Electronically Delivered

January 22, 2026

Licensee
Best Choice Home Care LLC
821 20th Avenue Ne
Minneapolis, MN 55418

RE: Project Number(s) SL3471301

Dear Licensee:

On January 12, 2026, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on October 23, 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,

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

HHH

Electronically Delivered

November 13, 2025

Licensee
Best Choice Home Care LLC
821 20th Avenue Northeast
Minneapolis, MN 55418

RE: Project Number(s) SL34713016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on October 23, 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 addition to any enforcement mechanism authorized in § 144G.20.

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

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00
St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $1,000.00

St - 0 - 0780 - 144g.45 Subd. 2 (a) (1) - Fire Protection And Physical Environment - $500.00
St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required $1,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

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

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

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

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

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

If you have any questions, please contact me.

Sincerely,

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

KKM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34713	A. BUILDING: _____ B. WING _____	10/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST CHOICE HOME CARE LLC	821 20TH AVENUE NE MINNEAPOLIS, MN 55418

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL34713016-0 On October 21, 2025, through October 23, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were five (5) residents receiving services under the Assisted Living license. An immediate correction order was identified on October 22, 2025, issued for SL34713016-0, tag identification 0775. During the survey, the licensee took action to mitigate the immediate risk for tag identification 0775. However, noncompliance remained, and the scope and level remain unchanged. An immediate correction order was identified on October 23, 2025, issued for SL34713016-0, tag	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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34713	A. BUILDING: _____ B. WING _____	10/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST CHOICE HOME CARE LLC	821 20TH AVENUE NE MINNEAPOLIS, MN 55418

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Continued From page 1 identification 1290. During the survey, the licensee took action to mitigate the immediate risk for tag identification 1290. However, noncompliance remained, and the scope and level remain unchanged.	0 000		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before	0 480		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34713	A. BUILDING: _____ B. WING _____	10/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST CHOICE HOME CARE LLC	821 20TH AVENUE NE MINNEAPOLIS, MN 55418

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 480	Continued From page 2 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 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large	0 480		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34713	A. BUILDING: _____ B. WING _____	10/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST CHOICE HOME CARE LLC	821 20TH AVENUE NE MINNEAPOLIS, MN 55418

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 480	Continued From page 3 portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated October 21, 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 to the FBEIR for any compliance dates.	0 480		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program that complies with accepted health care, medical and nursing standards for infection control to include appropriate use of gloves and hand hygiene for one of one employee (unlicensed personnel	0 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34713	A. BUILDING: _____ B. WING _____	10/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST CHOICE HOME CARE LLC	821 20TH AVENUE NE MINNEAPOLIS, MN 55418

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 510	Continued From page 4 (ULP)-B). 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 October 22, 2025, at 9:52 a.m., the surveyor observed ULP-B performed hand hygiene, apply gloves to administer medications to R2. ULP-B then discarded R2's medication cup and unlocked R1's medication cabinet and removed R1's medication storage container from the cabinet. ULP-B prepared the medication and administered medication to R1 without removing the gloves or performing hand hygiene between residents. ULP-B failed to remove gloves or wash hands before administering medication to the next resident. On October 22, 2025, at 9:52 a.m., ULP-B stated that he usually changes gloves and performs hand hygiene between residents, however R1 was rushing him at the time so he forgot to wash his hands. During interview on October 23, 2025, at 12:30 p.m., clinical nurse supervisor (CNS)-A stated all staff were trained on proper hand hygiene, and staff were to wash hands or use hand sanitizer after the removal of gloves and in between resident cares. Also, CNS-A stated that she	0 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34713	A. BUILDING: _____ B. WING _____	10/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST CHOICE HOME CARE LLC	821 20TH AVENUE NE MINNEAPOLIS, MN 55418

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 510	Continued From page 5 would retrain staff. The licensee's Infection Control policy dated April 22, 2022, indicated hands should be washed at the following times: before assisting with medications, and before and after treatments. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 650 SS=F	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.	0 650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34713	A. BUILDING: _____ B. WING _____	10/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST CHOICE HOME CARE LLC	821 20TH AVENUE NE MINNEAPOLIS, MN 55418

