Electronically Delivered

October 6, 2025

Licensee
Tabernacle Home Care
189 Ulmer Drive
Lino Lakes, MN 55014

RE: Project Number(s) SL39156016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 21, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement;
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;
Level 3: a fine of $1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 4: a fine of $3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 5: a fine of $5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

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

0780 - 144g.45 Subd. 2 (a) (1) - Fire Protection And Physical Environment - $500.00
0810 - 144g.45 Subd. 2 (b-F) - Fire Protection And Physical Environment - $1,000.00
2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - $1,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $2,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

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

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

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

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

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

If you have any questions, please contact me.

Sincerely,

Kelly Thorson

Kelly Thorson, Supervisor
State Evaluation Team
Email: kelly.thorson@state.mn.us
Telephone: 320-223-7336 Fax: 1-866-890-9290

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39156	A. BUILDING: _____ B. WING _____	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TABERNACLE HOME CARE	189 ULMER DRIVE LINO LAKES, MN 55014

(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: SL39156016-0 On August 18, 2025, through August 21, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there was 1 resident; 1 receiving services under the Assisted Living Facility license. An immediate correction order was identified on August 20, 2025, issued for SL39156016, tag identification 2310. During the course of 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.	

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0 480	Continued From page 1	0 480		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (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;	0 480		

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0 480	Continued From page 2 (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated August 19, 2025, for the specific	0 480		

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0 480	Continued From page 3 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		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) and Minnesota Department of Health (MDH), which included completion of an annual TB facility risk assessment. This practice resulted in a level two violation (a	0 660		

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0 660	Continued From page 4 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on August 18, 2025, at 12:29 p.m., licensed assisted living director/owner (LALD/O)-A stated the licensee was familiar with current minimum assisted living requirements. The licensee's Facility TB Risk Assessment Worksheet for Health Care Settings Licensed by MDH dated August 7, 2023, was completed by LALD/O-A. On page three (3), section: Quality Improvement 2: had written "Annually" for how frequently the TB risk assessment worksheet was conducted or updated by the licensee. On August 18, 2025, at 12:41 p.m., LALD/O-A stated he was aware of the requirement, but he did not remember to do the facility risk assessment this year. The licensee's TB Prevention and Control policy dated August 7, 2022, indicated a community TB risk assessment will be completed annually. The MDH guidelines Regulations for Tuberculosis Control in Minnesota Health Care Settings dated June 10, 2019, and based on CDC guidelines, indicated a facility TB risk assessment should be completed initially and on an annual basis.	0 660		

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0 660	Continued From page 5 The MDH Assisted Living Resources and Frequently Asked Questions (FAQs) last updated December 13, 2024, indicated each provider licensed by MDH is required to complete a TB risk assessment annually. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated;	0 780		

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0 780	Continued From page 6 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that were interconnected so that the actuation of one alarm caused all alarms in the dwelling unit to actuate. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On August 18, 2025, at approximately 12:00 p.m., the surveyor toured the facility with licensed assisted living director/owner (LALD/O)-A. During the tour, a test of the smoke alarms was conducted by LALD/O-A and it was observed that the smoke alarms in the facility were not interconnected. All smoke alarms are required to be interconnected so that the actuation of any one alarm causes all alarms within the facility to operate. The original hard wired smoke alarm in the hallways where not interconnected with the newer wireless interconnected smoke alarms. All	0 780		

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0 780	Continued From page 7 dwelling units required to have multiple smoke alarms are required to have interconnected alarms so activation of one alarm activates all alarms within the dwelling unit. On August 18, 2025, LALD/O-A acknowledged the deficiency and would work to correct the condition. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
0 810 SS=I	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 8 least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) 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 August 18, 2025, licensed assisted living director/owner (LALD/O)-A 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 failed to include the	0 810		

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0 810	Continued From page 9 following: The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. The FSEP 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 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. On August 18, 2025, LALD/O-A stated they understood the areas of their policy that were incomplete and would work on bringing them into compliance. TRAINING: The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. LALD/O-A stated they provide training to staff only upon hire and have not provided any additional training to staff. No other training documentation was provided. On August 18, 2025, LALD/O-A stated they understood the requirements for training staff and would implement a training program that was compliant with statute requirements. DRILLS: The licensee failed to conduct evacuation drills for employees twice per year, per shift with at	0 810		

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0 810	Continued From page 10 least one evacuation drill every other month. Record review of licensee's evacuation drill log, indicated evacuation drills were conducted on 5-27-24, and 12-20-24. LALD/O-A stated no evacuation drills have been conducted in 2025. No other documentation was provided. On August 18, 2025, LALD/O-A stated there were no additional documented drills for the facility. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section	01060		

