DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

October 9, 2025

Licensee
Caring Nurses LLC
7715 Brooklyn Boulevard
Brooklyn Center, MN 55443

RE: Project Number(s) SL33553016

Dear Licensee:

On September 2, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on June 4, 2025. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Benjamin Zwart

Benjamin J. Zwart, P.E., Supervisor
State Engineering Services Section
Health Regulation Division
Email: Benjamin.Zwart@state.mn.us
Telephone: 651-201-3715 Fax: 1-866-890-9290

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Electronically Delivered

August 4, 2025

Licensee
Caring Nurses LLC
7715 Brooklyn Boulevard
Brooklyn Center, MN 55443

RE: Project Number(s) SL33553016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 4, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

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

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

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

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

The correction order documentation should include the following:

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

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

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

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

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

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

the website listed above.

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

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

If you have any questions, please contact me.

Sincerely,

Renee L. Anderson

Renee L. Anderson, Supervisor
State Evaluation Team
Email: Renee.L.Anderson@state.mn.us
Telephone: 651-201-5871 Fax: 1-866-890-9290

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33553	A. BUILDING: _____ B. WING _____	06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING NURSES LLC	7715 BROOKLYN BOULEVARD BROOKLYN CENTER, MN 55443

(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 In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been 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: SL33553016-0 On June 2, 2025, through June 4, 2025, the Minnesota Department of Health conducted an initial survey at the above provider, and the following correction orders are issued. At the time of the survey, there were four (4) residents; four residents receiving services under the provider's Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL 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) 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: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated June 2, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer	0 480		

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0 480	Continued From page 3 to the FBEIR for any compliance dates.	0 480		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post the required information related to the grievance procedure and contact information for the Office of Ombudsman for Long-Term Care and Mental Health and Developmental Disabilities, as well as information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC). This had the potential to affect all of the licensee's current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 550		

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0 550	Continued From page 4 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: The licensee lacked a posting of the grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. In addition, there was no evidence of the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, or any information for reporting suspected maltreatment to MAARC. On June 2, 2025, at 11:10 a.m., during the facility tour, the surveyor observed the entry area and common areas, and noted postings on a bulletin board in the hallway, near the kitchen. The licensee lacked the required posting of the grievance procedure and information related to reporting suspected maltreatment to MAARC, in a conspicuous place within the facility. On June 2, 2025, at 11:35 a.m., licensed assisted living director (LALD)-A stated she thought the posting had been knocked down and not placed back on the bulletin board. The licensee's undated Complaint and Investigation Process policy lacked direction to post the information related to the grievance procedure. The licensee's undated Reporting Maltreatment	0 550		

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0 550	Continued From page 5 of Vulnerable Adult policy indicated licensee would support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: 1) Posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; and 2) Posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
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. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must	0 680		

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0 680	Continued From page 6 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 have a written emergency preparedness (EP) plan that included all required content and failed to post an emergency disaster plan prominently. This had the potential to affect all current 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 undated EP plan lacked the following required content: - annual review and updated EP plan, policies, and procedures; - annual review and updated hazard vulnerability risk assessment by likelihood of occurrence; - process for emergency preparedness (EP) cooperation with state and local EP officials/organizations; - development of a communication plan, including the names/contact information: staff, entities	0 680		

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0 680	Continued From page 7 providing services under agreement, residents' physicians, other facilities, volunteers; - communication plan including contact information for Federal, State, tribal, regional & local EP staff, State Licensing and Certification Agency, and MN Office of Ombudsman for LTC; - EP training and testing program; - EP training program for staff (including documentation of training provided); and - EP testing/annual testing requirements. On June 3, 2025, at 3:12 p.m., licensed assisted living director (LALD)-A stated via email, licensee had not conducted a full-scale exercise, or table-top exercise. On June 4, 2025, at approximately 3:50 p.m., LALD-A stated licensee had been working on updating the EP plan according to the information that had been discussed during a previous survey, regarding EP plan content. The licensee's undated Communication Plan for Emergency Preparedness policy indicated as part of the facility's overall emergency disaster plan, the facility would establish and maintain a communication plan that complies with Federal, State, and local laws. The licensee's undated Emergency Disaster Plan Orientation and Training policy indicated all employees would be oriented to the Emergency Disaster Plan (EDP), including their responsibilities in carrying out the plan. Furthermore, the orientation would be provided upon hire (during orientation) and all employees would participate in facility emergency preparedness plan in-service educational sessions annually. Moreover, attendance and demonstration of staff knowledge of emergency	0 680		