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 650	Continued From page 6 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the employee record contained the required content to include an annual performance evaluation for two of two employees (clinical nurse supervisor (CNS)-A), unlicensed personnel (ULP)-B). 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-A CNS-A was hired on January 1, 2019, to provide direct cares for the residents of the facility. CNS-A's record lacked evidence of annual performance reviews to identify areas of improvement needed and training needs. ULP-B ULP-B was hired on March 1, 2020, to provide direct cares for the residents of the facility. ULP-B's record included a performance evaluation dated July 21, 2023, but lacked evidence of annual performance reviews for 2024 and 2025 to identify areas of improvement needed and training needs.	0 650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34713	A. BUILDING: _____ B. WING _____	10/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST CHOICE HOME CARE LLC	821 20TH AVENUE NE MINNEAPOLIS, MN 55418

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 650	Continued From page 7 During interview on October 23, 2025, at 12:30 p.m., licensed assisted living director (LALD)-C stated they were aware of the required annul performance evaluations, but they were behind on the annual performance evaluations. The licensee's Personnel Records policy dated April 22, 2022, indicated all documents were kept in the personnel record including performance reviews. 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; 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	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34713	A. BUILDING: _____ B. WING _____	10/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST CHOICE HOME CARE LLC	821 20TH AVENUE NE MINNEAPOLIS, MN 55418

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 680	Continued From page 8 available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have a written emergency preparedness plan with all the required content and failed to post an emergency preparedness plan prominently. This had the potential to affect all residents receiving services under the assisted living license, 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 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On October 21, 2025, 12:00 p.m., licensed assisted living director (LALD)-C provided an Emergency Preparedness binder containing multiple documents dated October 16, 2025. LALD-C confirmed the licensee lacked a customized emergency preparedness plan reviewed which included the following required content: - a description of the population served by the	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34713	A. BUILDING: _____ B. WING _____	10/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST CHOICE HOME CARE LLC	821 20TH AVENUE NE MINNEAPOLIS, MN 55418

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 680	Continued From page 9 licensee; - procedure for tracking staff and residents; - subsistence needs for staff and residents during emergency situation; - development of policies/procedures to address: - evacuation plan (not customized for the facility); and - a tracking system used to document locations or residents and staff. During interview on October 23, 2025, at 12:30 p.m., LALD-C stated they were aware of the requirements of emergency preparedness and they would review it to ensure the emergency preparedness plan was customized to meet the need of the residents. The licensee's Emergency Preparedness policy dated February 15, 2021, indicated the licensee would have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupted services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 775 SS=I	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee	0 775		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34713	A. BUILDING: _____ B. WING _____	10/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST CHOICE HOME CARE LLC	821 20TH AVENUE NE MINNEAPOLIS, MN 55418

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 775	Continued From page 10 failed to maintain facility in compliance with Minnesota State Fire Code under Minnesota Rules Chapter 7511. This had the potential to affect some residents, staff, and visitors. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On October 22, 2025, from approximately 11:10 a.m. to 1:45 p.m., the surveyor toured the facility with licensed assisted living director (LALD)-C, unlicensed personnel (ULP)-B and maintenance (M)-D. During the tour the surveyor observed the following: The front door of the facility had a double cylinder deadbolt lock, which required a key to unlock the door from the inside. The front door was designated as the primary egress door by LALD-C and this locking mechanism would require special knowledge, effort or tools to open. This type of lock is not permitted as it is not readily openable and may delay or obstruct egress during an emergency. M-D acknowledged that the lock must be removed and stated that it would be replaced by the following day. Egress windows in resident room 1 and resident room 2 both had screws drilled into the window frame which limited the window's ability to open	0 775		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34713	A. BUILDING: _____ B. WING _____	10/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST CHOICE HOME CARE LLC	821 20TH AVENUE NE MINNEAPOLIS, MN 55418

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 775	Continued From page 11 fully. The screws in the window assemblies limited the egress windows to a maximum openable height of 13 inches high. The screws were removed during survey by M-D. Window assemblies must be maintained free of obstruction and allow an openable area of not less than 20 inches wide, 20 inches high and at least 628 square inches. The window in resident room 2 also was also partially obstructed by the headboard of the bed. The egress window should be maintained free of obstruction. A canister of gasoline and a fueled gas-powered lawn mower were stored in the basement. These materials are flammable and should not be stored in the facility. M-D acknowledged the fire hazard of storing the materials in the basement and stated they would be moved to the garage. A significant amount of improperly discarded smoking materials was present in the yard and near the fence and rear door. There were dozens of cigarette butts laying on the ground in the backyard and in the detached garage. The garage contained cigarette butts laying throughout on the floor, shelves and on top of old boxes, trash, a mattress, and furniture. The garage contained a significant quantity of flammable materials with improperly disposed of smoking materials touching or next to them which could pose a significant fire hazard. A discarded cigarette was observed on the floor behind the headboard of resident room 3. Improperly discarded smoking materials pose a fire risk and cigarette butts should be disposed of in an approved container. A space heater was present in resident room 3. This portable space heater may pose a fire risk	0 775		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34713	A. BUILDING: _____ B. WING _____	10/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST CHOICE HOME CARE LLC	821 20TH AVENUE NE MINNEAPOLIS, MN 55418