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01060	Continued From page 11 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with required content for an emergency relocation and failed to notify the Office of Ombudsman for Long-Term Care of the emergency relocation for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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:	01060		

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01060	Continued From page 12 During the entrance conference on August 18, 2025, at 12:29 p.m., licensed assisted living director/owner (LALD/O)-A stated the licensee was familiar with current minimum assisted living requirements. R1 was admitted to the licensee and started receiving assisted living services on June 22, 2023. R1's record indicated R1 was admitted to the hospital on August 8, 2024, for acute hypoxic respiratory failure. R1 returned to the licensee on August 12, 2024. R1's record lacked a written notice including: - the name and contact information for the location to which the resident has been relocated and any new service provider - contact information for the Office of Ombudsman for Long-Term Care - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. R1's record lacked notification to the Office of Ombudsman for Long-Term Care that the resident had been relocated and had not returned to the facility within four days. On August 19, 2025, at 9:52 a.m., clinical nurse supervisor (CNS)-B stated, "I did not know that I	01060		

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01060	Continued From page 13 needed to do that". The licensee's undated Emergency Relocation policy indicated in the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation (2) the name and contact information for the location to which the resident has been relocated and any new service provider (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility will provide contact information for the agency to which the resident may submit an appeal. (6) the notice required will be delivered as soon as practicable to: a) the resident, legal representative, and designated representative b) for residents who receive home and community-based waiver services under the resident's case manager c) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		

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01370 SS=F	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health	01370		

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01370	Continued From page 15 technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency evaluations were completed for all required skill areas, prior to providing services, for one of one unlicensed personnel (ULP-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 the residents). The findings include: During the entrance conference on August 18, 2025, at 12:37 p.m., licensed assisted living director/owner (LALD/O)-A stated the licensee was familiar with required contents of the employee records. ULP-C was hired on July 25, 2024, to provide direct care services to residents. ULP-C's employee record lacked documentation of the following required competencies to be completed by ULP: - appropriate and safe techniques in personal hygiene and grooming including hair care, bathing, care of teeth, gums and oral prosthetic devices, care and use of hearing aids, dressing and assisting with toileting	01370		

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01370	Continued From page 16 - standby assistance techniques and how to perform them On August 19, at 10:33 a.m., clinical nurse supervisor (CNS)-B stated she wasn't aware of the requirements. She stated, "I know I should do it, and have done it, but didn't document it." The licensee's Assisted Living Orientation-ULP Staff dated September 1, 2022, indicated ULP who were not registered nursing assistants will receive addition training on the following topics with a written or oral competency test and a skill demonstration including: - hair care - bathing - care of teeth, gums, and oral prosthetic devices - care and use of hearing aids - dressing - assisting with toileting - standby assistance techniques - medication reminders - exercise reminders - treatment reminders - reading and recording temperature, pulse, and respirations - safe transfer techniques and ambulation - range of motion and positioning - administering medications and/or treatments as required No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01380 SS=F	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn	01380		

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01380	Continued From page 17 (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency evaluations were completed for all required skill areas, prior to providing services, for one of one unlicensed personnel (ULP-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 the residents). The findings include: During the entrance conference on August 18,	01380		

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01380	Continued From page 18 2025, at 12:37 p.m., licensed assisted living director/owner (LALD/O)-A stated the licensee was familiar with required contents of the employee records. ULP-C was hired on July 25, 2024, to provide direct care services to residents. ULP-C's employee record lacked documentation of the following required competencies to be completed by ULP: - reading and recording temperature, pulse, and respirations of the resident - safe transfer techniques and ambulation - range of motioning and positioning - administering medications or treatments as required - Other registered nurse (RN) / professionally delegated tasks (i.e., monitor vital signs, catheter or stoma care, Broda chair, mechanical lifts) On August 19, at 10:33 a.m., clinical nurse supervisor (CNS)-B stated she wasn't aware of the requirements. She stated, "I know I should do it, and have done it, but didn't document it." The licensee's Assisted Living Orientation-ULP Staff dated September 1, 2022, indicated ULP who were not registered nursing assistants will receive addition training on the following topics with a written or oral competency test and a skill demonstration including: - hair care - bathing - care of teeth, gums, and oral prosthetic devices - care and use of hearing aids - dressing - assisting with toileting - standby assistance techniques	01380		

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01380	Continued From page 19 - medication reminders - exercise reminders - treatment reminders - reading and recording temperature, pulse, and respirations - safe transfer techniques and ambulation - range of motion and positioning - administering medications and/or treatments as required No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance.	01440		

