Electronically Delivered

April 3, 2026

Licensee
Care Plus Home Care LLC
2860 132nd Avenue Northwest
Coon Rapids, MN 55448

RE: Project Number(s) SL36802016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on March 4, 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 - 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 $1,000.00**. 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/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

Kelly Thorson

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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36802	A. BUILDING: _____ B. WING _____	03/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PLUS HOME CARE LLC	2860 132ND AVENUE NW COON RAPIDS, MN 55448

(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: SL36802016-0 On March 3, 2026, through March 4, 2026, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were three residents; three receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated March 3, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.	0 480		

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0 480	Continued From page 3 TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 630 SS=F	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 develop an individual abuse prevention plan (IAPP) with the required content for two of two residents (R1 and 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 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: R1	0 630		

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0 630	Continued From page 4 R1 was admitted to the licensee on June 13, 2023, with diagnoses that included familial chylomicronemia syndrome (a rare, inherited metabolic disorder), adjustment disorder, attention deficit hypersensitivity disorder (ADHD), major depressive disorder and posttraumatic stress disorder (PTSD). R1's IAPP dated December 19, 2025, indicated R1 was at risk of abuse by others but did not include: - statements of specific measures to be taken to minimize the risk of abuse to the resident and other vulnerable adults and risk of self-abuse. R2 R2 was admitted to the licensee on November 2, 2024, with diagnoses that included schizoaffective disorder, catatonia (neuropsychiatric syndrome, marked by extreme motor abnormalities), PTSD and social anxiety disorder. R2's IAPP dated December 10, 2025, indicated R2 was at risk of abuse by others but did not include: - assessment of the residents' risk of abusing other vulnerable adults or minors; and - statements of specific measures to be taken to minimize the risk of abuse to the resident and other vulnerable adults and risk of self-abuse. On March 4, 2026, at 9:10 a.m., clinical nurse supervisor (CNS)-B stated she agrees the IAPP for R2 is missing the risk for abuse to others and the IAPP for both R1 and R2 are missing specific interventions to mitigate risk of abuse. The licensee's Vulnerable Adult policy dated August 1, 2021, indicated an individual abuse	0 630		

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0 630	Continued From page 5 prevention plan shall be established for each vulnerable minor or adult for whom assisted living facility services are provided. - The plan shall contain an individualized assessment of the resident's susceptibility to abuse by another individual, including other vulnerable adults. - The plan shall contain the resident's risk of abusing other vulnerable adults. - The plan shall contain statements of specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. - The plan will be implemented immediately and evaluated at each supervisory visit or more frequently, if necessary. - Documentation will include results of the implementation. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of	0 660		

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0 660	Continued From page 6 the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), when the licensee failed to complete TB testing for one of two employees (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's TB facility risk assessment completed April 10, 2025, indicated the facility's TB risk level was low. ULP-C was hired on February 25, 2025, to provide assisted living services to residents. On March 3, 2026, at 12:50 p.m., the surveyor observed ULP-C administer oral medications to R1. ULP-C's personnel record included a QuantiFERON Gold TB test completed on April 9,	0 660		

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0 660	Continued From page 7 2025, and reported on April 11, 2025, had a positive result. ULP-C's personnel file lacked a documented TB test chest Xray (CXR) to indicate ULP-C's final TB status. On March 4, 2026, at 12:45 p.m., licensed assisted living director (LALD)-A agreed ULP-C's employee record was missing the CXR following the positive TB blood test. LALD-A stated she thought ULP-C had completed a CXR but was unable to find it in ULP-C's employee record. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines, indicated before the HCW has direct patient contact, the following should be documented in their record: 1. Test result, 2. Assessment for current TB symptoms, 3. Chest X-ray to rule out infectious TB disease. The chest X-ray should be done after the date of the positive TST or IGRA; however, a chest X-ray done within the three months prior to the TST/IGRA is acceptable, provided that the HCW has not been exposed to infectious TB disease since the chest X-ray was done, and 4. Medical evaluation to rule out a diagnosis of infectious TB disease. After the negative baseline chest X-ray is done and the results are documented, additional chest X-rays are not needed unless the HCW develops symptoms of active TB disease or a clinician recommends a repeat chest X-ray. The licensee's Tuberculosis Screening / Prevention policy dated August 1, 2021, indicated Employees with a newly-identified positive TST or blood assay for M. tuberculosis (BAMT): - Assess for current TB symptoms and risk	0 660		