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 775	Continued From page 12 and should not be supplied in resident rooms. A space heater was present in resident room 2. This portable space heater may pose a fire risk and should not be supplied in resident rooms. A light fixture was provided with the protective globes missing in resident room 5 and fabric was hanging directly from the exposed lightbulb to dim the room. The placement of fabric on the light bulb could pose a fire risk. The fixture should be provided with a protective globe, and the fixture should remain free of contact with flammable items. A cigarette butt was found behind the headboard of the bed in resident room 3 next to discarded items. Improper disposal of smoking materials poses fire risk and cigarettes should be properly disposed of in approved receptacles. TIME PERIOD FOR CORRECTION: Immediate	0 775		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (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;	0 780		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34713	A. BUILDING: _____ B. WING _____	10/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST CHOICE HOME CARE LLC	821 20TH AVENUE NE MINNEAPOLIS, MN 55418

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 780	Continued From page 13 (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 interconnected smoke alarms throughout the facility. 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). Findings include: On October 22, 2025, from approximately 11:10 a.m. to 1:45 p.m., the surveyor toured the facility with licensed assisted living director (LALD)-C, unlicensed personnel (ULP)-B and maintenance (M)-D. During the tour the surveyor observed the	0 780		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34713	A. BUILDING: _____ B. WING _____	10/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST CHOICE HOME CARE LLC	821 20TH AVENUE NE MINNEAPOLIS, MN 55418

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 780	Continued From page 14 following: During the tour M-D tested smoke alarms by activating alarms in the upper-level bedroom hallway. The facility had multiple smoke alarm systems with some resident rooms containing up to four different smoke alarms. Throughout the facility there were two main smoke alarms systems which did not interconnect with each other. When tested the hardwired alarms did not interconnect with supplied battery powered alarms. All supplied alarms should be interconnected such that the activation of any alarm causes all others to sound. The power supply of hard-wired alarms should be maintained. LALD-C acknowledged requirements. Smoke alarms in resident room 4, resident room 2, upper-level hallway and in basement were chirping and indicating low battery. Smoke alarms should be maintained in proper working order with power supplies properly functional. During the facility tour interview on October 22, 2025, LALD-C verified the above listed fire protection and physical environment observations while accompanying on the tour. and expressed that they would ensure interconnection and correct the deficiencies. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
0 790 SS=F	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code;	0 790		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34713	A. BUILDING: _____ B. WING _____	10/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST CHOICE HOME CARE LLC	821 20TH AVENUE NE MINNEAPOLIS, MN 55418

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 790	Continued From page 15 (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 and interview, the licensee failed to maintain the portable fire extinguishers. This deficient condition had the potential to affect all staff, residents, 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). Findings include: On October 22, 2025, from approximately 11:10 a.m. to 1:45 p.m., the surveyor toured the facility with licensed assisted living director (LALD)-C, unlicensed personnel (ULP)-B and maintenance (M)-D. During the tour the surveyor observed the following: -A fire extinguisher was provided in the basement area which had an annual service tag indicating servicing in February 2023. There was no current annual service tag or indication that the	0 790		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34713	A. BUILDING: _____ B. WING _____	10/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST CHOICE HOME CARE LLC	821 20TH AVENUE NE MINNEAPOLIS, MN 55418

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 790	Continued From page 16 extinguisher had been serviced. M-D stated that the extinguisher must have been missed and had not had a servicing that year. No records of monthly visual inspections of extinguishers were provided to the surveyor during inspection. LALD-C stated they were unaware of requirement for monthly inspections by staff. LALD-C confirmed no monthly inspections were being conducted. Staff should conduct and record monthly visual inspections of extinguishers. During the tour and interview, LALD-C acknowledged the deficiency and stated that staff would ensure regular inspections on all extinguishers. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 790		
0 800 SS=F	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	0 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34713	A. BUILDING: _____ B. WING _____	10/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST CHOICE HOME CARE LLC	821 20TH AVENUE NE MINNEAPOLIS, MN 55418