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01440	Continued From page 20 This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN) conducted direct supervision of staff performing a delegated task within 30 days of providing services for one of one employee (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on August 18, 2025, at 12:37 p.m., licensed assisted living director/owner (LALD/O)-A stated the licensee was familiar with required contents of the employee records. ULP-C started employment with the licensee to provide assisted living services on July 25, 2024. ULP-C's employee record lacked documentation of direct supervision of performing a delegated task within 30 days of providing services to verify the work was performed competently and to identify problems and solutions to address issues relating to the staff's ability to provide the	01440		

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01440	Continued From page 21 services. R1's Service Recap Summary dated August 2025, indicated ULP-C completed blood glucose checks for R1 on August 1, 6, 11, 12, 13, 14, 15 and 18, 2025. On August 20, 2025, at 3:12 p.m., clinical nurse supervisor (CNS)-A stated a 30-day supervision had not been completed for ULP-C. She stated, "I didn't know there was a form I needed to fill out, they always call if they have questions. I do document those things in resident charts, but I don't indicate who the staff person was". The licensee's Supervision of Unlicensed Personnel policy dated September 1, 2022, indicated direct supervision of unlicensed staff providing delegated nursing tasks, delegated treatments or assigned therapy tasks must be performed within 30 days after the person begins work for our facility and has been trained and determined competent to perform all the tasks assigned. It is the responsibility of the CNS, the registered Nurse (RN) and the appropriate licensed health professional to ensure that each instance of supervision of staff is appropriately documented in the staff person's personnel file, consistent with facility policies. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training	01500		

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01500	Continued From page 22 for each 12 months of employment. The training may be obtained from the facility or another 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	01500		

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01500	Continued From page 23 topics: (1) an explanation of age-related hearing loss 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 interview and record review, the licensee failed to ensure an employee received at least eight hours of annual training for each 12 months of employment for one of one employee (clinical nurse supervisor (CNS)-B). 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: During the entrance conference on August 18, 2025, at 12:37 p.m., licensed assisted living director/owner (LALD/O)-A stated the licensee was familiar with required contents of the employee records.	01500		

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01500	Continued From page 24 CNS-B had a hire date of September 18, 2023. CNS'-B's record lacked evidence of annual training to include: - reporting maltreatment of vulnerable adults or minors - 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 relating to the provision of assisted living services and how to implement those policies and procedures On August 19, 2025, at 10:18 a.m., LALD/O-A stated they use Educare (online training) and R-Tasks (electronic medical record and online training). He stated CNS-B did not complete the quiz at the end of each R-task module, so it appeared it wasn't completed. In addition, LALD/O-A stated Educare training had been assigned to CNS-B but not all modules were completed. On August 19, 2025, at 10:19 a.m., CNS-B stated she was not aware she was required to take a quiz to complete the training. On August 19, 2025, at 10:50 a.m., CNS-B stated she was unaware that she was required to meet the annual training requirements. The licensee's Assisted Living or Assisted Living with Memory Care Annual Training policy dated September 1, 2022, indicated all staff will complete annual education to keep knowledge	01500		

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01500	Continued From page 25 and skills current and provide quality care to residents. Annual training will be documented in accordance with the documentation policy. Direct-care staff will complete eight (8) hours of annual training for each 12 months of employment. All assisted living employees will complete annual education on the following topics: - reporting of maltreatment of vulnerable adults under section 626.557 - assisted living bill of rights - infection control - effective approaches for problem solving when working with challenging behaviors and for communication with residents with dementia, Alzheimer's disease or related disorders - review of policies and procedures - principles of person-centered planning service delivery No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		
01530 SS=F	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of	01530		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01530	Continued From page 26 training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure direct care staff received the required amount of dementia care training in the required time frame for one of two employees (clinical nurse supervisor (CNS)-B). In addition, the licensee failed to ensure direct care	01530		

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01530	Continued From page 27 staff received the required 2 hours of initial training on mental illness and de-escalation topics effective July 1, 2025, for two of two employees (CNS-B and unlicensed personnel (ULP)-C). This had the potential to affect all residents and staff. 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: During the entrance conference on August 18, 2025, at 12:37 p.m., licensed assisted living director/owner (LALD/O)-A stated the licensee was familiar with required contents of the employee records. ULP-C ULP-C began employment on July 25, 2024, to provide direct care services. ULP-C's employee record lacked documentation of the initial two (2) hours of mental illness and de-escalation training. CNS-B CNS-B began employment on September 18, 2023, to provide direct care services and supervision of staff.	01530		

