Electronically Delivered

June 5, 2026

Licensee
Careview Winchester Home
4207 Winchester Lane
Brooklyn Center, MN 55429

RE: Project Number(s) SL33522016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on May 12, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

STATE CORRECTION ORDERS

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

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

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

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,

Casey DeVries, Supervisor
State Evaluation Team
Email: Casey.DeVries@state.mn.us
Telephone: 651-201-5917 Fax: 1-866-890-9290

CLN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33522	A. BUILDING: _____ B. WING _____	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREVIEW WINCHESTER HOME	4207 WINCHESTER LANE BROOKLYN CENTER, MN 55429

(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: SL33522016-0 On May 11, 2026, through May 12, 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 four residents all of whom received 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 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, Food and Beverage Establishment Inspection Report (FBEIR) dated May 12, 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		
0 650 SS=E	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records included all required content for two of four employees (unlicensed personnel (ULP)-A, ULP-B). This practice resulted in a level two violation (a	0 650		

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0 650	Continued From page 4 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-A ULP-A was hired on June 19, 2017, under the licensee's former comprehensive license, and began providing assisted living services on August 1, 2021. ULP-A's personnel file lacked documentation of 30-day supervision and a training and competency evaluation related to unplanned times away. ULP-B ULP-B was hired on March 13, 2018, under the licensee's former comprehensive license, and began providing assisted living services on August 1, 2021. ULP-B's personnel file lacked documentation of 30-day supervision. On May 12, 2026, at 9:30 a.m., licensed assisted living director (LALD)-D verified ULP-A's personnel file lacked a training and competency evaluation related to unplanned time away. LALD-D stated the nurses added or removed training and competency content from the form titled DSP/PCA/HHA Expanded Duty Skills Competency Evaluation, depending on which	0 650		

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0 650	Continued From page 5 facility of the parent company the employee worked for because each facility had different resident needs. LALD-D stated the licensee completed 30-day supervisions on their ULP. ULP-B, who was also present, stated the nurse completed a supervision in 2018 shortly after they were hired. LALD-D stated they had looked two times through ULP-A and ULP-B's employee records and were unable to locate documentation of 30-day supervision. On May 12, 2026, at 10:48 a.m., via phone, ULP-A stated they were trained and completed a return demonstration for unplanned time away from home with owner/registered nurse (O/RN)-E. In addition, ULP-A stated they received 30-day supervision by the nurse shortly after they were hired. On May 12, 2026, at 11:08 a.m., clinical nurse supervisor (CNS)-C stated they completef 30-day supervision on all ULPs. CNS-C stated they watch ULP complete a medication pass and if reeducation was needed, they provided retraining at that time. CNS-C stated ULP-A and ULP-B both received 30-day supervision, and they did not know why it was missing from the personnel files. CNS-C stated they would look in the office for the paperwork and provide it to the surveyor if they were able to locate it. In addition, CNS-C stated they trained all ULP per the licensee's policy for unplanned time away from home. CNS-C stated they completed competency evaluations on unplanned time away and ULP-A had completed a competency evaluation. CNS-C stated after each survey they revise their competency evaluation checklists to meet the requirements, and they believed ULP-A's file had an older competency evaluation form.	0 650		

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0 650	Continued From page 6 The licensee's 4.05 Employee Records policy dated September 1, 2022, indicated the employee record would include records of all training and in-service education required and/or provided including record of competency testing as required. The licensee's 6.17 Supervision of Staff-Delegated Services policy dated September 1, 2022, indicated direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the licensee and first performs the delegated tasks for the residents and thereafter as needed based on performance. In addition, the documentation of the supervision activities would be retained in the employee's record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
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;	0 680		

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0 680	Continued From page 7 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 plan (EPP) with all the required content as defined in 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 potential to affect a large portion or all of the residents). The findings include: The licensee's Emergency Preparedness Manual last reviewed October 1, 2025, included a page titled Missing Resident Policy Review (Quarterly) and contained one signature on September 1, 2024. The EPP lacked evidence of the following required content:	0 680		