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0 660	Continued From page 8 factors for progression to active TB disease. - Obtain a chest x-ray to exclude a diagnosis of active infectious TB disease before direct resident contact. - For employees with L TBI, consult a physician regarding the need for treatment to prevent progression to active TB disease. - After documentation of negative results from a baseline chest x-ray, repeat xrays are not needed unless signs/symptoms of active TB disease develop or a clinician recommends a repeat chest x-ray. - Assess these employees annually for current TB symptoms. Instruct them to seek medical evaluation if TB symptoms develop at any time. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents.	0 680		

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0 680	Continued From page 9 (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 observation, interview and record review, the licensee failed to develop a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all residents, employees, and visitors to the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On March 3, 2026, at 9:30 a.m. during observations of licensee's required postings the surveyor obtained the EPP binder located in a cabinet of the dining room to review. On March 3, 2026, at 9:40 a.m., licensed assisted living director (LALD)-A arrived at the facility and noted the EPP binder and stated, "I have another EPP binder that had been working on and the	0 680		

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0 680	Continued From page 10 EPP binder from the cabinet might not have all the information in it." The licensee's emergency preparedness plan (EPP) lacked the required content: - annual review; - maintenance and annual emergency preparedness (EP) updated that included: - risk assessment; and - missing resident quarterly review. - description of the population served by licensee; - a process for EP collaboration with state and local EP officials/organizations; - the development of policies/procedures to address: - subsistence needs for staff and residents; - procedures for tracking staff and residents; - procedures for medical documents; - use of volunteers; - arrangement with other facilities; and - roles under a waiver declared by Secretary. - development of communication plan; - names and contact information for staff, entities providing services, resident physicians, other facilities, and volunteers; - emergency officials contact information; - primary/alternate means for communication; - methods for sharing information - develop and maintain EP training and testing program; and - emergency prep testing requirements. On March 3, 2026, at 3:00 p.m., LALD-A stated she agrees the EPP is missing most of the required content because she had been working on the EPP at home and the one at the facility at time of survey start had not been updated. LALD-A stated she did not realize the missing person policy needed to be reviewed quarterly and did not realize two drills of the EPP are to be	0 680		

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0 680	Continued From page 11 completed The licensee's Emergency Preparedness policy dated August 1, 2021, indicated the facility will have identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services. The emergency preparedness plan/program will be reviewed/updated at least annually. The licensee's Missing Resident policy dated August 1, 2021, indicated the missing resident procedure will be reviewed by the Director and Clinical Nurse Supervisor at least quarterly. Per Assisted Living Facilities: Minnesota Rules Chapter 4659, 4659.0110, Subp. 4. Review missing resident plan. The assisted living director and clinical nurse supervisor must review the missing person plan at least quarterly and document any changes to the plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
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	0 810		

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0 810	Continued From page 12 residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on 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	0 810		

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0 810	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 3-4-26, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty One Days.	0 810		
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; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints;	01470		

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01470	Continued From page 14 (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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employees received orientation to assisted living facility	01470		

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01470	Continued From page 15 licensing requirements and regulations prior to providing services for two of two employees (unlicensed personnel (ULP)-C and 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 potential to affect a large portion or all of the residents). The findings include: ULP-C ULP-C was hired on February 25, 2025, to provide assisted living services to residents. On March 3, 2026, at 12:50 p.m., the surveyor observed ULP-C administer oral medications to R1. ULP-D ULP-D was hired on March 25, 2024, to provide assisted living services to residents. ULP-C and ULP-D's employee records both lacked the following required orientation content: - an overview of the assisted living statutes; - review of types of Assisted Living services the employee will provide and provider's scope of license; and - principles of person-centered planning and service delivery. On March 4, 2026, at 12:45 p.m., licensed assisted living director (LALD)-A stated she agreed both ULP's employee records are missing	01470		

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01470	Continued From page 16 some of the required orientation topics, her husband is the one who assigns the classes and he must have not added these by accident. The licensee's Staff Orientation and Education policy dated August 1, 2021, indicated orientation topics will include, but not be limited to, the following: - Overview of Minnesota Assisted Living Statute 144G and Minnesota Rules Chapter 4659; - The principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff; and - the types of assisted living services the employee will be providing based on the Uniform Checklist Disclosure of Services and the organization's category of licensure. 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	01500		

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01500	Continued From page 17 standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss 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	01500		