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01530	Continued From page 28 CNS-B's employee record lacked evidence of completing the initial two (2) hours of mental illness and de-escalation training and completing the required two (2) hours of annual dementia training. In addition, CNS-B's record lacked evidence of completing any initial dementia care training in the following topics: - an explanation of Alzheimer's disease and other dementia's - assistance with activities of daily living - problem solving with challenging behaviors - communication skills - person-centered planning and service delivery On August 19, 2025, at 12:48 p.m., licensed assisted living director/owner (LALD/O)-A stated he recalls hearing about the required mental illness and de-escalation training at a summit training. LALD/O-A stated none of the staff had been assigned the education at this time. On August 19, 2025, at 1:03 p.m., LALD/O-A stated he was not aware CNS-A required annual training. He stated CNS-B had been assigned some of the initial dementia care training, but CNS-A did not complete it. On August 20, 2025, at 3:29 p.m., CNS-B stated she was not aware she was required to complete the training. The licensee's Assisted Living or Assisted Living with Memory Care Dementia Training policy dated September 1, 2022, indicated supervisors of direct staff will complete a minimum of 8 hours of initial training on dementia care topics. Initial training will be completed within 120 working hours of the employment stat date. Supervisors	01530		

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01530	Continued From page 29 of direct care staff will have a minimum of two (2) hours on topics related to dementia for each 12 months of employment after orientation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01530		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed	01620		

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01620	Continued From page 30 practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to ensure the registered nurse (RN) completed ongoing reassessments and monitoring on or before day 90 or with any change of condition and failed to use the uniform assessment tool for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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	01620		

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01620	Continued From page 31 the residents). The findings include: During the entrance conference on August 18, 2025, at 12:32 p.m., licensed assisted living director/owner (LALD/O)-A stated the RN completed nursing assessments pre-admission, admission, 14-day, and every 90-days, unless there is a major change. R1 admitted to the licensee and began receiving services on June 22, 2023. R1 had diagnoses to include paranoid schizophrenia, anxiety disorder, bipolar disorder, and chronic obstructive pulmonary disease. R1's record indicated the last nursing assessment completed was dated April 11, 2025. Additionally, the assessments did not include all the required elements of the uniform assessment tool including: - the resident's personal lifestyle preferences including leisure activities, routines that are important to the resident's qualify of life, spiritual and cultural preferences, and advanced health care directives - instrumental activities of daily living, including housekeeping, laundry, and transportation - review of medical dental, and emergency room visits in the past 12 months to the extent they are available to the RN - pain including location, frequency, intensity, duration, effectiveness of medication and nonmedication alternatives for pain - list of treatments including type, frequency and level of assistance needed	01620		

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01620	Continued From page 32 On August 20, 2025, at 3:18 p.m., clinical nurse supervisor (CNS)-B confirmed R1's most recent assessment was completed on April 11, 2025. She stated there are no additional assessments because she did not know how R-Tasks (electronic medical record) worked and thought the assessments were being saved, but they were not. In addition, CNS-B stated she was unaware that her paper assessments were missing required elements of a uniform assessment tool. The Minnesota Administrative Rule 4659.0150 dated August 11, 2021, indicated each licensee must develop a uniform assessment tool to include all the required elements. The licensee's Initial and On-Going Nursing Assessment of Residents policy dated September 1, 2022, indicated a RN will complete the following comprehensive nursing assessments of the resident's physical, mental, and cognitive needs as required: a. pre-admission assessment b. 14-day assessment: completed up to 14-days after start of service c. ongoing assessment: complete periodically but no less than every 90-days d. change in resident condition A comprehensive assessment includes but may not be limited to the requirements outlined by Minnesota rules. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		

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01640	Continued From page 33	01640		
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a service plan was developed for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	01640		

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01640	Continued From page 34 or has the potential to affect a large portion or all the residents). The findings include: During the entrance conference on August 18, 2025, at 12:29 p.m., licensed assisted living director/owner (LALD/O)-A stated the licensee was familiar with current minimum assisted living requirements. R1 admitted to the licensee and began receiving services on June 22, 2023. R1 had diagnoses to include paranoid schizophrenia, anxiety disorder, bipolar disorder, and chronic obstructive pulmonary disease. R1's record lacked a service plan. R1's Service Recap Summary dated August 2025, indicated R1 received services including behavioral management, blood glucose monitoring, bathing, grooming, dressing, escorts, housekeeping, incontinence care, meal reminder, vital sign monitoring, safety checks, socialization, skin care, wound care, and medication administration. On August 20, at 9:53 a.m., LALD/O-A stated R1 did not have a service plan. He stated the nurse documents any changes to R1's cares in the nursing notes. The licensee's Contents of Service Plan policy dated September 1, 2022, indicated all assisted living residents have an up-to-date service plan identifying services to be provided based on the assessment by the registered nurse (RN) and/or other licensed health professional.	01640		

