



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

April 16, 2026

Licensee
The Blessed Home Care
2441 Linwood Court East
Saint Paul, MN 55119

RE: Project Number(s) SL34027016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on March 26, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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 - 0470 - 144g.41 Subdivision 1 - Minimum Requirements - \$1,000.00

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - \$3,000.00

St - 0 - 0780 - 144g.45 Subd. 2 (a) (1) - Fire Protection And Physical Environment - \$1,000.00

St - 0 - 0810 - 144g.45 Subd. 2 (b-F) - Fire Protection And Physical Environment - \$1,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$6,000.00**. 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/Bm5uQEpHV>**. 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,

A handwritten signature in black ink that reads "Renee L. Anderson". The signature is written in a cursive, flowing style.

Renee L. Anderson, Supervisor

State Evaluation Team

Email: Renee.L.Anderson@state.mn.us

Telephone: 651-201-5871 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34027	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/26/2026
NAME OF PROVIDER OR SUPPLIER THE BLESSED HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 2441 LINWOOD COURT EAST SAINT PAUL, MN 55119			
(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: SL34027016-0 On March 23, 2026, through March 26, 2026, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 4 residents, 3 of whom were receiving services under the provider's Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. 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 surveyors' 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 pursuant to 144G.31 Subd. 1, 2 and 3.		
0 470 SS=I	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of	0 470			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 470	Continued From page 1 staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the facility had sufficient staffing 24/7 to meet the scheduled and reasonably foreseeable unscheduled needs, as required by the residents' assessments and service plans, for two of two resident (R4, R5). The licensee further failed to develop, review, and implement a staffing plan at least twice a year, to determine staffing levels to meet the needs of all residents, potentially affecting all the licensee's current residents, staff, and visitors. This practice resulted in a level three violation (a	0 470			

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0 470	Continued From page 2 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: STAFFING PLAN On March 23, 2026, during an entrance conference at 10:00 a.m., owner/clinical nurse supervisor (O/CNS)-A stated they had been doing weekly planning for staffing but did not keep a record of it. O/CNS-A further stated they did not need a staffing plan because they only had four residents. SUFFICIENT STAFFING R5 R5's service plan, dated February 15, 2026, indicated R5 received services including assistance with activities of daily living ADLs), medication management, wheelchair mobility, and required a hoyer lift for transfers. On March 23, 2026, at 12:30 p.m., R5 was observed lying in a hospital style bed and stated they were unable to walk. R5's Master Care Plan, dated February 13, 2026, indicated R5 required a "hoyer" (mechanical lift) for transfers and unable to walk. R5's nursing assessment, dated February 28, 2026, indicated R5 required assist of two staff and a hoyer with all transfers. R4	0 470			

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0 470	Continued From page 3 R4's service plan, dated March 30, 2025, indicated R4 received services including assistance with ADLs, medication management, wheelchair mobility, and required a two person lift for transfers. R4's nursing note dated March 20, 2026, indicated R4 was sent to the hospital due to confusion and dark colored urine. R4 was in the hospital at the time of the survey. R4's Master Care Plan, dated March 24, 2026 indicated R4 required a "hoyer" lift for transfers and was unable to walk. R4's nursing assessment dated February 2, 2026, indicated R4 required a hoyer lift for transfers. The licensee's untitled daily schedule for the weeks of February 20, 2026, to March 25, 2026, indicated the licensee had only one staff member scheduled from 12:00 a.m. to 8:00 a.m. The schedule further indicated unlicensed personnel (ULP)-D and ULP-E were available to contact on the night shift to assist with transfers, if needed. On March 25, 2026, at 12:45 p.m., O/CNS-A stated two staff were required for all hoyer transfers. O/CNS-A also stated ULP-E was "usually" on site Friday through Sunday from 12:00 a.m., to 8:00 a.m., to assist with transfers, but there was only one staff scheduled for night shifts. O/CNS-A stated the residents slept through the night so two staff were not necessary. O/CNS-A further stated she lived close to the facility and was also available to come in and assist as needed. O/CNS-A stated she had been told by a consulting agency she only needed one staff scheduled as long as someone was within	0 470			