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01500	Continued From page 18 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 employees (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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: ULP-D ULP-D was hired on March 25, 2024, to provide assisted living services to residents. ULP-D employee record lacked evidence of annual training had been completed as required in the following areas: - review of provider's policies and procedures. March 4, 2026, at 12:45 p.m., licensed assisted living director (LALD)-A stated they do not have any documentation that the staff complete an annual review of their policies and procedures. The licensee's Staff Orientation and Education policy dated August 1, 2021, indicated All staff providing assisted living services will complete at least eight (8) hours of education for every twelve	01500		

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01500	Continued From page 19 (2) months of employment. Education topics will include, but not be limited to, the following: - review of the organization's policies and procedures related to provision of assisted living services and how to implement them. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
01530 SS=D	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	01530		

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01530	Continued From page 20 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 all direct care staff received at least eight hours of initial dementia care training within the first 160 working hours of employment for direct care employees as required for one of one employee unlicensed personnel (ULP)-C. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: ULP-C was hired on February 25, 2025, to provide assisted living services to residents.	01530		

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01530	Continued From page 21 On March 3, 2026, at 12:50 p.m., the surveyor observed ULP-C administer oral medications to R1. ULP-C's employee record indicated ULP-C completed 3.75 hours of initial dementia training, thus did not contain documentation ULP-C completed the required initial eight hours of dementia training, within 160 working hours of ULP-C's employment start date under the assisted living license. March 4, 2026, at 12:45 p.m., licensed assisted living director (LALD)-A stated she agreed ULP-C only had 3.75 hours of dementia training and not the required eight (8) hours and was not sure why the full eight (8) hours had not been completed. The licensee's Dementia Education policy dated August 1, 2021, indicated direct care employees must have completed at least eight (8) hours of initial education within 160 working hours of the employment start date in the following topics: - An explanation of Alzheimer's Disease and other dementias; - Assistance with activities of daily living (ADL's); - Problem solving with challenging behaviors; - Communication skills; and - Person-centered planning and service delivery. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01530		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication	01760		

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01760	Continued From page 22 Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to document the reason why medication administration was not completed as prescribed and failed to document any follow-up procedures that were provided to meet the residents' needs when medication was not administered as prescribed for one of two residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On March 3, 2026, at 12:50 p.m., the surveyor observed ULP-C administer oral medications to	01760		

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01760	Continued From page 23 R1. R1 was admitted to the licensee on June 13, 2023, with diagnoses that included Familial Chylomicronemia Syndrome (a rare, autosomal recessive metabolic disorder that prevents the breakdown of dietary fats, leading to extremely high triglyceride levels), attention deficit hypersensitivity disorder (ADHD), major depression and posttraumatic stress disorder (PTSD). R1's service plan signed on September 30, 2024, indicated R1 received assistance with medication administration three times daily. R1's prescriber orders dated June 4, 2025, indicated R1 was prescribed the following medication: - benzoyl peroxide 10% external liquid, apply topically daily for acne. R1's record did not include an order for the following prescribed medication: - lubricant eye drops, place one drop into both eyes four times daily for dry eye. R1's medication administration record (MAR) dated January 11, 2026, through January 31, 2026, for benzoyl peroxide 10% administration time of a.m., lacked documentation that medication administration was completed on January 1, 2, 3, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, and 31. The MAR indicated lubricant eye drop administration times of 8:00 a.m., 12:00 p.m., 4:00 p.m., and 8:00 p.m. was refused at least three times daily on January 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, and 31. The	01760		

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01760	Continued From page 24 MAR indicated the reason the medications were not given was resident refused. R1's MAR dated February 1, 2026, through February 28, 2026, for benzoyl peroxide 10% administration time of a.m., lacked documentation that medication administration was completed on February 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, and 28. The MAR indicated lubricant eye drop administration times of 8:00 a.m., 12:00 p.m., 4:00 p.m., and 8:00 p.m. was refused at least three times daily on February 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, and 28. The MAR indicated the reason the medications were not given was resident refused. R1's MAR dated March 1, 2026, through March 2, 2026, for benzoyl peroxide 10% administration time of a.m., lacked documentation that medication administration was completed on March 1 and 2. The MAR indicated lubricant eye drop administration times of 8:00 a.m., 12:00 p.m., 4:00 p.m., and 8:00 p.m. was refused at least three times daily on March 1 and 2. The MAR indicated the reason the medications were not given was resident refused. On March 4, 2026, at 9:10 a.m., clinical nurse supervisor (CNS)-B stated she did not have a reason she had not followed up with the resident or the resident's provider to notify them of R1's refusals for both the benzol peroxide and the lubricant eye drop but she should have. CNS-B agreed the refusals were on a regular basis for at least two months and will contact the provider to either change the order or get the medication discontinued.	01760		