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01640	Continued From page 35 No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01710 SS=F	144G.71 Subd. 3 Individualized medication monitoring and reas A registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed annual medication reassessments for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: During the entrance conference on August 18, 2025, at 12:31 p.m., licensed assisted living	01710		

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01710	Continued From page 36 director/owner (LALD/O)-A stated the licensee provided medication management services to residents at the facility. R1 admitted to the licensee and began receiving services on June 22, 2023. R1's medication administration record for August 2025 indicated R1 received medication administration daily. R1's medication assessment was undated and unsigned. On August 18, 2025, LALD/O-A provided an Individualized Medication Management Plan that was undated and printed on August 18, 2025, the second day of the survey. On August 20, 2025, at 3:18 p.m., clinical nurse supervisor (CNS)-B stated R1 had no additional assessments because she did not know how Rtask (electronic medical record) worked and thought the assessments were being saved, but they were not. The licensee's initial and On-Going Nursing Assessment of Residents policy dated September 1, 2022, indicated nursing assessments are completed by a registered nurse based upon the required assessment schedule and as needed based upon resident condition. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01710		

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01790	Continued From page 37	01790		
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided;	01790		

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01790	Continued From page 38 (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed training and competencies for the unlicensed personnel (ULP) providing medications for residents with unplanned time away from home when the licensed nurse was not available for one of one unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	01790		

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01790	Continued From page 39 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 the residents). The findings included: During the entrance conference on August 18, 2025, at 12:37 p.m., licensed assisted living director/owner (LALD/O)-A stated the licensee was aware of the required contents of the employee records. ULP-C started employment with the licensee to provide assisted living services on July 25, 2024. ULP-C's employee record lacked documentation of training and competencies for providing medications to residents with medication management who have unplanned time away from home. On August 20, at 3:15 p.m., clinical nurse supervisor (CNS)-B stated she had not completed the training or competencies for medications for residents with unplanned time away from home. She stated that ULP's can set up medications if the resident has unplanned time away from home, however, the ULP's usually contact LALD/O-A when medications need to be set up. The licensee's Delegation of Medications to be Given to Residents by Unlicensed Staff for Residents Time Away From Home policy dated September 1, 2022, indicated only unlicensed staff that have been trained and have satisfactorily demonstrated competency will be assigned to place medications prepared by a	01790		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01790	Continued From page 40 pharmacist or a licensed nurse in the appropriate container for an unplanned leave of absence not to exceed seven (7) days of medication. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were maintained bearing legible information including the original prescription label and opened-on date or expiration date for time sensitive medication for one of one resident (R1) who received medication management 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 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).	01890		

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	39156	A. BUILDING: _____ B. WING _____	08/21/2025

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01890	Continued From page 41 The findings include: During the entrance conference on August 18, 2025, at 12:31 p.m., licensed assisted living director/owner (LALD/O)-A stated the licensee provided medication management services to residents at the facility. On August 19, 2025, at 9:30 a.m., the surveyor reviewed R1's medication locker with unlicensed personnel (ULP)-C and clinical nurse supervisor (CNS)-B and observed R1's Anoro Ellipta inhaler lacked a prescription label and an opened date or expiration date. On August 19, 2025, at 9:40 a.m., ULP-C stated they use the meter on the inhaler to know how much medicine is left. She stated she did not know they need to have an open date or expiration date. On August 19, 2025, at 9:42 a.m. CNS-B stated inhalers normally come with a prescription label, and she didn't know why this one did not have one. She stated that the resident takes the medicine every day and the medicine is reordered based on the meter of the inhaler. CNS-B stated staff are trained to label insulin with an open date. The manufacturer's instructions for Anoro Ellipta inhaler, dated June 2019, indicated to discard unused medication six (6) weeks after opened or when the counter reads zero (0), whichever comes first. The licensee's Individualized Medication, Treatment and Therapy Management Plans dated September 1, 2022, indicated the	01890		

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01890	Continued From page 42 registered nurse (RN) will develop a medication management plan for each resident receiving medication management services. The medication management plan will include a description of medication storage based upon the resident's needs, preferences, risk of diversion, and in keeping with the manufacturer's instructions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01940 SS=F	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to	01940		

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01940	Continued From page 43 documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a treatment or therapy management plan to include the required content for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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 the residents). The findings include: During the entrance conference on August 18, 2025, at 12:34 p.m., licensed assisted living director/owner (LALD/O)-A stated the licensee provided treatment or therapy management services that included blood glucose checks and catheters. . R1 was admitted to the facility on June 22, 2023. R1 had diagnoses to include paranoid schizophrenia, anxiety disorder, bipolar disorder,	01940		