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0 470	Continued From page 4 "15 minutes" from the facility to assist as needed. On March 25, 2026, at 3:15 p.m., ULP-B stated staff always use two people to transfer residents who require a hoyer lift. The licensee's Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) dated June 30, 2025, noted the number of unlicensed direct care staff typically scheduled was two, and transfers with assistance of two staff was available. Minnesota Administrative Rule 4659.0180, Subpart 5 dated August 11, 2021, indicated "A minimum of two direct-care staff must be scheduled and available to assist at all times whenever a resident requires the assistance of two direct-care staff for scheduled reasonably foreseeable and unscheduled needs, as reflected in the resident's assessments and service plan." The licensee's Staffing policy date August 1, 2021, indicated the clinical nurse supervisor would prepare and implement a 24-hour daily staffing plan that ensured adequate staffing to meet residents' needs. The policy further indicated "at least two (2) home health aides will be scheduled and available for residents requiring the assistance of two home health aides for scheduled and reasonably foreseeable unscheduled needs as reflected in the assessment and service plan." No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	0 470			

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0 480	Continued From page 5	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 6 (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 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated March 23, 2026, for the specific Minnesota Food Code violations. The Inspection	0 480			

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0 480	Continued From page 7 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			
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to engage in and maintain documentation of quality management activity appropriate to the size of the facility and relevant to the type of services provided. This had the potential to affect all 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	0 580			

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0 580	Continued From page 8 failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee lacked documentation on quality management activities to evaluate quality of care. On March 23, 2026, during an entrance conference at 10:30 a.m., owner/clinical nurse supervisor (O/CNS)-A stated they had quality management meetings once a year, but they had not been documenting quality management activity. The licensee's Quality Improvement policy dated August 1, 2021, indicated the licensee would monitor organizational trends related to safety and resident care in order to address unsafe clinical practices. The policy further indicated documentation of quality management activity would be maintained for at least two years. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 580			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency;	0 680			

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0 680	Continued From page 9 (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a written emergency preparedness (EP) plan with all required content as defined in Centers for Medicare and Medicaid Services (CMS) Appendix Z. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's EP plan, last reviewed by the	0 680			

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0 680	Continued From page 10 licensee May 21, 2025, lacked evidence of the following required content: - a communication plan that included arrangement with other facilities; and - documentation of two emergency preparedness exercises (an annual full-scale exercise or individual facility-based functional exercise and a second full-scale exercise that was either community-based, an individual facility based functional exercise, a mock disaster drill, or a table-top exercise. On March 23, 2026, at 11:48 a.m., owner/clinical nurse supervisor (O/CNS)-A stated they had conducted fire drills and one functional exercise, but they had not completed any additional exercises. O/CNS-A further stated they had a verbal arrangement with another provider to receive residents, but they did not have a written agreement. O/CNS-A stated they were not aware of the requirement. The licensee's Emergency Preparedness policy dated August 1, 2021, indicated the licensee would conduct an annual full-scale exercise or individual facility-based functional exercise and a second full-scale exercise that was either community-based, an individual facility based functional exercise, a mock disaster drill, or a table-top exercise. The policy indicated the exercised would be documented. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 775 SS=L	144G.45 Subd. 2. (a) Fire protection and physical environment	0 775			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 775	Continued From page 11 Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level four violation (a violation harmed a resident ' s health or safety, not including serious injury or death, or a violation that was likely to lead to serious injury 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: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated March 25, 2026 , for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775			
0 780 SS=I	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:	0 780			

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

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0 780	Continued From page 13 has affected or has potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated March 25, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780			
0 790 SS=F	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a	0 790			

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0 790	Continued From page 14 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated March 25, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790			
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	0 810			

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0 810	Continued From page 15 upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level 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: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated March 25, 2026, for the specific violations related	0 810			

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0 810	Continued From page 16 the physical environment under Minnesota Statute 144G. 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 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;	01060			