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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
01760	Continued From page 25 The licensee's Medication Documentation policy dated August 1, 2021, indicated if the administration of one or more medications was not completed, staff will document the following: - The reason why the medication was not administered; - Follow up procedures to meet the resident's needs in compliance with the medication management plan; - Appropriate notification to RN Supervisor or other persons as instructed regarding missed dosages; and - Medication error report, if appropriate. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01820 SS=F	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure current written or electronically recorded prescriptions were obtained for all medications the licensee managed for two of two residents (R1 and 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	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36802	A. BUILDING: _____ B. WING _____	03/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PLUS HOME CARE LLC	2860 132ND AVENUE NW COON RAPIDS, MN 55448

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01820	Continued From page 26 cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: R1 On March 3, 2026, at 12:50 p.m., the surveyor observed unlicensed personnel (ULP)-C administer oral medications to R1. R1 was admitted to the licensee on June 13, 2023, with diagnoses that included Familial Chylomicronemia Syndrome (a rare, autosomal recessive metabolic disorder that prevents the breakdown of dietary fats, leading to extremely high triglyceride levels), attention deficit hypersensitivity disorder (ADHD), major depression and posttraumatic stress disorder (PTSD). R1's service plan signed on September 30, 2024, indicated R1 received assistance with medication administration three times daily. R1's medication administration record (MAR) dated March 2026, included the following scheduled medications: - benzoyl peroxide 10%, wash daily for acne - buspirone 10 milligrams (mg), take one tablet by mouth twice daily for anxiety - dextroamphetamine-amphetamine 30 mg, take one tablet daily for ADHD - ferosul 325 mg, take one tablet every other day for iron supplement - folbic tablet, take one tablet daily for vitamin supplement - gabapentinn 100 mg, take one capsule three	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01820	Continued From page 27 times daily for chronic pancreatitis - hydroxyzine pamoate 50 mg, take one capsule by mouth three times daily for adjustment disorder - lubricant eye drops 0.5%, place one drop into both eyes four times daily for dry eyes - sertraline 50 mg, take one tablet daily along with 100mg dose for total daily of 150 mg for adjustment disorder - sertraline 100 mg, take one tablet daily along with the 50 mg dose for total daily of 150 mg for adjustment disorder - tolterodine tartrate ER 4 mg, take one capsule by mouth daily for urge incontinence - fenofibrate 145 mg, take one tablet by mouth once daily with a meal for hypertriglyceridemia - doxepin 10 mg, take one capsule by mouth at bedtime for adjustment disorder - mirtazapine 15 mg, take one tablet by mouth at bedtime for adjustment disorder - rosuvastatin 40 mg, take one tablet by mouth at bedtime for hyperlipidemia - topiramate 50 mg, take one tablet by mouth every night at bedtime for adjustment disorder - tryngolza 80 mg/ 0.8 milliliters (ml), subcutaneous injection once every 30 days for Familial Chylomicronemia Syndrome R1's records lacked signed physician's orders for the following medications: - dextroamphetamine-amphetamine 30 mg, take one tablet daily for ADHD - ferosul 325 mg, take one tablet every other day for iron supplement - folbic tablet, take one tablet daily for vitamin supplement - gabapentinn 100 mg, take one capsule three times daily for chronic pancreatitis - hydroxyzine pamoate 50 mg, take one capsule by mouth three times daily for adjustment	01820		

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	36802	A. BUILDING: _____ B. WING _____	03/04/2026