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01940	Continued From page 44 and chronic obstructive pulmonary disease. R1 lacked a service plan. R1's Master Care Plan dated August 19, 2025, indicated R1 received assistance with blood glucose checks and foley catheter care. R1 lacked an Individualized Treatment and Therapy Management Plan. R1's Service Recap Summary record for January 1, 2025, through June 30, 2025, indicated blood glucose checks were completed daily January 1, 2025, through March 31, 2025. The frequency changed to twice daily on April 1, 2025, through August 18, 2025. R1's Service Recap Summary record for January 1, 2025, through May 7, 2025, lacked foley catheter care. R1's record lacked evidence of an individualized treatment or therapy management plan which included the following for blood glucose checks and foley catheter care. - a statement of the type of services that would be provided - documentation of specific resident instructions relating to the treatments or therapy administered - identification of treatment or therapy tasks that would be delegated to unlicensed personnel - procedures for notifying an RN or appropriate licensed health professional when a problem arises with treatments or therapy services; and - any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment or therapy was administered as prescribed; and monitoring	01940		

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01940	Continued From page 45 of treatment or therapy to prevent possible complications or adverse reactions. On August 19, 2025, at 3:26 p.m., clinical nurse supervisor (CNS)-B stated she did not know what a treatment or therapy management plan was. CNS-B stated, I did not see a treatment plan in R-Tasks (electronic medical record), I didn't see that there was anything else I needed to do". On August 20, 2025, at 10:44 a.m., LALD/O-A stated R1 traveled to Washington state and returned with a foley catheter in October 2024. LALD/O-A verified that R1's file lacked a treatment or therapy management plan. On August 20, 2025, at 3:24 p.m., CNS-B stated R1's blood glucose checks were ordered once daily, and she was unsure why it changed to twice daily on April 4, 2025, through today, August 20, 2025. On August 21, 2024, at 9:44 a.m., LALD/O-A stated R1's foley catheter was removed on May 7, 2025 The licensee's Documentation of Medication, Treatment and Therapy Management Services policy dated September 1, 2022, indicated the RN will document the services the resident will receive on the resident's individualized medication management plan and individualized treatment and therapy plan and resident's medication/treatment record or MAR/TAR. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		

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01950 SS=F	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) specified, in writing, specific instructions for one of one resident (R1) receiving treatment management 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 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 the residents).	01950		

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01950	Continued From page 47 The findings include: During the entrance conference on August 18, 2025, at 12:36 p.m., licensed assisted living director/owner (LALD/O)-A stated the licensee provided treatment and therapy services to residents at the facility. R1 admitted to the licensee and began receiving services on June 22, 2023. R1 had diagnoses to include paranoid schizophrenia, anxiety disorder, bipolar disorder, and chronic obstructive pulmonary disease. R1's record lacked a service plan. R1's Service Recap Summary dated August 2025, indicated R1 received services including behavioral management, blood glucose monitoring, bathing, grooming, dressing, escorts, housekeeping, incontinence care, meal reminder, vital sign monitoring, safety checks, socialization, skin care, wound care, and medication administration. R1's Master Care Plan dated August 19, 2025, indicated R1 received foley catheter care. R1's nursing assessment dated April 11, 2025, indicated R1 received foley catheter care R1's Service Recap Summaries dated January 1, 2025, through August 18, 2025, indicated incontinence care was documented AM (morning) and PM (afternoon). R1 lacked an Individualized Treatment and	01950		

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01950	Continued From page 48 Therapy Management Plan and prescriber orders. R1's record lacked the following: - to instruct the ULP's in the proper methods with respect to resident and the unlicensed personnel has demonstrated the ability to competently follow procedures - specified, in writing, specific instructions for the resident and documented those instructions in the resident's record - communicated with the ULP's about the individual needs of the resident On August 19, 2025, at 3:26 p.m., clinical nurse supervisor (CNS)-B stated she did not know what a treatment or therapy management plan was. CNS-B stated the care was not listed as foley catheter care on the ULP's services flowsheet and was documented under incontinence care. In addition, she stated, "I did not see a treatment plan in R-Tasks (electronic medical record), I didn't see that there was anything else I needed to do". On August 20, 2025, at 10:44 a.m., LALD/O-A stated R1 returned to the facility, from Washington state, on October 22, 2024, with a foley catheter in place. The foley catheter was removed on May 7, 2025. He confirmed R1 lacked an Individualized Treatment and Therapy Management Plan and physician orders. LALD/O-A stated the facility provided foley catheter care. In addition, he stated, "I did not charge for it, and I sent him to urology frequently". The licensee's Delegation of Nursing Tasks policy dated September 1, 2022, indicated the RN will	01950		