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01060	Continued From page 17 (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 observation, interview and record review, the licensee failed to provide the resident or their representative with a written notice after an emergency relocation for one of one resident (R3). 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: R3's unsigned service plan, dated March 25, 2026, indicated R3 received services including assistance with medication administration. On March 24, 2026, at 8:45 a.m., unlicensed personnel (ULP)-F was observed assisting R3 with medication administration.	01060			

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01060	Continued From page 18 A resident note dated November 6, 2025, at 1:11 p.m., indicated R3 had been sent to the hospital. A resident note dated February 16, 2026, at 5:38 p.m., indicated R3 had returned to the facility "around" 2:00 p.m., that day. R3's record lacked documentation a notice was provided to the resident, legal representative, and designated representative with the following required content: (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 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. The record further lacked evidence the notice was sent to the Office of Ombudsman for Long-Term Care when the resident had not returned to the facility within four days. On March 24, 2026, at 11:30 a.m., owner/licensed assisted living director (O/LALD)-A stated R3 was hospitalized from November 6, 2025, to February 16, 2026, and an emergency relocation notification had not been provided to the resident, or the Office of	01060			

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01060	Continued From page 19 Ombudsman for Long-Term Care. O/LALD-A stated they were not aware of the requirement. The licensee's Discharge and Transfer of Residents policy dated August 1, 2021, indicated in the event of an emergency relocation, the licensee would provide written notice to the resident or resident representative, as soon as possible. The policy further indicated the Office of Ombudsman for Long-Term Care would be notified within four days following the emergency relocation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060			
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person;	01470			

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01470	Continued From page 20 (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) 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.	01470			

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01470	Continued From page 21 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received orientation to include all required content for one of one employee (unlicensed personnel (ULP)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-D was hired January 18, 2025, to provide direct care services for the licensee's residents. ULP-D's employee record lacked documentation the following orientation topics were completed prior to providing assisted living services: - an overview of the appropriate Assisted Living statutes 144G and rules; and - the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights. On March 24, 2026, at 12:20 p.m., owner/clinical nurse supervisor (O/CNS)-A provided the surveyor with a form titled: Table of Contents-The (facility) Orientation Manual, dated 2017, and stated the orientation manual was prepared for her by a home care consulting agency and it was what she used for orientation. O/CNS-A further stated the orientation covered home care statutes and home care bill of rights, but it did not cover	01470			

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01470	Continued From page 22 an overview of the Assisted Living Statutes or the Assisted Living Bill of Rights, and she needed to modify the orientation. The licensee's Staff Orientation and Education policy, dated August 1, 2021, indicated orientation would include all the required topics and be documented in the employee record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470			
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 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	01500			

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01500	Continued From page 23 when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss 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 annual training included all required topics for each 12 months of employment for one of one employee (unlicensed personnel (ULP)-D).	01500			

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01500	Continued From page 24 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-D was hired January 18, 2025, to provide direct care services for the licensee's residents. ULP-D's employee record lacked documentation the employee had successfully completed at least eight hours of annual training for every 12 months of employment as required under 144G.63, Subd.5, to include the following: -training on reporting of maltreatment of vulnerable adults under section 626.557; -assisted living bill of rights; -infection control techniques; -effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; -review of providers policies and procedures; and -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. On March 24, 2026, at 12:30 p.m., owner/clinical nurse supervisor (O/CNS)-A stated she had did not have a way to document annual education, and she was not sure what was required.	01500			

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01500	Continued From page 25 The licensee's Staff Orientation and Education policy, dated August 1, 2021, indicated annual education would include all the required topics and be documented in the employee record. 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 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	01530			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34027	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/26/2026
NAME OF PROVIDER OR SUPPLIER THE BLESSED HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 2441 LINWOOD COURT EAST SAINT PAUL, MN 55119			
(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 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 employees completed initial dementia care training (at least eight hours within 160 working hours of the employment start date) and two hours of annual dementia care training for one of one employee (unlicensed personnel (ULP)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-D was hired January 18, 2025, to provide direct care services for the licensee's residents.	01530			