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01820	Continued From page 28 disorder - lubricant eye drops 0.5%, place one drop into both eyes four times daily for dry eyes - sertraline 50 mg, take one tablet daily along with 100mg dose for total daily of 150 mg for adjustment disorder - sertraline 100 mg, take one tablet daily along with the 50 mg dose for total daily of 150 mg for adjustment disorder - doxepin 10 mg, take one capsule by mouth at bedtime for adjustment disorder - tryngolza 80 mg/ 0.8 milliliters (ml), subcutaneous injection once every 30 days for Familial Chylomicronemia Syndrome R2 On March 3, 2026, at 1:40 p.m., the surveyor observed ULP-C administer oral medications to R2. R2 was admitted to the licensee on November 2, 2024, with diagnoses that included schizoaffective disorder, catatonia (neuropsychiatric syndrome, marked by extreme motor abnormalities), PTSD and social anxiety disorder. R2's service plan dated September 5, 2025, indicated R2 received assistance with medication administration five times daily. R2's MAR dated March 2026, included the following scheduled medications: - risperidone 3 mg, take one tablet by mouth twice a day for schizoaffective disorder - fluoxetine 40 mg, take two capsules every morning for depression with catonia - gabapentin 600 mg, take one tablet by mouth three times daily for social anxiety disorder - lorazepam 2 mg, take one tablet by mouth twice	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01820	Continued From page 29 daily for anxiety R1's records lacked signed physician's orders for the following medications: - risperidone 3 mg, take one tablet by mouth twice a day for schizoaffective disorder On March 4, 2026, at 8:20 a.m., clinical nurse supervisor (CNS)-B stated she was unable to find all the electronic prescriptions for R1 and R2, so they are missing some medication orders. CNS-B stated they also do not have signed orders for the standing order house medications (commonly used over the counter as needed medications) for any of the residents. The licensee's Medication Orders policy dated August 1, 2021, indicated [the facility] will maintain a current written or electronically recorded prescription for all prescribed medications managed for the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
01830 SS=F	144G.71 Subd. 14 Renewal of prescriptions Prescriptions must be renewed at least every 12 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter 152. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure prescriptions	01830		

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01830	Continued From page 30 were renewed at least every 12 months for two of two residents (R1 and R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: R1 On March 3, 2026, at 12:50 p.m., the surveyor observed unlicensed personnel (ULP)-C administer oral medications to R1. R1 was admitted to the licensee on June 13, 2023, with diagnoses that included Familial Chylomicronemia Syndrome (a rare, autosomal recessive metabolic disorder that prevents the breakdown of dietary fats, leading to extremely high triglyceride levels), attention deficit hypersensitivity disorder (ADHD), major depression and posttraumatic stress disorder (PTSD). R1's service plan signed on September 30, 2024, indicated R1 received assistance with medication administration three times daily. R1's medication administration record (MAR) dated March 2026, included the following scheduled medications: - benzoyl peroxide 10%, wash daily for acne - buspirone 10 milligrams (mg), take one tablet by mouth twice daily for anxiety	01830		

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01830	Continued From page 31 - dextroamphetamine-amphetamine 30 mg, take one tablet daily for ADHD - ferosul 325 mg, take one tablet every other day for iron supplement - folbic tablet, take one tablet daily for vitamin supplement - gabapentinn 100 mg, take one capsule three times daily for chronic pancreatitis - hydroxyzine pamoate 50 mg, take one capsule by mouth three times daily for adjustment disorder - lubricant eye drops 0.5%, place one drop into both eyes four times daily for dry eyes - sertraline 50 mg, take one tablet daily along with 100mg dose for total daily of 150 mg for adjustment disorder - sertraline 100 mg, take one tablet daily along with the 50 mg dose for total daily of 150 mg for adjustment disorder - tolterodine tartrate ER 4 mg, take one capsule by mouth daily for urge incontinence - fenofibrate 145 mg, take one tablet by mouth once daily with a meal for hypertriglyceridemia - doxepin 10 mg, take one capsule by mouth at bedtime for adjustment disorder - mirtazapine 15 mg, take one tablet by mouth at bedtime for adjustment disorder - rosuvastatin 40 mg, take one tablet by mouth at bedtime for hyperlipidemia - topiramate 50 mg, take one tablet by mouth every night at bedtime for adjustment disorder - tryngolza 80 mg/ 0.8 milliliters (ml), subcutaneous injection once every 30 days for Familial Chylomicronemia Syndrome R1's provider orders were expired for all medications except the following two: - benzoyl peroxide 10%, wash daily for acne - tolterodine tartrate ER 4 mg, take one capsule by mouth daily for urge incontinence	01830		

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01830	Continued From page 32 R2 On March 3, 2026, at 1:40 p.m., the surveyor observed ULP-C administer oral medications to R2. R2 was admitted to the licensee on November 2, 2024, with diagnoses that included schizoaffective disorder, catatonia (neuropsychiatric syndrome, marked by extreme motor abnormalities), PTSD and social anxiety disorder. R2's service plan dated September 5, 2025, indicated R2 received assistance with medication administration five times daily. R2's MAR dated March 2026, included the following scheduled medications: - risperidone 3 mg, take one tablet by mouth twice a day for schizoaffective disorder - fluoxetine 40 mg, take two capsules every morning for depression with catonia - gabapentin 600 mg, take one tablet by mouth three times daily for social anxiety disorder - lorazepam 2 mg, take one tablet by mouth twice daily for anxiety R2's provider orders were expired for all medications. On March 3, 2026, at 2:30 p.m., clinical nurse supervisor (CNS)-B stated she is working on finding all the medication order for R1 and R2 but they only have electronic prescriptions from the pharmacy and some of them are older than a year. CNS-B stated she did not realize the electronic charting system they use has a provider orders report that can be printed and sent to the primary care provider annually, but	01830		