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0 680	Continued From page 8 - strategies for addressing facility and community-based risks which included staffing surges and shortages; and - quarterly missing resident plan review. On May 12, 2026, at 11:20 a.m., licensed assisted living director (LALD)-D stated the missing resident policy was reviewed quarterly at quality meetings. The surveyor requested quality meeting minutes. LALD-D stated the EPP did not address staffing shortages however, owner/registered nurse (O/RN)-E, clinical nurse supervisor (CNS)-C, or themselves would work a shift if there was a staffing shortage. On May 12, 2026, at 11:32 a.m., the surveyor reviewed the licensee's quality meeting minutes and did not observe documentation of the missing resident policy being reviewed quarterly. The surveyor did see the minutes addressed policies, but it did not indicate which policies were addressed. The licensee's 9.01 Emergency Preparedness Plan - Appendix Z Compliance policy dated September 1, 2022, indicated it was the licensee's intent to have in place an effective and compliant emergency preparedness plan. The intent was the plan would be aligned with the Centers for Medicare and Medicaid Services State Operation Manual Appendix Z. Minnesota Administrative Rule 4659.0100 Emergency Disaster and Preparedness Plan dated August 11, 2021, indicated assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.73, or successor requirements. The code references documents, specifications,	0 680		

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0 680	Continued From page 9 methods, and standards in the State Operations Manual Appendix Z - Emergency Preparedness for All Provider and Certified Supplier Types. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 790 SS=F	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when	0 790		

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0 790	Continued From page 10 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 May 11, 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=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the	0 810		

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0 810	Continued From page 11 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 two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated May 11, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty-one	0 810		

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0 810	Continued From page 12 (21) days	0 810		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure assisted living contracts did not include language waiving the licensee's liability for health, safety, or personal property of a resident for three of three residents (R1, R2, R3). This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 was admitted to the licensee on January 23, 2026, and began receiving assisted living services. R2 was admitted to the licensee on April 1, 2026, and began receiving assisted living services.	0 970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33522	A. BUILDING: _____ B. WING _____	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREVIEW WINCHESTER HOME	4207 WINCHESTER LANE BROOKLYN CENTER, MN 55429

(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
0 970	Continued From page 13 R3 was admitted to the licensee on September 27, 2018, under the licensee's former comprehensive license, and began receiving assisted living services on August 1, 2021. R1, R2, and R3's record included a signed contract titled Assisted Living Contract dated January 23, 2026, April 1, 2026, January 5, 2026, respectively. The contracts included the following statement, "The resident hereby releases [the licensee] from liability for any personal injury or property damaged suffered by the resident or the resident's agents, guests, or invitees, unless caused by the negligence of [the licensee] or its employees or agents." On April 12, 2026, at 11:15 a.m., licensed assisted living director (LALD)-D stated they were aware the contract could not include language waiving the licensee's liability. LALD-D stated during a previous survey of a different license they managed they were made aware of this and changed a portion of the licensee's contract. LALD-D stated they did not see the statement above when they made changes to the contract and stated, "I missed that one on my part. I fixed the first part." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01320 SS=F	144G.60 Subd. 4 (a) Unlicensed personnel (a) Unlicensed personnel providing assisted living services must have: (1) successfully completed a training and competency evaluation appropriate to the	01320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33522	A. BUILDING: _____ B. WING _____	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREVIEW WINCHESTER HOME	4207 WINCHESTER LANE BROOKLYN CENTER, MN 55429

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01320	Continued From page 14 services provided by the facility and the topics listed in section 144G.61, subdivision 2, paragraph (a); or (2) demonstrated competency by satisfactorily completing a written or oral test on the tasks the unlicensed personnel will perform and on the topics listed in section 144G.61, subdivision 2, paragraph (a); and successfully demonstrated competency on topics in section 144G.61, subdivision 2, paragraph (a), clauses (5), (7), and (8), by a practical skills test. Unlicensed personnel who only provide assisted living services listed in section 144G.08, subdivision 9, clauses (1) to (5), shall not perform delegated nursing or therapy tasks. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to ensure staff demonstrated competency for topics listed in section 144G.61, subdivision 2, paragraph (a) clause 5, by a practical skills test for one of three unlicensed personnel ((ULP)-A). 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-A was hired on June 19, 2017, under the licensee's former comprehensive license, and began providing assisted living services on	01320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33522	A. BUILDING: _____ B. WING _____	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREVIEW WINCHESTER HOME	4207 WINCHESTER LANE BROOKLYN CENTER, MN 55429