Minnesota Department of Health

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01530	Continued From page 27 ULP-D's record lacked documentation they completed at least eight hours of initial dementia care training on required topics within 160 working hours, including: -an explanation of Alzheimer's disease and other dementia; -assistance with activities of daily living; -problem solving with challenging behaviors; -communication skills; and -person-centered planning and service delivery. ULP-D's employee record further lacked documentation of at least two hours of annual dementia care training. On March 24, 2026, at 12:30 p.m., owner/clinical nurse supervisor (O/CNS)-A stated ULP-D had completed 5 hours of the initial required dementia care training. O/CNS-A stated she had only been providing 5 hours of training for staff. O/CNS-A also questioned, "has it always been eight" hours of training required?" O/CNS-A stated she did not have a way to document annual education, and she was not sure what was required. On March 25, 2026, at 10:23 a.m., O/CNS-A stated ULP-D had worked 160 hours from their start date. The licensee's Dementia Education policy dated August 1, 2021, indicated direct care staff would have eight (8) hours of dementia training within 160 hours of the employment start date, and at least two (2) hours of education on topics related to dementia for each twelve (12) months of employment thereafter. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530			

Minnesota Department of Health

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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. 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 observation, interview and record review, the licensee failed to finalize a current written service plan within 14 calendar days after the date services were first 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	01640			

Minnesota Department of Health

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01640	Continued From page 29 limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R2 was admitted June 30, 2025, with diagnoses including Guillain-Barré Syndrome (a condition in which the body's immune system attacks the nerve sheaths and can cause weakness, numbness or paralysis). R2's service plan dated July 24, 2025, indicated R2 received services including assistance with activities of daily living and medication administration. On March 24, 2026, at 9:30 a.m., the surveyor observed unlicensed personnel (ULP)-F assisting R2 with medication administration. R2's record included a medication administration record (MAR) for June 1, 2025, to June 30, 2025. The MAR indicated the licensee's staff began providing medication administration services June 30, 2025. R2's record lacked a finalized written service plan within 14 calendar days after the date services were first provided. On March 24, 2026, at 11:55 a.m., owner/clinical nurse supervisor (O/CNS)-A stated R2's service plan was not signed until July 24, 2025, because R2 had wanted their mother to review it. O/CNS-A stated she had not documented any attempts to obtain a signature from the resident or the resident's representative. The licensee's Service Plan policy dated August	01640			

Minnesota Department of Health

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01640	Continued From page 30 1, 2021, indicated a finalized service plan would be completed no later than 14 days after initiation of services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640			
01700 SS=D	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications.	01700			

Minnesota Department of Health

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01700	Continued From page 31 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) completed a face-to-face medication management assessment prior to providing medication management services 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 was admitted June 30, 2025, with diagnoses including Guillain-Barré Syndrome (a condition in which the body's immune system attacks the nerve sheaths and can cause weakness, numbness or paralysis). R2's service plan dated July 24, 2025, indicated R2 received services including assistance with activities of daily living and medication administration. On March 24, 2026, at 9:30 a.m., the surveyor observed unlicensed personnel (ULP)-F assisting R2 with medication administration. R2's record included a medication administration record (MAR) for June 1, 2025, to June 30, 2025. The MAR indicated the licensee's staff had	01700			

Minnesota Department of Health

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01700	Continued From page 32 assisted R2 with medication administration beginning June 30, 2025. R2's record included a face-to-face medication management assessment dated July 16, 2025, but lacked an indication the RN completed a face-to-face assessment prior to providing medication management services. On March 24, 2026, at 11:46 a.m., owner/clinical nurse supervisor (O/CNS)-A stated R2 should have had a medication management assessment done prior to providing services, and she thought she had done one for all residents. O/CNS stated, "I guess not," and she was not sure how it was missed. The licensee's Assessment of Medications policy, dated August 1, 2021, indicated the RN would complete a face-to-face medication management assessment prior to providing services to determine what medication management services would be provided and how they would be implemented. . No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700			