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0 680	Continued From page 8 procedures would be notated in the employee's personnel file. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to comply with Minnesota State Fire Code, under Minnesota Rules Chapter 7511. 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: On June 4, 2025, at 1:00 p.m., the surveyor toured the facility with unlicensed personnel (ULP)-D. During the tour of the facility, the surveyor observed the following: LOCKING A sliding chain lock was installed 63 inches above the top step on the basement door exiting to the backyard. This door was labeled as an	0 775		

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0 775	Continued From page 9 emergency exit on the evacuation floor plan posted in the basement. During the facility tour interview, ULP-D verified the above listed locking observation. The installed locking hardware could delay escape from the building in the event of an emergency. SMOKING MATERIAL DISPOSAL The designed smoking area was outside at the front of the facility. The top part of the listed smoking material disposal container was missing. There were burnt cigarettes in the bottom part of this disposal container. Additionally, there was an uncovered metal bucket with burnt cigarettes in the bottom. Both of these disposal containers used for smoking materials were stored alongside the building. During the facility tour interview, ULP-D verified the above listed smoking material disposal observations. ULP-D stated they did not know where the top part of the listed disposal container was and that residents should not be using the bucket. ELECTRICAL On the exterior of facility on the back side of the building, there was an uncovered electrical outlet box with capped wires located above a security camera. During the facility tour interview, ULP-D verified the above listed electrical observation. Electrical outlet boxes are required to be properly covered to prevent water damage, electrical shocks, and fires. TIME PERIOD FOR CORRECTION: Two (2) days	0 775		
0 780 SS=E	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter	0 780		

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0 780	Continued From page 10 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that complied with fire protection requirements. 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	0 780		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 780	Continued From page 11 situation has occurred repeatedly; but is not found to be pervasive). The findings include: On June 4, 2025, at 1:00 p.m., the surveyor toured the facility with unlicensed personnel (ULP)-D. During the tour of the basement, the surveyor observed the following: 1. The battery operated smoke alarm on the ceiling in the living room did not work when tested by ULP-D. Smoke alarms must be maintained in operable condition. 2. The smoke alarm installed on the ceiling in the storage room (labeled as "other" on the floor plan) did not actuate when the main floor smoke alarms were tested by ULP-D. All dwelling unit smoke alarms must be interconnected so actuation of one alarm causes all alarms in the dwelling unit to operate. During the facility tour interview, ULP-D verified the above listed smoke alarm observations. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 790 SS=E	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	0 790		

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	33553	A. BUILDING: _____ B. WING _____	06/04/2025

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0 790	Continued From page 12 This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to maintain the portable fire extinguishers as required by statute. 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 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 June 4, 2025, at 1:00 p.m., the surveyor toured the facility with unlicensed personnel (ULP)-D. During the tour of the facility, the surveyor observed the following: The gauge indicated the main floor hallway 1A:10B:C fire extinguisher was empty and the pin was noted as missing. Tags or labels indicating monthly inspections and annual maintenance performed by certified service personnel were not attached to the 1A:10B:C portable fire extinguishers installed in the following locations: - main floor hallway - main floor kitchen Monthly inspections were not recorded on the back of the tags attached to the basement and main floor living room portable fire extinguishers indicating these inspections had been completed. Fire extinguisher inspections must be conducted every month to ensure each installed extinguisher is in its designated place, it has not been tampered with, and there is no obvious physical damage or condition that would interfere with its use or operation.	0 790		

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0 790	Continued From page 13 During the facility tour interview, ULP-D verified the above listed fire extinguisher observations. All portable fire extinguishers must be maintained to ensure the extinguisher is operable in the event of an emergency. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
0 800 SS=E	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This 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	0 800		

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0 800	Continued From page 14 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 June 4, 2025, at 1:00 p.m., the surveyor toured the facility with unlicensed personnel (ULP)-D. During the tour of the facility, the surveyor observed the following: - There was a power connector in an open ceiling fixture in the main floor resident bathroom - In the basement bathroom, the exhaust fan cover was missing, the toilet paper holder was broken, and the paper towel dispenser on the wall was cracked. During the facility tour interview, ULP-D verified the above listed physical environment observations. ULP-D stated the basement bathroom was only used by employees. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive	0 810		