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 800	Continued From page 17 continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level 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 October 22, 2025, from approximately 11:10 a.m. to 1:45 p.m., the surveyor toured the facility with licensed assisted living director (LALD)-C, unlicensed personnel (ULP)-B and maintenance (M)-D. During the tour the surveyor observed the following: -Resident room 3 had dirt and discarded items on the floor and stains on the walls. There was trash and discarded items jammed behind the headboard of the bed. Rooms should be maintained clean and free of stains and dirt. -The door handle to resident room 3 was not properly connected to the door and was hanging loose. The door handle assembly should be repaired and maintained in proper working order. -There was a hole in the wall of resident room 3. M-D indicated the hole was caused by the doorknob hitting the wall. The wall should be maintained in proper state of repair.	0 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34713	A. BUILDING: _____ B. WING _____	10/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST CHOICE HOME CARE LLC	821 20TH AVENUE NE MINNEAPOLIS, MN 55418

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 800	Continued From page 18 -The grout around the bathtub in the upper-level bathroom was discolored and degraded. Grout should be kept in proper condition. -Light fixtures were provided with the protective globes missing in resident room 2. Globes should be added where missing and maintained. -The egress window in resident room 1 was altered to allow full opening during the tour. After alteration the window would not shut properly, and the window assembly was damaged. The window should be repaired and maintained in proper working order. -The seal around the toilet in the lower-level bathroom was degraded and not watertight. The seal should be replaced and maintained. -The rear railing was rusted and no attached properly to the building which made it wobbly and loose. Railing should be repaired or replaced and maintained. -Piles of trash and rubble were present in the backyard. M-D stated that the refuse is allowed to accumulate to make it easier for a contractor to haul the trash all in one go. The lawn should be cleaned and maintained without significant amounts of refuse and rubble. -The garage had a significant amount of trash and old furniture such as chairs, desks and a mattress that were in poor condition. Garage is open to residents and should be maintained in clean and sanitary condition to avoid harboring pest or germs. -The fence around the property was damaged	0 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34713	A. BUILDING: _____ B. WING _____	10/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST CHOICE HOME CARE LLC	821 20TH AVENUE NE MINNEAPOLIS, MN 55418

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 800	Continued From page 19 and sagging in several location along the side yard and the front corner of the house. M-D stated the fence was scheduled to be repaired. M-D and LALD-C acknowledged the noted deficiency during the tour and expressed that they would correct the deficiencies. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year.	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34713	A. BUILDING: _____ B. WING _____	10/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST CHOICE HOME CARE LLC	821 20TH AVENUE NE MINNEAPOLIS, MN 55418

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 810	Continued From page 20 (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 develop the fire safety and evacuation plan with required content. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) 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 October 22, 2025, at approximately 2:00 p.m., licensed assisted living director (LALD)-C, unlicensed personnel (ULP)-B and maintenance (M)-D provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. The licensee FSEP failed to include the following:	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34713	A. BUILDING: _____ B. WING _____	10/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST CHOICE HOME CARE LLC	821 20TH AVENUE NE MINNEAPOLIS, MN 55418

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 810	Continued From page 21 The FSEP failed to include appropriate employee actions to take during a fire or similar emergency. Provided documents were not specific to the building and contained general information on fire safety, but did not contain specific employee actions for evacuation or fire. The FSEP failed to include appropriate resident actions to take during a fire or similar emergency. LALD-C stated they were unaware of requirements for resident actions but would add them to the FSEP. The FSEP failed to identify any unique resident needs for evacuation. LALD-C stated they were unaware of requirements for identifying resident needs but would develop and maintain documentation in the future. The FSEP failed to include records of employee training on the FSEP upon hire and at least twice a year thereafter. The only record provided was for one employee on October 16, 2025. No other records were provided. All employees should be provided FSEP training at least twice a year and upon hire. Evacuation drills were provided for the facility which included drills during first and second shifts only. Evacuation drills should be conducted for employees at least once every other month and at least twice per shift per year. LALD-C confirmed that no drills were performed during third shift. During an interview on September 30, 2025, at approximately 2:30 p.m., the surveyor explained the requirements for site specific policies and FSEP documentation. LALD-C stated they	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34713	A. BUILDING: _____ B. WING _____	10/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST CHOICE HOME CARE LLC	821 20TH AVENUE NE MINNEAPOLIS, MN 55418