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01830	Continued From page 33 now that she is aware of this process she will be using this moving forward. The licensee's Medication Orders policy dated August 1, 2021, indicated [the facility] will maintain a current written or electronically recorded prescription for all prescribed medications managed for the resident. Medication orders will be renewed at least every 12 months or as required by the physician, the RN assessment and/or regulation. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01830		
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to monitor for expired medications for three of three residents (R1, R2 and 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) and was issued at a widespread scope (when problems are pervasive	01890		

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01890	Continued From page 34 or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On March 3, 2026, at 1:40 p.m., the surveyor observed the medication cabinet with unlicensed personnel (ULP)-C. The surveyor noted Imodium (treats diarrhea) which expired February 2026 in the house stock standing order medications (commonly used over the counter as needed medications) and Ibuprofen 600 mg for R3 which expired March 13, 2025. ULP-C confirmed the expired Imodium and ibuprofen with the surveyor. On March 3, 2026, at 2:00 p.m., clinical nurse supervisor (CNS)-B stated all three residents had the standing orders on their medication administration records (MAR) and verified the Imodium and ibuprofen for R3 were expired. CNS-B stated she must have missed these when she last did the medication cabinet check. The licensee's Medication Administration policy dated August 1, 2021, indicated the licensed nurse is responsible for assessing medications to assure that all medications are current and ordered by the prescriber and to identify any expired or outdated medications, which will be disposed according to policy. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

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

Food & Beverage Inspection Report

Establishment Info

Care Plus Home Care LLC
2860 132nd Ave NW
Coon Rapids, MN 55448
Anoka County
Parcel:

Phone:
info@careplusassistedlivinghomes.com

License Info

License: HFID 36802

Risk:
License:
Expires on:
CFPM: GAIL NGAFUA
CFPM #: 18200; Exp: 9/1/2027

Inspection Info

Report Number: F1029261061
Inspection Type: Full - Single
Date: 3/3/2026 Time: 10:15:50 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 5
Total Priority 2 Orders: 2
Total Priority 3 Orders: 3
Delivery:

! **New Order: 2-200 Employee Health**
2-201.11C *Priority Level: Priority 1 CFP#: 3*
MN Rule 4626.0040C The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority at the specific request of the regulatory authority.
COMMENT: NO EMPLOYEE ILLNESS LOG. ILLNESS LOG PROVIDED TO PERSON IN CHARGE DURING INSPECTION. EMPLOYEE ILLNESS LOGGING, EXCLUSION, AND REPORTING REQUIREMENTS REVIEWED.
Comply By: 3/3/2026 Originally Issued On: 3/3/2026

New Order: 3-300C Protection from Contamination: equipment/utensils, consumers
3-304.14F *Priority Level: Priority 3 CFP#: 41*
MN Rule 4626.0285F Single-use disposable sanitizer wipes must be used according to US EPA approved manufacturer's label use instructions.
COMMENT: DISPOSABLE WIPES PRESENT NOT INTENDED FOR FOOD CONTACT SURFACES. PERSON IN CHARGE INSTRUCTED TO USE DISPOSABLE WIPES INTENDED FOR FOOD CONTACT SURFACES IF SELECTED AS AN OPTION FOR FOOD CONTACT SURFACES.

