Electronically Delivered

November 10, 2025

Licensee
Tender Care Group Homes LLC
2640 Polk Street Northeast
Minneapolis, MN 55418

RE: Project Number(s) SL35977016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on October 1, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

§ 144G.20;

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

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

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

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

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

REQUESTING A HEARING

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

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

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

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

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

If you have any questions, please contact me.

Sincerely,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: Jess.Schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

CLN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35977	A. BUILDING: _____ B. WING _____	10/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TENDER CARE GROUP HOMES LLC	2640 POLK STREET NE MINNEAPOLIS, MN 55418

(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: SL35977016-0 On September 29, 2025, through October 1, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were three (3) residents receiving services under the Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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

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0 480	Continued From page 2 existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated September 30, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee	0 480		

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0 480	Continued From page 3 within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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).	0 630		

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0 630	Continued From page 4 The findings include: R2 admitted to the licensee on July 30, 2022, with diagnoses that included but were not limited to illness, unspecified. R2's Service Plan, dated September 30, 2025, indicated R2 received assistance with medication administration, reminders for bathing, vital signs, and behavior management. R2's IAPP dated July 5, 2025, indicated R2 was at risk for being abused due to vulnerability and inability to assess risk. Caregivers were also properly trained and supervised to report suspected abuse. However, R2's IAPP lacked R2's risk of abusing other vulnerable adults. During an interview on October 1, 2025, at 1:30 p.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A acknowledged R2's IAPP was missing assessment of the risk of abusing other vulnerable adults. CNS/LALD-A stated they would work to improve on their IAPP assessments and interventions. The licensee's Individual Abuse Prevention Plans Policy dated August 1, 2021, indicated the individual abuse prevention plan would include an individualized review or assessment of the person's susceptibility to abuse by another individual, including: a. other vulnerable adults b. the person's risk of abusing other vulnerable adults, and c. statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults.	0 630		

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0 630	Continued From page 5 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain facility in compliance with Minnesota State Fire Code under Minnesota Rules Chapter 7511. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On September 29, 2025, from approximately 2:25 p.m. to 3:30 p.m., the surveyor toured the facility with clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A. During the tour the surveyor observed the following: The dryer ventilation was not properly attached to	0 775		

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0 775	Continued From page 6 the clothing dryer and a significant amount of lint had accumulated behind the dryer which may pose a risk of fire. The lint should be cleaned and the ventilation repaired and maintained in proper working condition. Extension cords and unapproved multiplug adapters were in use in resident room 2 to power multiple devices including a minifridge. Extension cords are not rated for continuous use and should not be used in lieu of permanent wiring. Use of extension cords in this capacity increases risk of fire. CNS/LALD-A acknowledged use of extension cords and stated that they would be removed from resident rooms. CNS/LALD-A acknowledged the noted deficiencies during the tour and expressed that they would correct the deficiencies. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775		
0 800 SS=B	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee	0 800		

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0 800	Continued From page 7 failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level one violation (a violation that will cause only minimal impact on the client and does not affect health or safety) and was issued at a pattern scope (when more than a limited number of clients are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On September 29, 2025, from approximately 2:25 p.m. to 3:30 p.m., the surveyor toured the facility with clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A. During the tour the surveyor observed the following: One of the balusters on the rear staircase was damaged and loose, although the railing remained stable overall. The damaged baluster should be repaired and maintained in proper condition. CNS/LALD-A indicated that repairs were already scheduled. The carpet in resident room 1 had a large, discolored spot. The carpet should be cleaned and maintained in proper condition. CNS/LALD-A indicated a new rug had been ordered to replaced stained rug. The basement dryer vent had a buildup of dust and should be cleaned and maintained free of dirt and dust.	0 800		

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0 800	Continued From page 8 CNS/LALD-A acknowledged the noted deficiencies during the tour and expressed that they would correct the deficiencies. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at 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	0 810		

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0 810	Continued From page 9 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 required content. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 September 29, 2025, at approximately 3:10 p.m.., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. The licensee FSEP failed to include the following: The FSEP failed to include appropriate employee actions to take during a fire or similar emergency. The FSEP contained general information regarding fire safety procedures. These	0 810		