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 810	Continued From page 22 understood the requirements. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 830 SS=F	144G.45 Subd. 3 Local laws apply Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements, except a facility with a licensed resident capacity of six or fewer is exempt from rental licensing regulations imposed by any town, municipality, or county. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to follow applicable state and local laws, regulations, standards, ordinances, and codes related to smoking for one of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	0 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34713	A. BUILDING: _____ B. WING _____	10/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST CHOICE HOME CARE LLC	821 20TH AVENUE NE MINNEAPOLIS, MN 55418

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 830	Continued From page 23 On October 22, 2025, at 11:00 a.m., the surveyor and licensed assisted living director (LALD)-C observed a cigarette butt floating in a bottle of water placed on the stairs to the basement. LALD-C stated she wasn't sure whether a resident or staff member had placed the bottle, and they would need to review the cameras to investigate. On October 22, 2025, at 11:45 a.m., the engineering surveyor and nurse surveyor observed an empty Newport cigarette carton, and lighter on the table next to the bed in room 5, and a cigarette butt in an ashtray. Also, the surveyors observed a lighter on the window and a glass hand pipe in room 2. On October 22, 2025, at 12:30 p.m., an unidentified resident stated he knows that he was not supposed to smoke in his room, but he did sometimes. The resident stated he knew where the designated smoking area was located. On October 22, 2025, at 1:00 p.m., unlicensed personnel (ULP)-B stated they encouraged the residents to smoke outside in the designated smoking area. R1 admitted to the facility on May 5, 2019. R1's diagnoses included schizoaffective disorder. R1's Service Plan (Waiver) dated December 1, 2024, indicated R1 received the following services: medication administration, activity assistance, manage behavior, grooming, appointment reminder, and housekeeping. R1's 90 days Assessment (Nursing) dated July	0 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34713	A. BUILDING: _____ B. WING _____	10/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST CHOICE HOME CARE LLC	821 20TH AVENUE NE MINNEAPOLIS, MN 55418

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 830	Continued From page 24 29, 2025, indicated the resident was a current smoker and assessment noted the following: - resident goes outside to smoke daily and he smoked about 12 cigarettes; - smoking materials stored in his room; - resident was aware of the designated smoking areas; - no signs in the apartment of mishandled cigarettes such as burns in carpet or furniture; - no signs of burning on the resident's clothing; and - no concern with smoking at this time. Resident was an independent smoker. R2 admitted to the facility on July 13, 2023. R2's diagnoses included schizoaffective disorder. R2's Service Plan (Waiver) dated May 1, 2025, indicated R2 received the following services: medication administration, manage behavior, appointment reminder, and housekeeping. R2's Clinical Update Assessment (Nursing) dated September 17, 2025, indicated the resident was a current smoker and assessment noted the following: - smoking materials stored in his room; - resident was aware of the designated smoking areas; - no signs in the apartment of mishandled cigarettes such as burns in carpet or furniture; - no signs of burning on the resident's clothing; and - resident able to smoke safely, independently, without intervention. During interview on October 23, 2025, at 12:30 p.m., clinical nurse supervisor (CNS)-A stated	0 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34713	A. BUILDING: _____ B. WING _____	10/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST CHOICE HOME CARE LLC	821 20TH AVENUE NE MINNEAPOLIS, MN 55418

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 830	Continued From page 25 residents were not allowed to smoke in the facility and there was a designated smoking area with a proper cigarette butt disposal container. Also, LALD-C stated the residents have mental health diagnoses and sometimes it was challenging, but they would continue to remind residents to smoke at the designated areas. The Minnesota Clean Indoor Air Act (MCIAA) indicated, "The Freedom to Breathe (FTB) provisions amended the Minnesota Clean Indoor Air Act (MCIAA) further protect employees and the public from the health hazards of secondhand smoke. These provisions went into effect on October 1, 2007. In 2019, the MCIAA was amended again to expand the definition of smoking to include vaping, the use of electronic delivery devices (also known as e-cigarettes or vapes). The amendment is effective on August 1, 2019. On August 1, 2023, adult-use cannabis was legalized in Minnesota. Vaping and smoking cannabis products is included in the definition of smoking under the MCIAA. Minnesota's cannabis law and local ordinances have additional requirements regarding the use of these products in the indoor environment. For more information, please contact the Office of Cannabis Management." The MCIAA defines smoking as inhaling, exhaling, burning, or carrying any lighted or heated cigar, cigarette, pipe or any other lighted or heated product containing, made or derived from nicotine, tobacco, marijuana, or other plant intended for inhalation. As of August 1, 2019, this definition includes carrying or using an activated electronic delivery device. The licensee's smoking policy, undated, indicated "smoking is prohibited inside the group home building, including bathrooms, office, and all	0 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34713	A. BUILDING: _____ B. WING _____	10/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST CHOICE HOME CARE LLC	821 20TH AVENUE NE MINNEAPOLIS, MN 55418

