessment and resident preferences; and - the identification of staff or categories of staff who will provide the services. On August 11, 2026, at 2:40 p.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated they were not aware their service plan was missing required content.	01650			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/13/2026
NAME OF PROVIDER OR SUPPLIER TOTAL HOME HEALTH SERVICES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 6949 IDAHO AVENUE NORTH BROOKLYN PARK, MN 55428		
(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
01650	Continued From page 27 The licensee's Service Plan for Medication Management policy dated February 3, 2023, indicated [licensee] will prepare and document a Medication Management Plan as part of the Service Plan for each resident receiving medication management services. The policy lacked verbiage for a resident service plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650			
01760 SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure documentation for medication administration included the signature and title of the person who administered medications for two of two residents	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/13/2026
NAME OF PROVIDER OR SUPPLIER TOTAL HOME HEALTH SERVICES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 6949 IDAHO AVENUE NORTH BROOKLYN PARK, MN 55428		
(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
01760	Continued From page 28 (R1, R2). In addition, the licensee failed to ensure prescriber orders were accurately transcribed for one of two residents (R1) receiving medication services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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: R1 R1 was admitted to the licensee on February 20, 2024, for assisted living services. R1's diagnoses included schizophrenia, vitamin D deficiency, and attention deficit hyperactivity disorder (ADHD). R1's Service Plan dated February 20, 2024, indicated R1 received medication management and resident review/reassessment. On August 11, 2026, at 10:22 a.m., the surveyor observed clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A administer medications to R1 in the living area. R1's medication administration record (MAR) for August 2026, indicated R1 received the following medications: metformin 500 milligram (mg) take two tablets by mouth once daily, vitamin D3 25 microgram (mcg) take one capsule by mouth once daily, omeprazole 20 mg take one capsule	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/13/2026
NAME OF PROVIDER OR SUPPLIER TOTAL HOME HEALTH SERVICES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 6949 IDAHO AVENUE NORTH BROOKLYN PARK, MN 55428		
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01760	Continued From page 29 by mouth once daily, and olanzapine 20 mg dissolve one tablet by mouth at bedtime. R1's Physician's Order signed and dated September 16, 2025, indicated metformin 500 mg take one tablet by mouth once daily. The licensee failed to ensure R1's MAR instructions for metformin were transcribed to match the signed prescriber's order. On August 11, 2026, at 11:20 a.m., the surveyor asked CNS/LALD-A to compare the dosage of metformin ordered and what was being administered in the MAR. CNS/LALD-A stated they needed to call the provider to clarify the order. R2 R2 was admitted to the licensee on February 20, 2024, for assisted living services. R2's diagnoses included schizophrenia, paranoid, and pervasive developmental disorder. R2's Service Plan dated February 20, 2024, indicated R2 received medication management and resident review/reassessment. R2's MAR dated August 2026, indicated R2 was taking the following medication: aripiprazole solution 1 mg/milliliter (ml) take 20 mg by mouth once daily, and fluticasone nasal spray 50 mcg instill two sprays in each nostril once daily. R1 and R2's MARs indicated medications administered were documented by initials and lacked the corresponding signatures and title of the persons who completed the administration. On August 11, 2026, at 2:20 p.m., CNS/LALD-A	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/13/2026
NAME OF PROVIDER OR SUPPLIER TOTAL HOME HEALTH SERVICES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 6949 IDAHO AVENUE NORTH BROOKLYN PARK, MN 55428			
(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
01760	Continued From page 30 stated they had not audited the MAR to ensure medication documentation included all required information. The licensee's undated Medication Management Policy indicated medication management program is at the discretion of the registered nurse and based on a professional face-to-face nursing assessment that includes the following elements: resident, resident's designated representative and/or resident's legal representative ability in medication self-management, home environment: safety and sanitation, storage/security of medications, and coordination/communication with prescriber and other providers involved with medication management. The policy lacked verbiage for medication documentation. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure written or electronically recorded prescriptions were obtained for one of two residents (R2).	01820			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/13/2026
NAME OF PROVIDER OR SUPPLIER TOTAL HOME HEALTH SERVICES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 6949 IDAHO AVENUE NORTH BROOKLYN PARK, MN 55428			
(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
01820	Continued From page 31 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: R2 was admitted to the licensee on February 20, 2024, for assisted living services. R2's diagnoses included schizophrenia, paranoid, and pervasive developmental disorder. R2's Service Plan dated February 20, 2024, indicated R2 received medication management and resident review/reassessment. R2's unsigned After Visit Summary dated December 1, 2025, indicated R2 was taking the following medications: amoxicillin clavulanate 400-57 milligram/5 milliliter (mg/5 ml) take 10.94 ml by mouth 2 times daily for seven days, aripiprazole solution 1 mg/milliliter (ml) take 20 mg by mouth once daily, and fluticasone nasal spray 50 mcg instill two sprays in each nostril once daily. R2's medication administration record (MAR) dated August 2026, indicated R2 was taking the following medication: aripiprazole solution 1 mg/milliliter (ml) take 20 mg by mouth once daily, and fluticasone nasal spray 50 mcg instill two sprays in each nostril once daily. R2's record lacked a current written or	01820			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36648	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/13/2026
NAME OF PROVIDER OR SUPPLIER TOTAL HOME HEALTH SERVICES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 6949 IDAHO AVENUE NORTH BROOKLYN PARK, MN 55428		
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01820	Continued From page 32 electronically recorded prescription for all prescribed medications that the licensee was managing for R2. On August 11, 2026, at 2:30 p.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated they forgot to send R2's medication list to the provider for signing. The licensee's Medication Orders dated February 3, 2023, indicated [licensee] will administer medications as prescribed by the authorized prescriber and in accordance with all the rights defined in the Assisted living Bill of Rights and in the Health Insurance Portability and Accountability Act. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820			