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0 810	Continued From page 15 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 record review and interview, the licensee failed to develop the fire safety and evacuation plan with required content and provide required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On June 4, 2025, unlicensed personnel (ULP)-D directed the surveyor to binders stored on the	0 810		

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0 810	Continued From page 16 shelf in the kitchen which contained documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee FSEP failed to include the following: An accurate floor plan that identified the location and number of resident sleeping rooms evident by a review of the FSEP evacuation floor plans. On June 4, 2025, at 1:00 p.m., the surveyor toured the facility with ULP-D. During the tour of the facility, the surveyor observed the following: - Numbers 1, 2, 3, 4, and 5 were posted at the doors of the resident sleeping rooms on the main floor. - Evacuation floor plans for the main floor were posted throughout the facility, all posted copies of these floor plans did not match, there were floor plans that labeled five sleeping rooms and there were floor plans that labeled six sleeping rooms. - Record review of the FSEP floor plans in the emergency preparedness binders indicated there were six resident sleeping rooms on the main floor Accurate resident sleeping room numbers are required to be included on the fire safety and evacuation floor plan and correspond with the numbers installed at the resident sleeping room doors to provide efficient communication for exiting in the event of a fire or similar emergency. The FSEP floor plan did not clearly label the exits for the facility, small green symbols were used to indicate the exit locations. FSEP floor plans shall be easy to read and readily understandable by the building occupants in the event of an emergency in order to direct occupants to these	0 810		

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0 810	Continued From page 17 exits in the event of an emergency. Record review of the available documentation indicated the licensee failed to develop and maintain the FSEP with procedures specific to the facility and the building occupants evident by the following: The FSEP included a template from a third party provider titled Caring Nurses LLC Fire Safety and Evacuation Plan. This template included inaccurate information and referenced pull fire alarms, corridors, an addressable fire alarm system with automatic smoke detection, smoke comparments, and an automatic fire sprinkler system, none of which were installed in the building. The FSEP included a fire emergency response plan with standard employee procedures, but 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 FSEP failed to include fire safety and evacuation instructions for residents evident by no procedures in the plan. The FSEP included standard resident evacuation procedures, but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency. During an interview on June 4, 2025, at 2:45 p.m., maintenance (M)-F verified the FSEP required revision. M-F stated they had updated evacuation floor plans and would be replacing the inaccurate floor plans posted in the facility and in	0 810		

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0 810	Continued From page 18 the binders. TRAINING Record review indicated the licensee failed to provide fire safety and evacuation training to residents at least once per year evident by a review of a client fire training log. Two training sessions were recorded on the log dated July 20, 2023, and January 27, 2024. Record review indicated the licensee failed to provide training to employees on the FSEP upon hire and at least twice per year evident by a review of a staff fire training log. Two training sessions were reocrded on the log dated July 20, 2023, and January 30, 2024. Additionally, the names of the employees who completed the training were not recorded. During an interview on June 4, 2025, at 2:45 p.m., M-F verified the training records were lacking the required frequency and documentation. DRILLS Record review indicated the licensee failed to maintain employee evacuation drill documentation with the required information evident by a review of the licensee fire drill logs. Seven fire drills were recorded between May 2024 and May 2025. The names of the employees who had participated in these drills were not recorded. During an interview on June 4, 2025, at 2:45 p.m., M-F verified the fire drill records were lacking the required information. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		

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01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve 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	01500		

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01500	Continued From page 20 subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employees received at least eight (8) hours of annual training for each 12 months of employment for three of three employees (clinical nurse supervisor (CNS)-B, unlicensed personnel (ULP)-D, ULP-E). This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: CNS-B was hired January 30, 2008, and provided	01500		