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

Food & Beverage Inspection Report

Page: 1

Establishment Info

THE BLESSED HOME CARE
2441 LINWOOD COURT EAST
St Paul, MN 55119
Ramsey County
Parcel:

Phone:

License Info

License: HFID 34027

Risk:
License:
Expires on:
CFPM:
CFPM #: ; Exp:

Inspection Info

Report Number: F8058261088
Inspection Type: Full - Single
Date: 3/23/2026 Time: 1:42:49 PM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 1
Total Priority 2 Orders: 0
Total Priority 3 Orders: 1
Delivery: Emailed

New Order: 2-100 Supervision

2-102.12AMN Priority Level: Priority 3 CFP#: 2

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

COMMENT: MISSING CFPM

Comply By: 5/31/2026 Originally Issued On: 3/23/2026

! New Order: 4-700 Sanitizing Equipment and Utensils

4-703.11B Priority Level: Priority 1 CFP#: 16

MN Rule 4626.0905B Sanitize food contact surfaces of equipment and utensils after cleaning by using mechanical hot water operations that achieve a utensil surface temperature of 160 degrees F (71 degrees C) and are set up and maintained in accordance with the specifications of NSF International and the manufacturer's data plate.

COMMENT: DISH MACHINE TWICE RECORDED TEMPERATURES BELOW REQUIRED THRESHOLD - REPAIR OR REPLACE

Comply By: 4/30/2026 Originally Issued On: 3/23/2026

Food & Beverage General Comment

HRD INSPECTOR TAMMY CARLSON

RESIDENTIAL HOME WITH NON COMMERCIAL FINISHES AND APPLIANCES INCLUDING WOODEN CABINETS, LAMINATE COUNTER SURFACES AND FLOOR, SHEETROCK TEXTURED CEILING SURFACE

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 F8058261088 from 3/23/2026

JANETTE LEE
OWNER

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

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL34027016	Date: 3/25/2026
Facility Name: Blessed Home Care	
Facility Address: 2441 Linwood Ct. E, St. Paul, MN 55119	

☒ **TAG IDENTIFICATION: 0775**

SCOPE/ SEVERITY: Level 4; Widespread

TIME PERIOD OF CORRECTION: Seven (7) days

1. Each assisted living facility must comply with the provisions of the Minnesota State Fire Code (MSFC) in Minnesota Rules chapter 7511. [Minn. Stat. 144G.45 subd. 2]
2. In buildings that contain a fuel-burning appliance or fireplace, or attached private garage, carbon monoxide detection shall be installed in dwelling units within ten feet of bedrooms. Where a fuel burning appliance is located in a bedroom or its attached bathroom, carbon monoxide detection shall be installed within the bedroom. Carbon monoxide detection can be provided by carbon monoxide alarms installed in dwelling or sleeping units or a carbon monoxide detection system installed in the room or space that contains the fuel-burning appliance. [Minn. Stat. 144G.45 subd. 2; MSFC 915]

Comments: The facility did not have sufficient carbon monoxide alarms installed. No carbon monoxide detectors were present in the basement and carbon monoxide alarms were not installed within 10 feet of resident rooms.

3. Single- and multiple-station smoke alarms shall be replaced when they fail to respond to operability tests or exceed ten years from the date of manufacture. Smoke alarms shall be replaced with smoke alarms having the same type of power supply. [Minn. Stat. 144G.45 subd. 2; MSFC 1103.8.1]

Comments: The hardwired smoke alarm installed in the basement hallway exceeded 10 years in age. Expired smoke alarms should be replaced with operable alarms that have the same power supply.

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

Comments: The egress window in the occupied basement bedroom was obstructed by furniture, stored items and plastic sheeting over the windows that prevented the window from being readily openable during an emergency. Egress windows in resident rooms should be maintained free of obstruction.

☒ **TAG IDENTIFICATION: 0780**

SCOPE/ SEVERITY: Level 3; Widespread

TIME PERIOD OF CORRECTION: Seven (7) days

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

Comments: No smoke alarms were present in resident room 2, resident room 3, or any of the basement resident rooms. Smoke alarms should be installed in all resident rooms to ensure proper notification to all building occupants during a fire.