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01320	Continued From page 15 August 1, 2021. ULP-A's personnel file included an EduCare (training software) transcript which indicated hearing loss training completed on August 26, 2020. ULP-A's personnel file lacked a competency evaluation for care and use of hearing aids. On May 12, 2026, at 9:30 a.m., licensed assisted living director (LALD)-D verified ULP-A's personnel file lacked care and use of hearing aids competency evaluation. LALD-D stated the nurses added or removed training and competency content from the form titled DSP/PCA/HHA Expanded Duty Skills Competency Evaluation, depending on which facility of the parent company the employee worked for because each facility had different resident needs. LALD-D stated if there were residents who resided in the facility who used a hearing aid the licensee would train and complete a competency evaluation with the ULP. LALD-D stated they had three employees who were not certified nursing assistants (CNAs) at the facility who would lack a hearing aid competency evaluation. On May 12, 2026, 11:08 a.m., clinical nurse supervisor (CNS)-C stated the licensee's facility did not have any residents who used a hearing aid. CNS-C stated they train ULP on hearing aids by use of YouTube and EduCare. CNS-C stated employees who were recently hired received a hearing aid competency evaluation however, older employees did not receive hearing aid competency evaluations because they believe it was not required back then. On May 12, 2026, at 12:39 p.m., CNS-C,	01320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33522	A. BUILDING: _____ B. WING _____	05/12/2026

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01320	Continued From page 16 LALD-D, and owner/registered nurse (O/RN)-E, all stated they believed the topic listed above was optional if they did not have any residents residing in the facility who wore a hearing aid. Although hearing loss training is an optional training for orientation and annual training, the care and use of hearing aids (the actual device) is a requirement for all ULP not CNA certified. The licensee's 5.02 Competency Training Evaluations policy dated September 1, 2022, indicated training and competency evaluations of ULPs would be conducted by a registered nurse (RN), or another instructor may provide the training in conjunction with a RN. In addition, the licensee's training and competency evaluations for all ULP would include care and use of hearing aids. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01320		
01880 SS=E	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to store all medications in a securely locked location for two of four residents (R1, R2).	01880		

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	33522	A. BUILDING: _____ B. WING _____	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01880	Continued From page 17 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On May 11, 2026, at 10:25 a.m., the surveyor observed an unsecured medication refrigerator located in the licensee's main living room. The refrigerator was taped shut and the following medications were unsecured within: - five pens of Mounjaro 7.5 milligrams (mg)/ 0.5 milter (ml) for R2; and - four pens of Lantus SoloStar 100 units (u)/ 1 ml for R1. Clinical nurse supervisor (CNS)-C, who was present during the observation, stated the medication refrigerator used to have a lock however, it fell off so they taped it shut. CNS-C stated the licensee was working on obtaining a new lock for the medication refrigerator. The licensee's 7.11 Medication Storage policy dated September 1, 2022, indicated that when medications were managed and stored by the licensee, medications would be kept securely locked and stored per manufacturer's directions. Only authorized staff would have access to stored medications. No further information was provided.	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01880	Continued From page 18 TIME PERIOD FOR CORRECTION: Seven (7) days	01880		

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

Food & Beverage Inspection Report

Establishment Info

Careview Winchester Home
4207 Winchester lane
Brooklyn Center, MN 55429
Hennepin County
Parcel:

Phone:

License Info

License: HFID 33522

Risk:
License:
Expires on:
CFPM: Alloys O. Onkundi
CFPM #: 120012; Exp: 11/11/2026

Inspection Info

Report Number: F8044261143
Inspection Type: Full - Single
Date: 5/12/2026 Time: 9:47:43 AM
Duration: minutes
Announced Inspection: Yes
Total Priority 1 Orders: 0
Total Priority 2 Orders: 1
Total Priority 3 Orders: 5
Delivery: Emailed

New Order: 4-300 Equipment Numbers and Capacities
4-302.13B *Priority Level: Priority 2 CFP#: 48*
MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.
COMMENT: No irreversible thermometer or stickers/strips for dishwasher.
Comply By: 5/25/2026 Originally Issued On: 5/12/2026

New Order: 4-400 Equipment Location and Installation
4-402.11A *Priority Level: Priority 3 CFP#: 47*
MN Rule 4626.0725A Space fixed equipment to allow access for cleaning along the sides, behind and above the unit, or seal to adjoining equipment or walls.
COMMENT: Countertop separated from wall
Comply By: 6/12/2026 Originally Issued On: 5/12/2026