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0 810	Continued From page 10 procedures referenced a fire alarm system and smoke compartments with automatic closing doors which are not features present in the facility. No accurate and facility specific employee actions were provided. CNS/LALD-A indicated they would create written site-specific evacuation procedures for employees. The FSEP failed to identify specific fire protection actions for residents. There was no section in the provided documents that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. Fire procedures must be provided for residents. CNS/LALD-A indicated they would create written site-specific evacuation procedures for residents. During an interview on September 29, 2025, at approximately 3:25 p.m.., the surveyor explained the requirements for evacuation procedures and FSEP documentation. CNS/LALD-A stated they understood the requirements. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
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	01530		

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01530	Continued From page 11 working hours of the employment start date. Supervisors 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; (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 observation, interview, and record review, the licensee failed to ensure direct care staff received the required two hours of initial training on mental illness and de-escalation	01530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35977	A. BUILDING: _____ B. WING _____	10/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TENDER CARE GROUP HOMES LLC	2640 POLK STREET NE MINNEAPOLIS, MN 55418

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01530	Continued From page 12 topics for two of two employees (clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A), unlicensed personnel (ULP)-B). 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, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: CNS/LALD-A CNS/LALD-A was hired January 26, 2024, and provided supervision of staff and provided direct care services to the residents. CNS/LALD-A's records lacked documentation CNS/LALD-A completed the required two hours of initial training on mental illness and de-escalation topics which became effective July 1, 2025. ULP-B ULP-B was hired November 1, 2023, to provide direct care services to the residents of the facility. On September 29, 2025, at 6:55 a.m., the surveyor observed ULP-B administer R1's scheduled morning medications. ULP-B's records lacked documentation ULP-B completed the required two hours of initial	01530		

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01530	Continued From page 13 training on mental illness and de-escalation topics which became effective July 1, 2025. During an interview on October 1, 2025, at 1:30 p.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A acknowledged ULP-B and CNS/LALD-A's records were missing documentation of the required two hours of initial training on mental illness and de-escalation topics which became effective July 1, 2025. Also, CNS/LALD-A stated they were not aware of training and planned to ensure that all staff completed the training. The licensee's Dementia Education policy dated August 1, 2021, indicated direct care staff and supervisors must satisfy eight hours of initial training for dementia, however, the policy did not include two hours of mental health and de-escalation training to be completed by July 1, 2025. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01640 SS=D	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.	01640		

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01640	Continued From page 14 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 the current service plan included a signature or other authentication by the resident/resident's representative and the licensee to document agreement on the services to be provided for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 admitted to the licensee on July 30, 2022, with diagnoses that included but were not limited to illness, unspecified.	01640		

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01640	Continued From page 15 R2's Service Plan with effective date September 30, 2025, indicated R2 received assistance with medication administration, reminders for bathing, vital signs, and behavior management. R2's service plan lacked a signature or other authentication by the resident/resident's representative and the licensee to document agreement on the services to be provided. During an interview on October 1, 2025, at 1:30 p.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated R2's service plan was missing signatures. CNS/LALD-A stated they were aware the service plan required a signature but it was missed. The licensee's Service Plan policy, dated August 1, 2021, indicated the initial service plan and any revisions were signed by a representative from the licensee and the resident or resident's representative, indicating agreement with the services to be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01640		
02290 SS=F	144G.91 Subd. 2 Legislative intent The rights established under this section for the benefit of residents do not limit any other rights available under law. No facility may request or require that any resident waive any of these rights at any time for any reason, including as a condition of admission to the facility. This MN Requirement is not met as evidenced	02290		

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02290	Continued From page 16 by: Based on observation, interview, and record review, the licensee limited the rights of residents when the licensee required all residents who resided in the facility to follow certain house rules. 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: On September 29, 2025, at 11:30 a.m.., the surveyor observed an undated document titled House rules posted in the common areas. The document included the following house rules: - possession of alcoholic beverages, illegal drugs, and other paraphernalia was not permitted and may result in violation and discharge from the facility; and - curfew was 10:00 p.m. and quiet hours were from 11:00 p.m.-6:00a.m. On September 30, 2025, at 10:30 a.m., R2 stated that she did not like the house rules including curfew of 11:00 p.m., and R2 stated she wanted to stay in the common area past 11:00 p.m., but staff enforced the curfew, so she had to go to her room. R2 stated that bringing alcohol into house was not allowed. During an interview on October 1, 2025, at 1:30 p.m., clinical nurse supervisor/licensed assisted	02290		