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

Comments: There were several sets of smoke alarms provided throughout the facility that did not interconnect such that the activation of any one alarm would cause all other alarms to sound in the facility. Smoke alarms must all be interconnected and maintained in proper working order.

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

Comments: The smoke alarm installed in the basement hallway was a hardwired alarm, but was not functional when tested. The smoke alarm exceeded 10 years from manufacture and should be replaced. Hardwired smoke alarms that are replaced must be replaced with alarms of the same power type and should be maintained as hardwired.

☒ **TAG IDENTIFICATION: 0790**

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Seven (7) days

1. Portable fire extinguishers have a minimum 2-A:10-B:C rating within Group R-3 occupancies and travel distance to the nearest fire extinguisher does not exceed 75 feet. [Minn. Stat. 144G.45 subd.2]

Comments: The fire extinguishers provided within the facility did not meet size requirements and were rated at less than 2-A:10-B-C. The extinguisher provided in the kitchen was rated as 1-A:10-B-C. Extinguishers complying with rating requirements should be installed and maintained in working condition.

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

Comments: The fire extinguishers supplied in the facility were not properly maintained. The provided extinguisher in the garage was not in proper condition with the pressure gauge indicating that it was not properly pressured for operation. The extinguisher in the garage was manufactured in 2018, but did not have any current annual service tags indicating servicing by authorized contractor to ensure operability and condition of the device. The extinguisher provided in the kitchen was not properly mounted and was placed on the floor in a corner of the room with stored items such as lifts obstructing access to the device in an emergency. The extinguisher in the kitchen was not readily accessible or properly mounted and did not have record of monthly staff inspections. The extinguisher provided in the basement office was not properly mounted and was placed in a corner on the ground where it was not readily accessible. None of the provided extinguishers had records of monthly staff inspections. Extinguishers should be properly installed and maintained to ensure availability and operability during an emergency.

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 3; Widespread

TIME PERIOD OF CORRECTION: Twenty One (21) days

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

Comments: The licensee provided FSEP documents that were not properly maintained, with many outdated and inaccurate documents. The FSEP was missing many required documents and difficult to utilize. The FSEP designated the kitchen rear sliding door and garage door as an exit, which licensee indicated is inaccurate. The FSEP should be reviewed for accuracy and maintained with correct and relevant information.

2. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that include the location and number of resident rooms. [Minn. Stat. 144G.45 subd.2]

Comments: The facility maps in the FSEP did not include the basement level and were not accurate to the facility. Facility maps should encompass the entire facility and be properly maintained.

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

Comments: The licensee failed to provide any site specific employee actions or plans for evacuation. The staff actions provided in the FSEP documents were general fire safety procedures written by a third party and were not relevant to this specific facility.

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

Comments: The licensee failed to provide documentation of fire protection procedures for residents. Fire protection procedures for residents should be created and maintained.

5. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that include procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. [Minn. Stat. 144G.45 subd.2]

Comments: The licensee failed to provide documentation of unique resident needs for evacuation. Specific needs for resident evacuation should be documented and maintained as updated.

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

Comments: The licensee failed to provide documentation of employee training on the FSEP. The licensee indicated that staff was trained at hire, but that no further trainings were conducted and that no documentation was created. Staff should be trained on the FSEP upon hire and at least twice thereafter and documentation of the trainings should be maintained.

7. Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. [Minn. Stat. 144G.45 subd.2]

Comments: The licensee failed to provide documentation of resident training on the FSEP and indicated that residents are not offered training on the FSEP. Residents should be offered training on the FSEP at least once a year and that training should be documented.

8. Evacuation drills are required for employees 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. [Minn. Stat. 144G.45 subd.2]

Comments: The licensee supplied documentation of drills which indicated that only one drill was conducted in 2025, and no drills were conducted in 2026. Drills should occur at least twice per shift per year and at least once every other month.