New Order: 4-600 Cleaning Equipment and Utensils
4-601.11C *Priority Level: Priority 3 CFP#: 49*
MN Rule 4626.0840C Clean non-food contact surfaces of equipment and maintain free of accumulations of dust, dirt, food residue, and other debris.
COMMENT: Soiled doors of cabinets and equipment in kitchen.
Comply By: 5/18/2026 Originally Issued On: 5/12/2026

New Order: 4-600 Cleaning Equipment and Utensils
4-603.16 *Priority Level: Priority 3 CFP#: 48*
MN Rule 4626.0885 Rinse washed utensils and equipment with water to remove abrasives or cleaning chemicals before sanitizing or use an approved detergent-sanitizer procedure.
COMMENT: Dishes currently washed in two compartment sink while dishwasher is broken. Dishes not rinsed before sanitizing.
Comply By: 5/12/2026 Originally Issued On: 5/12/2026

New Order: 6-200 Physical Facility Design and Construction
6-202.15A *Priority Level: Priority 3 CFP#: 38*
MN Rule 4626.1395A Seal holes, gaps, and other openings along floors, walls and ceilings to the outside of the building and provide self-closing, tight-fitting doors and windows for all outside openings.
COMMENT: Daylight visible below back door.
Comply By: 6/12/2026 Originally Issued On: 5/12/2026

New Order: 6-500 Physical Facility Maintenance/Operation and Pest Control
6-501.12A *Priority Level: Priority 3 CFP#: 55*
MN Rule 4626.1520A Clean and maintain all physical facilities clean.
COMMENT: Soiled backsplash below upper cabinets in kitchen.
Comply By: 5/18/2026 Originally Issued On: 5/12/2026

Food & Beverage General Comment

HRD inspection conducted with nurse evaluator with Ashley Crews. Inspection report reviewed with Alloys.

FLOOR IS LAMINATE, CABINETS ARE WOOD WITH HALLOWED ENCLOSED BASES, LAMINATE COUNTER TOPS AND SMOOTH CEILING. ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT ANY TIME THERE IS FOUND TO BE A RISK OF CONTAMINATION OR CONCERN THE PHYSICAL FACILITIES WILL BE REQUIRED TO BE
BROUGHT UP TO CODE.

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

I acknowledge receipt of the Rochester District Office inspection report number F8044261143 from 5/12/2026

Alloys Onkundi

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

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

Temperature Observations/Recordings

Establishment Info

Careview Winchester Home
Brooklyn Center
County/Group: Hennepin County

Inspection Info

Report Number: F8044261143
Inspection Type: Full
Date: 5/12/2026
Time: 9:47:43 AM

Food Temperature: Product/Item/Unit: Milk**; Temperature Process:** Cold-Holding
Location: Refrigerator at 37.4 Degrees F.
Comment:
Violation Issued?: No

Equipment Temperature: Product/Item/Unit: ; Temperature Process: Cold-Holding
Location: Refrigerator at 37.0 Degrees F.
Comment:
Violation Issued?: No

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

Sanitizer Observations/Recordings

Establishment Info

Careview Winchester Home
Brooklyn Center
County/Group: Hennepin County

Inspection Info

Report Number: F8044261143
Inspection Type: Full
Date: 5/12/2026
Time: 9:47:43 AM

Sanitizing Chemical: **Product:** Chlorine**; Sanitizing Process:** Spray Bottle
Location: Kitchen **Equal To** 50 PPM
Comment:
Violation Issued?: No

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL33522016-0	**Date:** May 11, 2026
Facility Name: Careview Winchester Home	
Facility Address: 4207 Winchester Ln, Brooklyn Center, MN 55429	

☒ **TAG IDENTIFICATION: 0790**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Seven (7) days

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

   Comments: The portable fire extinguishers in the facility lacked annual service tags. Owner/registered nurse (O/RN)-E stated that they had been told that the fire extinguishers didn't need to be serviced annually if they were replaced annually. The monthly checks that were on a tag on the fire extinguishers started in 2024, and there was a date of 2024 stamped on the bottom of the extinguishers.

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 2; 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 FSEP failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. 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: The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency.

3. 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 FSEP failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents.

4. 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: During record review O/RN-E stated that staff training records were not kept on site, and that another employee was at the off site office and was going to be bringing the staff training records.

At approximately 1:45 p.m. on May 11, 2026, O/RN-E showed the surveyor a photo on their phone of staff training records that they said was sent from the employee at the off site office. The photo was of 1 training for 2025 on FSEP. O/RN-E confirmed that there was only 1 staff training record and stated that staff are trained annually on the FSEP.