PERSON IN CHARGE FOUND VIABLE FOOD CONTACT SURFACE DISPOSABLE WIPES ONLINE DURING INSPECTION.
Comply By: 3/6/2026 Originally Issued On: 3/3/2026

! **New Order: 3-500B Microbial Control: hot and cold holding**
3-501.16A2 *Priority Level: Priority 1 CFP#: 22*
MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.
COMMENT: REFRIGERATOR NOT MAINTAINING SAFE COLD HOLDING TEMPERATURES THROUGHOUT COOLER. TCS TEMPERATURE ABUSED FOODS DISCARDED BY PERSON IN CHARGE. PERSON IN CHARGE INSTRUCTED TO ENSURE STAFF AND/OR CLIENTS ARE NOT LEAVING THE DOOR AJAR TO ELIMINATE BEHAVIOR AS A CAUSE FOR THE OBSERVED TEMPERATURE ABUSE AND TO VERIFY SAFE COLD HOLDING TEMPERATURES THROUGHOUT THE REFRIGERATOR PRIOR TO PLACING TCS ITEMS WITHIN.
Comply By: 3/3/2026 Originally Issued On: 3/3/2026

New Order: 3-500C Microbial Control: date marking
3-501.17B *Priority Level: Priority 2 CFP#: 23*
MN Rule 4626.0400B Mark the refrigerated, ready-to-eat, TCS food prepared and packaged in a processing plant and opened and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded. The date must not exceed the manufacturer's use-by-date.
COMMENT: OPEN BAG OF SALAD MIX WITHOUT DATE MARK. OPEN JUG OF BEEF BROTH WITH DATE MARK BUT WITH MANUFACTURER USE BY DATE OF 1/17/26. OPERATOR INSTRUCTED TO DATE MARK REQUIRED ITEMS AND TO NOT EXCEED THE MANUFACTURER'S USE BY DATE.
Comply By: 3/3/2026 Originally Issued On: 3/3/2026

! **New Order: 3-500D Microbial Control: disposition of food**
3-501.18A *Priority Level: Priority 1 CFP#: 23*
MN Rule 4626.0405A Discard all TCS food prepared in the establishment or opened commercially packaged food when the time exceeds 7 days from the preparation or opening date or if the container or package is not marked.
COMMENT: OPENED BAG OF SALAD MIX WITHOUT DATE MARK. OPEN JUG OF CHICKEN BROTH WITH A 1/16/26 OPEN DATE MARK. OPEN JUG OF BEEF BROTH WITH A 1/16/26 OPEN DATE MARK. PERSON IN CHARGE INSTRUCTED TO DATE MARK REQUIRED ITEMS AND TO DISCARD AFTER 7TH DAY.
Comply By: 3/3/2026 Originally Issued On: 3/3/2026

New Order: 4-300 Equipment Numbers and Capacities
4-302.14 *Priority Level: Priority 2 CFP#: 48*
MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.
COMMENT: NO CL TEST STRIPS. SMALL SUPPLY OF TEST STRIPS PROVIDED, PICTURE TAKEN OF CONCENTRATION COLOR CHART ON SIDE OF TEST STRIP BOTTLE, AND DEMONSTRATION PROVIDED ON HOW TO USE CL TEST STRIPS IN SANITIZER SOLUTION TO VERIFY 50-200 PPM. PERSON IN CHARGE INSTRUCTED TO OBTAIN AND MAINTAIN CL TEST STRIP SUPPLY UNTIL DISHWASHER IS REPAIRED OF REPLACED.
Comply By: 3/6/2026 Originally Issued On: 3/3/2026

New Order: 4-500 Equipment Maintenance and Operation
4-501.11AB *Priority Level: Priority 3 CFP#: 47*
MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.
COMMENT: DISHWASHER NOT REACHING SANITIZING TEMPERATURES AND, RULING OUT BEHAVIORAL INTERVENTIONS, THE REFRIGERATOR IS NOT MAINTAIN AT 41F OR BELOW THROUGHOUT. PERSON IN CHARGE INSTRUCTED TO ADJUST/REPAIR/REPLACE EQUIPMENT TO ENSURE SAFE OPERATING PARAMETERS.
Comply By: 3/27/2026 Originally Issued On: 3/3/2026

! **New Order: 4-700 Sanitizing Equipment and Utensils**
4-702.11 *Priority Level: Priority 1 CFP#: 16*
MN Rule 4626.0900 Sanitize utensils and food contact surfaces of equipment before use, after cleaning.
COMMENT: DISHWASHER NOT REACHING SANITIZING TEMPERATURES. PERSON INSTRUCTED TO USE SINK FOR FINAL SANITIZING STEP AS SHORT TERM FIX UNTIL THE DISHWASHER IS REPAIRED OR REPLACED. LIQUID SODIUM HYPOCHLORITE SOLUTION ONSITE AND USED TO MIX SANITIZER SOLUTION DURING INSPECTION.
Comply By: 3/3/2026 Originally Issued On: 3/3/2026