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

Page: 1

Establishment Info

TOTAL HOME HEALTH SERVICES LLC
6949 Idaho Ave N
Brooklyn Park, MN 55428
Hennepin County
Parcel:

Phone:

License Info

License: HFID 36648

Risk:
License:
Expires on:
CFPM: Ginni O. Ali
CFPM #: FM12649; Exp: 07/30/2027

Inspection Info

Report Number: F1005261197
Inspection Type: Full - Single
Date: 8/10/2026 Time: 11:20 AM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 2
Total Priority 2 Orders: 1
Total Priority 3 Orders: 0
Delivery: Emailed

! New Order: 3-300B Protection from Contamination: cross-contamination, eggs

3-302.11A(1) *Priority Level: Priority 1 CFP#: 15*

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

COMMENT: RAW SHELL EGGS WERE STORED ON THE TOP SHELF OF THE REFRIGERATOR, OVER READY-TO-EAT FOODS. EGGS WERE MOVED TO THE BOTTOM DRAWER. CORRECTED ON SITE.

Comply By: 8/10/2026 Originally Issued On: 8/10/2026

! New Order: 3-500B Microbial Control: hot and cold holding

3-501.16A2 *Priority Level: Priority 1 CFP#: 22*

MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

COMMENT: TCS FOODS IN THE FRIDGE WERE ABOVE 41 DEGREES F, BECAUSE FRIDGE WAS SET AT 44 DEGREES F. FRIDGE WAS ADJUSTED TO A COLDER TEMPERATURE, MONITOR FOOD TEMPERATURES TO ENSURE THEY COME TO 41 DEGREES F OR BELOW.

Comply By: 8/10/2026 Originally Issued On: 8/10/2026

New Order: 3-500C Microbial Control: date marking

3-501.17B *Priority Level: Priority 2 CFP#: 23*

MN Rule 4626.0400B Mark the refrigerated, ready-to-eat, TCS food prepared and packaged in a processing plant and opened and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded. The date must not exceed the manufacturer's use-by-date. COMMENT: TCS FOODS IN THE REFRIGERATOR, INCLUDING OPENED MILK AND TURKEY DELI MEAT, WERE NOT DATE MARKED. CORRECTED ON SITE. FACT SHEET SENT WITH REPORT.

Comply By: 8/10/2026 Originally Issued On: 8/10/2026

Food & Beverage General Comment

INSPECTION COMPLETED WITH DIRECTOR AND REVIEWED WITH HRD NURSING EVALUATOR BENARD NYANGENA.

A MAXIMUM REGISTERING THERMOMETER WAS ON SITE. OPERATOR SENT INSPECTOR A PICTURE OF THE THERMOMETER AFTER RUNNING IT THROUGH THE DISHWASHER, SHOWING IT PROVIDED A UTENSIL SURFACE TEMPERATURE OF 175.8 DEGREES F.

DISCUSSED DATE MARKING, GLOVE USE, COOKING TEMPERATURES, CROSS-CONTAMINATION, AND EMPLOYEE ILLNESS.

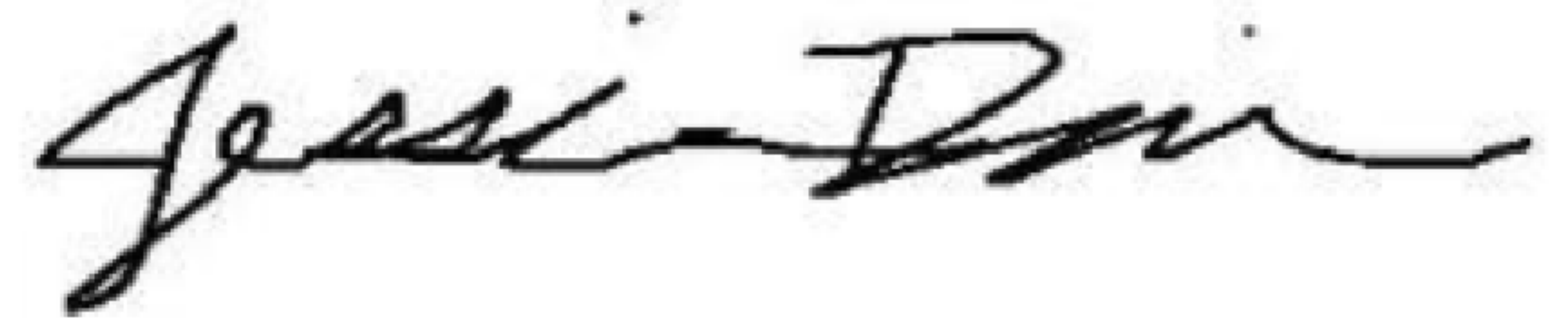
KITCHEN IS RESIDENTIAL AND FOOD IS PREPARED FOR SAME DAY SERVICE.