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01500	Continued From page 21 supervision to staff, and cares and services to residents of the assisted living facility. ULP-D was hired February 19, 2024, and provided direct cares and services to residents of the assisted living facility. ULP-E was hired February 5, 2024, and provided direct cares and services to residents of the assisted living facility. On June 3, 2025, at 8:30 a.m., the surveyor observed ULP-D preparing breakfast for residents. CNS-B, ULP-D, and ULP-E's employee records lacked evidence of eight (8) hours of annual training. On June 3, 2025, at 11:38 a.m., licensed assisted living director (LALD)-A stated ULP-D was assigned annual training; however, had not completed the training courses. On June 3, 2025, at 12:25 p.m., LALD-A stated she was still gathering training documentation for CNS-B. On June 3, 2025, at 4:55 p.m., LALD-A stated ULP-E was assigned annual training, but had not completed the training courses. On June 4, 2025, at 3:55 p.m., the surveyor conducted the exit conference via telephone. LALD-A had not provided surveyor any annual training documentation for CNS-B. The licensee's undated Annual Training Requirements policy indicated all staff that provided direct care services in assisted living	01500		

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01500	Continued From page 22 would complete at least eight (8) hours of annual training for each 12 months of employment. The policy indicated annual training topics would include the following: - training on reporting of maltreatment of vulnerable adults under section 626.557; - review of the Assisted Living Bill of Rights and staff responsibilities related to ensuring the exercise and protection of those rights; - review of infection control techniques used in the home and implementation of infection control standards including: a. a review of hand-washing techniques b. need for and use of protective gloves, gowns, and masks c. appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes and razor blades d. disinfecting reusable equipment e. disinfecting environmental surfaces f. reporting of communicable diseases - effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease or related disorders; - review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; and - training on providing services to residents with hearing loss. The policy further indicated evidence the employee had completed the orientation and training would be kept in the employee file.	01500		

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01500	Continued From page 23 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
01530 SS=F	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related 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	01530		

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01530	Continued From page 24 requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure direct care staff received the required amount of annual dementia care training in the required time frame for three of three employees (clinical nurse supervisor (CNS)-B, unlicensed personnel (ULP-D, ULP-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: CNS-B was hired January 30, 2008, and provided supervision to staff, and cares and services to residents of the assisted living facility. ULP-D was hired February 19, 2024, and provided direct cares and services to residents of the assisted living facility.	01530		

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01530	Continued From page 25 ULP-E was hired February 5, 2024, and provided direct cares and services to residents of the assisted living facility. On June 3, 2025, at 8:30 a.m., the surveyor observed ULP-D preparing breakfast for residents. CNS-B, ULP-D, and ULP-E's employee records lacked documentation of the required two hours of annual dementia care training. On June 3, 2025, at 11:38 a.m., licensed assisted living director (LALD)-A stated ULP-D was assigned annual dementia training, but had not completed the training courses. On June 3, 2025, at 12:25 p.m., LALD-A stated she was still gathering annual dementia training documentation for CNS-B. On June 3, 2025, at 4:55 p.m., LALD-A stated ULP-E was assigned annual dementia training, but had not completed the training courses. On June 4, 2025, at 3:55 p.m., the surveyor conducted the exit conference via telephone. LALD-A had not provided surveyor any annual training documentation for CNS-B. The licensee's undated Annual Training Requirements policy indicated all staff that provided direct care services in assisted living would complete at least eight (8) hours of annual training for each 12 months of employment. Furthermore, annual training topics would include the following: - effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with	01530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33553	A. BUILDING: _____ B. WING _____	06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING NURSES LLC	7715 BROOKLYN BOULEVARD BROOKLYN CENTER, MN 55443

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01530	Continued From page 26 residents who have dementia, Alzheimer's disease or related disorders. Moreover, evidence that each employee had completed the orientation and training would be kept in the employee file. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the required notice was posted at the main entry way of the establishment displaying statutory language to disclose electronic monitoring activity, potentially affecting all current residents in the assisted living facility, staff and any visitors of the licensee. This practice resulted in a level one violation (a violation that has not potential to cause more than a 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	03090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33553	A. BUILDING: _____ B. WING _____	06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING NURSES LLC	7715 BROOKLYN BOULEVARD BROOKLYN CENTER, MN 55443