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02290	Continued From page 17 living director (CNS/LALD)-A stated there was no alcohol allowed in the facility, and residents had a history of alcohol and drug use, so restrictions were put in place. Also, CNS/LALD-A stated the curfew was established to help other residents get sleep, as there were incidents where some residents would argue late into the night and disturb other's sleep. CNS/LALD-A stated she was not aware that these house rules violated residents' rights. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02290		

Rochester District Office
Minnesota Department of Health
3425 40th Ave NW, Suite 115
Rochester, MN 55901
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

TENDER CARE GROUP HOMES LLC
2640 POLK STREET NE
Minneapolis, MN 55418
Hennepin County
Parcel:

Phone:
TCGROUPHOMES@GMAIL.COM

License Info

License: HFID 35977

Risk:
License:
Expires on:
CFPM: Sumaya B. Ahmed
CFPM #: 119948; Exp: 11/14/2026

Inspection Info

Report Number: F8044251216
Inspection Type: Full - Single
Date: 9/30/2025 Time: 9:03:46 AM
Duration: minutes
Announced Inspection: Yes
Total Priority 1 Orders: 1
Total Priority 2 Orders: 1
Total Priority 3 Orders: 1
Delivery: Emailed

! **New Order: 3-500B Microbial Control: hot and cold holding**
3-501.16A2 *Priority Level: Priority 1 CFP#: 22*
MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.
COMMENT: TCS foods in refrigerator measured at 43 degrees. See temperatures for details.

Temperature in refrigerator measured below 41 degrees F at end of inspection.
Comply By: 9/30/2025 Originally Issued On: 9/30/2025

New Order: 4-200 Equipment Design and Construction
4-201.11GMN *Priority Level: Priority 3 CFP#: 47*
MN Rule 4626.0506G Discontinue serving TCS foods that are held for more than same-day service in an adult or child care center or boarding establishment or provide equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.
COMMENT: Leftovers in refrigerator from previous day.
Comply By: 9/30/2025 Originally Issued On: 9/30/2025

New Order: 6-300 Physical Facility Numbers and Capacities
6-301.12 *Priority Level: Priority 2 CFP#: 10*
MN Rule 4626.1445 Provide and maintain a supply of individual disposable towels, a continuous towel system, a heated-air hand drying device, or an approved ambient air temperature hand drying device at each handwashing sink or group of adjacent handwashing sinks.
COMMENT: Cloth towel provided in bathrooms instead of paper towels.
Comply By: 9/30/2025 Originally Issued On: 9/30/2025

Food & Beverage General Comment

HRD inspection conducted with nurse evaluator Safia Hassan. Inspection report reviewed on site with Sumaya Ahmed.

The kitchen is of residential build and should serve food for same-day service only.
The kitchen has wood cabinets with hollow base, vinyl loor, painted walls and ceiling and laminate countertops.
The kitchen refrigerator/freezer are of residential grade.
A 2-compartment sink is present in kitchen. 1 compartment is designated for handwashing only.
A residential dishwashing machine is present in the kitchen.

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 Rochester District Office inspection report number F8044251216 from 9/30/2025

Sumaya Ahmed

Michael DeMars, RS
Public Health Sanitarian 3
michael.demars@state.mn.us

Rochester District Office
Minnesota Department of Health
3425 40th Ave NW, Suite 115
Rochester, MN 55901

Temperature Observations/Recordings

Establishment Info

TENDER CARE GROUP HOMES LLC
Minneapolis
County/Group: Hennepin County

Inspection Info

Report Number: F8044251216
Inspection Type: Full
Date: 9/30/2025
Time: 9:03:46 AM

Food Temperature: Product/Item/Unit: Milk, sliced deli turkey**; Temperature Process:** Cold-Holding
Location: Refrigerator at 43.0 Degrees F.
Comment:
Violation Issued?: Yes

Equipment Temperature: Product/Item/Unit: ; Temperature Process: Cold-Holding
Location: Refrigerator at 43.0 Degrees F.
Comment:
Violation Issued?: No

Rochester District Office
Minnesota Department of Health
3425 40th Ave NW, Suite 115
Rochester, MN 55901

Sanitizer Observations/Recordings

Establishment Info

TENDER CARE GROUP HOMES LLC
Minneapolis
County/Group: Hennepin County

Inspection Info

Report Number: F8044251216
Inspection Type: Full
Date: 9/30/2025
Time: 9:03:46 AM

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** DIshwasher
Location: Kitchen **Equal To** 180.0 Degrees F.
Comment:
Violation Issued?: No