New Order: 6-500 Physical Facility Maintenance/Operation and Pest Control
6-501.19 *Priority Level: Priority 3 CFP#: 53*
MN Rule 4626.1555 Keep the toilet room doors closed except during cleaning and maintenance operations.
COMMENT: TOILET ROOM DOORS OPEN. CLOSED DURING INSPECTION. PERSON IN CHARGE INSTRUCTED TO KEEP CLOSED WHEN NOT CLEANING AND/OR MAINTAINING.
Comply By: 3/3/2026 Originally Issued On: 3/3/2026

! **New Order: 7-200 Toxic Supplies and Applications**
7-204.11 *Priority Level: Priority 1 CFP#: 28*
MN Rule 4626.1620 Discontinue using chemical sanitizers, including chemical sanitizing solutions generated on site and other chemical antimicrobials on food-contact surfaces that do not meet the requirements specified in 40 CFR part 180, section 180.940, or part 180, subpart E, section 180.2020.
COMMENT: CHEMICAL SPRAY NOT INTENDED FOR FOOD CONTACT SURFACES BEING USED ON FOOD CONTACT SURFACES. PERSON IN CHARGE INSTRUCTED TO DISCONTINUE USING SPRAY ON FOOD CONTACT SURFACES.
Comply By: 3/3/2026 Originally Issued On: 3/3/2026

Food & Beverage General Comment

FOOD AND BEVERAGE INSPECTION CONDUCTED AT ALF AS PART OF HRD NURSING SURVEY. IDENTIFIED FOOD SAFETY ISSUES REVIEWED WITH STAFF AND RELAYED TO NURSING SURVEYOR FOLLOWING INSPECTION.

ESTABLISHMENT IS RESIDENTIAL IN NATURE AND DOES NOT SERVE A HIGHLY SUSCEPTIBLE POPULATION.

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Metro District Office inspection report number F1029261061 from 3/3/2026

GAIL NGAFUA
PERSON IN CHARGE

Trevor McCliment

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

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

Temperature Observations/Recordings

Establishment Info

Care Plus Home Care LLC
Coon Rapids
County/Group: Anoka County

Inspection Info

Report Number: F1029261061
Inspection Type: Full
Date: 3/3/2026
Time: 10:15:50 AM

New Record: Product/Item/Unit: BAGGED SALAD MIX**; Temperature Process:** Cold-Holding
Location: FRIDGE at 44 Degrees F.
Comment:
Violation Issued?: Yes

New Record: Product/Item/Unit: BAGGED SALAD MIX**; Temperature Process:** Cold-Holding
Location: FRIDGE at 48 Degrees F.
Comment:
Violation Issued?: Yes

New Record: Product/Item/Unit: BEEF BROTH**; Temperature Process:** Cold-Holding
Location: FRIDGE at 43 Degrees F.
Comment:
Violation Issued?: Yes

New Record: Product/Item/Unit: CHICKEN BROTH**; Temperature Process:** Cold-Holding
Location: FRIDGE at 45 Degrees F.
Comment:
Violation Issued?: Yes

New Record: Product/Item/Unit: RAW UNPASTEURIZED SHELL EGGS**; Temperature Process:** Cold-Holding
Location: FRIDGE at 41 Degrees F.
Comment:
Violation Issued?: No

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

Sanitizer Observations/Recordings

Establishment Info

Care Plus Home Care LLC
Coon Rapids
County/Group: Anoka County

Inspection Info

Report Number: F1029261061
Inspection Type: Full
Date: 3/3/2026
Time: 10:15:50 AM

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Kitchen **Less Than** 150 Degrees F.
Comment:
Violation Issued?: Yes

Sanitizing Chemical: **Product:** Chlorine**; Sanitizing Process:** KITCHEN SINK
Location: Equal To 50 PPM
Comment:
Violation Issued?: No

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ASSISTED LIVING | ASSISTED LIVING WITH DEMENTIA CARE

Project No: SL36802016-0	**Date:** 3/4/2026
Facility Name: CARE PLUS HOME CARE LLC	
Facility Address: 2860 132nd Ave NW, Coon Rapids, Minnesota 55448)	

☒ **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 include employee actions to be taken in the event of a fire or similar emergency. [Minn. Stat. 144G.45 subd.2]

   Comments: The provided FSEP was from a third-party provider and had not been updated to the specific facility.

2. 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: Licensed assisted living director (LALD)-A stated no resident policy was in place at this time.

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

   Comments: LALD-A stated no training has been provided to the residents.

4. 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: Review of the facility evacuation drill log indicated no evacuation drill exercises have taken place since 5-16-23