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01950	Continued From page 49 develop a service plan for providing the services according to the resident's needs and preferences. When needed, the RN will provide written instructions for performing the procedure to the ULP. Changes in care will be communicated to the ULP and further education and instruction provided as needed. The licensee's Documentation of Medication, Treatment and Therapy Management Services policy dated September 1, 2022, indicated The RN will document the services the resident will receive on the resident's individualized medication management plan and individualized treatment and therapy plan and resident's medication/treatment record or MAR/TAR. No further information was provided. TIME PERIOD OF CORRECTION: Seven (7) days	01950		
01970 SS=F	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to ensure up-to-date written or electronically recorded orders were maintained	01970		

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01970	Continued From page 50 for one of one resident (R1) receiving treatments. 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 the residents). The findings include: During the entrance conference on August 18, 2025, at 12:36 p.m., licensed assisted living director/owner (LALD/O)-A stated the licensee provided treatment and therapy services to residents at the facility. R1 admitted to the licensee and began receiving services on June 22, 2023. R1 had diagnoses to include paranoid schizophrenia, anxiety disorder, bipolar disorder, and chronic obstructive pulmonary disease. R1 lacked a service plan. R1's Master Care Plan dated August 19, 2025, indicated R1 received assistance with blood glucose checks and foley catheter care. R1's medical record lacked foley catheter and blood glucose monitoring orders. On August 20, 2025, at 10:44 a.m., LALD/O stated R1 returned to the facility, from Washington state, on October 22, 2024, with a	01970		

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01970	Continued From page 51 foley catheter in place. The foley catheter was removed on May 7, 2025. He confirmed R1's medical record was missing treatment orders regarding foley catheter care and current glucose monitoring. LALD/O stated the facility provided foley catheter care. In addition, he stated, "I did not charge for it, and I sent him to urology frequently". On August 20, 2025, at 3:24 p.m., CNS-B stated R1's blood glucose checks was ordered once daily, and she was unsure why it changed to twice daily on April 4, 2025, through today, August 20, 2025. The licensee's Documentation of Medication, Treatment, and Therapy Management Services policy dated August 1, 2021, indicated the registered nurse (RN) will document the services the resident will receive on the resident's individualized medication management plan and individualized treatment and therapy plan and resident's medication/treatment record or MAR/TAR. The nurse will document actions to implement a new prescription when it is received, and actions to request and obtain needed refills for residents, including communications with the prescriber, pharmacy, resident and/or resident's representative or family. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted	02310		

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02310	Continued From page 52 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 one resident (R1) with hospital-style bed rails. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident), 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 admitted to the licensee and began receiving services on June 22, 2023. R1 had diagnoses to include paranoid schizophrenia, anxiety disorder, bipolar disorder, and chronic obstructive pulmonary disease. R1 lacked a service plan. R1's Service Recap Summary dated August 2025, indicated R1 received assistance with bathing, dressing, grooming, housekeeping, incontinence care, activities, meal reminders, vital sign monitoring, blood glucose monitoring, medication administration, escort/mobility, wound	02310		

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02310	Continued From page 53 care, skin care, and safety checks. On August 18, 2025, at 11:55 a.m., surveyor observed R1's bed had bilateral (two sides) half rail hospital-style bed rails located at the head of the hospital bed. The bed rails were firmly attached to the bed. R1's record lacked a bed rail assessment to include: - purpose and intention of the bed rail - condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail - the resident's bed rail use/need assessment - risk vs. benefits discussion (individualized to each resident's risks) - the resident's preferences - installation and use according to manufacturer's guidelines - 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". - bed rail measurements and that the bed rail has not shifted and is securely attached to the bed frame per manufacturer recommendations. On August 20, 2025, at 10:21 a.m., licensed assisted living director/owner (LALD/O)-A stated the bed rail assessment was completed by R1's hospice provider and not the registered nurse (RN). He stated there was no documentation in the resident record regarding bed rails. On August 20, 2025, at 3:16 p.m., clinical nurse supervisor (CNS)-B stated the resident had been	02310		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 54 admitted and discharged from hospice several times since his admission to the assisted living. She stated she thought hospice staff were responsible as they ordered the hospital bed for the resident. CNS-B stated she did not know the registered nurse (RN) at the facility was responsible and she was not aware of all the requirements for bed rails and had not completed a bed rail assessment. The Food and Drug Administration's (FDA), A Guide to Bed Safety, dated 2000, and revised April 2010, indicated following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." The March 10, 2006, FDA Side Rail Entrapment Zones and Dimensional Recommendations indicated to reduce the risk of entrapment, zone 1 (within the rail) should not exceed 4 and 3/4 inches, zone 2 (under the rail, between rail supports or next to a single rail support) should not exceed 4 and 3/4 inches, zone 3 (between the rail and the mattress), should not exceed 4 and 3/4 inches, and zone 4 (under the rail, at the ends of the rail) should not exceed 2 and 3/8 inches or be greater than a 60 degree angle. 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
	39156	A. BUILDING: _____ B. WING _____	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TABERNACLE HOME CARE	189 ULMER DRIVE LINO LAKES, MN 55014