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03090	Continued From page 27 the residents). The findings include: On June 2, 2025, at 10:15 a.m., upon arriving at the facility, the surveyor observed the outside front entrance had signage which stated, "Security Alert, 24-Hour Video Surveillance". On June 2, 2025, at 11:10 a.m., during the facility tour, the surveyor observed the main entry area and common areas, and noted licensee lacked the required notice posted for electronic monitoring devices, displaying the required statutory language. On June 2, 2025, at 11:35 a.m., licensed assisted living director (LALD)-A stated she thought the information noted on the signage, outside the front entrance was sufficient enough to meet the requirement. The licensee's Electronic Monitoring policy dated January 1, 2020, indicated, "effective January 1, 2020, facility complies with the Minnesota Electronic Monitoring law. Residents or the resident representative may conduct electronic monitoring in the resident's room or private living unit consistent with the consent notification and other requirements set forth in the law. If the resident has a roommate, the facility must get written consent from that person to allow the use of monitoring in the shared room." The policy did not reflect the requirements of 144G Assisted Living statutes. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33553	A. BUILDING: _____ B. WING _____	06/04/2025

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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

Caring Nurses LLC
7715 Brooklyn Blvd
Brooklyn Park, MN 55443
Hennepin County
Parcel:

Phone:

License Info

License: HFID 33553

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

Inspection Info

Report Number: F1039251024
Inspection Type: Full - Single
Date: 6/2/2025 Time: 11:15:00
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 2
Total Priority 3 Orders: 1
Delivery: Emailed

New Order: 2-100 Supervision
2-102.12AMN *Priority Level: Priority 3 CFP#: 2*
MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.
COMMENT: *REISSUE FROM PREVIOUS INSPECTION* STAFF MUST COMPLETE AN APPROVED FOOD SAFETY COURSE AND REGISTER WITH MDH CFPM PROGRAM.
Comply By: 6/16/2025 Originally Issued On: 6/2/2025

New Order: 4-300 Equipment Numbers and Capacities
4-302.12A *Priority Level: Priority 2 CFP#: 36*
MN Rule 4626.0705A Provide a readily accessible food temperature measuring device to ensure attainment and maintenance of food temperatures.
COMMENT: DIGITAL FOOD PROBE THERMOMETER OBSERVED AS NONFUNCTIONAL DURING INSPECTION. REPLACE BATTERIES TO MAKE FUNCTION OR REPLACE WITH NEW THERMOMETER.
Comply By: 6/9/2025 Originally Issued On: 6/2/2025

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 CHLORINE TEST STRIPS ON-HAND. MAINTAIN SUPPLY AND USE TO VERIFY 50-200 PPM CHLORINE IN SANITIZER SOLUTION (PREPARE BY MIXING 1 TEASPOON BLEACH CONCENTRATE INTO WATER IN SPRAY BOTTLE).
Comply By: 6/9/2025 Originally Issued On: 6/2/2025

Food & Beverage General Comment

The inspection was completed with the person in charge and reviewed with MDH nurse evaluator Rhona Makela.

The kitchen is of residential build and should serve food for same-day service only.

The kitchen has wood cabinets with hollow base and mix of faux stone and stainless countertops, tile floor, painted walls and ceiling. These kitchen finishes and surfaces are clean and well maintained.

The kitchen refrigerator/freezer are of residential grade.

A 1-compartment sink is present in kitchen. A separate handwashing sink is provided in kitchen.

A residential dishwashing machine is present in the kitchen. During inspection, a run of the dish machine was started with a

color-change thermos test strip. Results of the run where shared by person-in-charge via email showing a rinse temperature between 150 and 160 degrees F.

A supply of single-use gloves is present in kitchen. Bleach sanitizer spray was present in kitchen.

Discussed the following with the person-in-charge: minimum cook temps for animal proteins, food source, foodborne illness symptoms and exclusion of ill employees, avoiding bare hand contact with ready to eat foods, handwashing, sanitizing., all orders on this report.

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 F1039251024 from 6/2/2025

Brandi Stamper
person-in-charge

Aron Goodner,
Public Health Sanitarian 1
651-201-4910
aron.goodner@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

Caring Nurses LLC
Brooklyn Park
County/Group: Hennepin County

Inspection Info

Report Number: F1039251024
Inspection Type: Full
Date: 6/2/2025
Time: 11:15:00

Food Temperature: Product/Item/Unit: GRAPE**; Temperature Process:** HOLD IN REFRIGERATOR
Location: at 41 Degrees F.
Comment:
Violation Issued?: No

FREEZER: Product/Item/Unit: ; Temperature Process:
Location: at Degrees F.
Comment: FROZEN
Violation Issued?: No