CABINETS ARE WOOD WITH HOLLOW BASE AND COUNTERS ARE LAMINATE. ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT SUCH A TIME THEY ARE FOUND TO BE A CONCERN OR RISK OF CONTAMINATION, THEY WILL BE ORDERED TO BE REPLACED AND BROUGHT UP TO CODE.

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 F1005261197 from 8/10/2026

GINNI ALI
DIRECTOR



Jessica Davis, REHS
Public Health Sanitarian 3
651-201-3961
jessica.davis@state.mn.us



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

Temperature Observations/Recordings

Page: 1

Establishment Info

TOTAL HOME HEALTH SERVICES LLC
Brooklyn Park
County/Group: Hennepin County

Inspection Info

Report Number: F1005261197
Inspection Type: Full
Date: 8/10/2026
Time: 11:20 AM

Food Temperature: Product/Item/Unit: DELI MEAT; Temperature Process: Cold-Holding

Location: Refrigerator at 44 Degrees F.

Comment:

Violation Issued?: Yes

Food Temperature: Product/Item/Unit: MILK; Temperature Process: Cold-Holding

Location: Refrigerator at 40 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: Product/Item/Unit: STRAWBERRY; Temperature Process: Cold-Holding

Location: Refrigerator at 44 Degrees F.

Comment:

Violation Issued?: No



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

Sanitizer Observations/Recordings

Page: 1

Establishment Info	Inspection Info
TOTAL HOME HEALTH SERVICES LLC	Report Number: F1005261197
Brooklyn Park	Inspection Type: Full
County/Group: Hennepin County	Date: 8/10/2026
	Time: 11:20 AM

Sanitizing Equipment: Product: Hot Water; **Sanitizing Process:** Dishwasher

Location: Equal To 176 Degrees F.

Comment:

Violation Issued?: No

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL36648016	Date: 8/11/2026
Facility Name: Total Home Health Services LLC	
Facility Address: 6949 Idaho Ave. N. Brooklyn Park, MN 55428	

☒ TAG IDENTIFICATION: 0780

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Seven (7) days

1. Smoke alarms are provided in each room used for sleeping purposes. [Minn. Stat. 144G.45 subd.2]

Comments: Bedroom #1 (unoccupied) did not have a smoke alarm.

2. Smoke alarms 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: Bedroom #3 smoke alarm was not interconnected to the rest of the smoke alarms throughout the facility.

☒ TAG IDENTIFICATION: 0790

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Seven (7) days

1. Portable fire extinguishers installed and maintained to MN State Fire Code. [Minn. Stat. 144G.45 subd.2]

Comments: The fire extinguishers were still in the box and not hung on the wall or readily available. The sales receipts had August 10, 2026 as a purchase date.

☒ TAG IDENTIFICATION: 0800

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Seven (7) days

1. The physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment are 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. [Minn. Stat. 144G.45 subd.2]

Comments: Bedroom 4 window cover made it difficult to open the egress window. The floor vent cover was missing by the patio door in the dining room. The patio screen door was difficult to open. Some of the boards on the deck in the backyard were coming up and the finishes were coming off.

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Seven (7) days

1. Each assisted living facility shall develop and maintain fire safety and evacuation plans that are readily available at all times within the facility. [Minn. Stat. 144G.45 subd.2]

Comments: The fire safety and evacuation plans were requested and Licensed assisted living director (LALD)-A was unable to provide them at the time of the survey.

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

Comments: The fire safety and evacuation plan was not provided at the time of the survey.

3. Each assisted living facility shall develop and maintain fire safety and evacuation plans that include fire protection procedures necessary for residents. [Minn. Stat. 144G.45 subd.2]

Comments: The fire safety and evacuation plan was not provided at the time of the survey.

4. Each assisted living facility shall develop and maintain fire safety and evacuation plans that include 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. [Minn. Stat. 144G.45 subd.2]

Comments: The fire safety and evacuation plan was not provided at the time of the survey.

5. Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. [Minn. Stat. 144G.45 subd.2]

Comments: LALD-A failed to provide documentation showing any training was offered or training was scheduled for a future date for employees on the FSEP.

6. 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. [Minn. Stat. 144G.45 subd.2]

Comments: LALD-A failed to provide documentation showing any training was offered or training was scheduled for a future date for residents on the FSEP.