(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 55 Frequently-Asked Questions (FAQs) indicated, "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 bed rails includes, but is not limited to: - purpose and intention of the bed rail - condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail - the resident's bed rail use/need assessment - risk vs. benefits discussion (individualized to each resident's risks) - the resident's preferences - installation and use according to manufacturer's guidelines - physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation - any necessary information related to interventions to mitigate safety risk or negotiated risk agreements" Additionally, the MDH website indicated for hospital-style bed rails, the licensee must include in their documentation, the bed rail measurements and that the bed rail has not shifted and is securely attached to the bed frame per manufacturer recommendations. A bed rail policy was requested but not received.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39156	A. BUILDING: _____ B. WING _____	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TABERNACLE HOME CARE	189 ULMER DRIVE LINO LAKES, MN 55014

(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 56 No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	02310		

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

Food & Beverage Inspection Report

Establishment Info

Tabernacle Home Care
189 Ulmer Drive
Lino Lakes, MN 55014
Anoka County
Parcel:

Phone:

License Info

License: 0041674

Risk:
License: -1
Expires on: 12/31/2023
CFPM: LAMESSA TESSO BOKA
CFPM #: 14287; Exp: 3/28/2028

Inspection Info

Report Number: F1029251111
Inspection Type: Full - Single
Date: 8/19/2025 Time: 9:16:39 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 1
Total Priority 2 Orders: 1
Total Priority 3 Orders: 1
Delivery:

! **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: 8/8/23-8/19/25: RAW UNPASTEURIZED SHELL EGGS ABOVE READY TO EAT ITEMS - MILK, APPLESAUCE. ENSURE RAW ANIMAL PROTEINS ARE SAFELY SEPARATED FROM READY TO EAT FOODS.
Comply By: 8/23/2023 Originally Issued On: 8/19/2025

New Order: 4-300 Equipment Numbers and Capacities
4-302.13B *Priority Level: Priority 2 CFP#: 48*
MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.
COMMENT: MIN/MAX THERMOMETER PRESENT BUT NOT WORKING - WATER BEHIND DISPLAY. ENSURE WORKING MIN/MAX THERMOMETER OR THERMAL STICKERS ARE PRESENT TO VERIFY DISHWASHER'S SANITIZING TEMPERATURES.
Comply By: 8/29/2025 Originally Issued On: 8/19/2025

New Order: 6-500 Physical Facility Maintenance/Operation and Pest Control
6-501.11 *Priority Level: Priority 3 CFP#: 55*
MN Rule 4626.1515 Maintain the physical facilities in good repair.
COMMENT: EXPOSED MDF ON SOME MILLWORK. SEAL TO PRECLUDE MOISTURE INTRUSION.
Comply By: 7/31/2026 Originally Issued On: 8/19/2025

Food & Beverage General Comment

Food and beverage inspection of facility performed as part of HRD nursing survey. Identified issues reviewed with staff and nurse surveyor. Establishment's kitchen residential in nature and prepares TCS foods only for same-day service. Establishment serves one client and the client is part of a highly susceptible population.

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 F1029251111 from 8/19/2025

Trevor McPliment

LAMESSA BOKA
LALD

Trevor McCliment,
Public Health Sanitarian 3
651-201-3957
trevor.mccliment@state.mn.us

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

Temperature Observations/Recordings

Establishment Info

Tabernacle Home Care
Lino Lakes
County/Group: Anoka County

Inspection Info

Report Number: F1029251111
Inspection Type: Full
Date: 8/19/2025
Time: 9:16:39 AM

New Record: **Product/Item/Unit:** MILK; **Temperature Process:** REFRIGERATOR
Location: 39 at Degrees F.
Comment:
Violation Issued?: No

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

Sanitizer Observations/Recordings

Establishment Info

Tabernacle Home Care
Lino Lakes
County/Group: Anoka County

Inspection Info

Report Number: F1029251111
Inspection Type: Full
Date: 8/19/2025
Time: 9:16:39 AM

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Kitchen **Equal To** 150 Degrees F.
Comment:
Violation Issued?: No