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 830	Continued From page 26 common areas. A designated outdoor smoking area will be provided." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 830		
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure background studies were conducted prior to staff providing services for one of one employee (maintenance (M)-D). This had the potential to affect all residents currently receiving services. This practice resulted in a level three violation (a violation that harmed a resident's health or	01290	During the survey, the licensee took action to mitigate the immediate risk for tag identification 1290. However, noncompliance remained, and the scope and level remain unchanged.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34713	A. BUILDING: _____ B. WING _____	10/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST CHOICE HOME CARE LLC	821 20TH AVENUE NE MINNEAPOLIS, MN 55418

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01290	Continued From page 27 safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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 October 22, 2025, from 11:10 a.m. to 1:45 p.m., the surveyor observed M-D toured the facility with the engineering surveyor and entered residents' rooms. M-D began working for the licensee in 2021 to assist with maintenance work and handyman tasks. On October 23, 2025, at 10:52 a.m., a Minnesota Department of Human Services (DHS) NETStudy 2.0 screenshot indicated M-D has never had a background study submitted in the DHS NETStudy 2.0 system by the licensee. M-D's employee record lacked evidence a DHS NETStudy 2.0 background study had been completed prior to M-D working for the licensee and having access to the licensee's residents. On October 22, 2025, at 3:00 p.m., licensed assisted living director (LALD)-C stated M-D had been working with the licensee since 2021,and M-D worked independently while onsite. Also, LALD-C stated, "I sent him to do the background study this year, but it hasn't come back yet, I am not sure if he completed fingerprint process or not, I will have to check.". On October 22, 2025, at 3:27 p.m., LALD-C stated M-D was not an employee or a contractor. LALD-C stated the licensee has a separate	01290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34713	A. BUILDING: _____ B. WING _____	10/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST CHOICE HOME CARE LLC	821 20TH AVENUE NE MINNEAPOLIS, MN 55418

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01290	Continued From page 28 contractor that performed contractor duties for the licensee. LALD-C stated M-D performed only handyman type duties for the licensee. The licensee's 4.02 Background Studies policy dated August 1, 2021, indicated "No employee may provide direct services and have independent direct contact with any residents until acceptable result of the background study have been received.". No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01290		
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;	01500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34713	A. BUILDING: _____ B. WING _____	10/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST CHOICE HOME CARE LLC	821 20TH AVENUE NE MINNEAPOLIS, MN 55418

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01500	Continued From page 29 (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received at least eight hours of annual training for each 12	01500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34713	A. BUILDING: _____ B. WING _____	10/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST CHOICE HOME CARE LLC	821 20TH AVENUE NE MINNEAPOLIS, MN 55418

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01500	Continued From page 30 months of employment for two of two employees (clinical nurse supervisor (CNS)-A), unlicensed personnel (ULP)-B). 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-A was hired on January 1, 2019, to provide direct cares for the residents of the facility. ULP-B was hired on March 1, 2020, to provide direct cares for the residents of the facility. CNS-A and ULP-B's employee training records lacked evidence CNS-A and ULP-B had successfully completed annual training as required in the following areas: -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 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;	01500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34713	A. BUILDING: _____ B. WING _____	10/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST CHOICE HOME CARE LLC	821 20TH AVENUE NE MINNEAPOLIS, MN 55418

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01500	Continued From page 31 disinfecting environmental surfaces; and reporting 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; and -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. During interview on October 23, 2023, at 12:30 p.m., licensed assisted living director (LALD)-C stated they were aware of the required annual training. CNS-A stated they previously had a nurse consultant who was responsible for maintaining the employee personal files, however the nurse was no longer with the organization. Also, LALD-C stated they had a plan to audit all employee files to ensure all required trainings completed. The licensee's 5.06 Annual Required Staff Training policy dated January 3, 2025, indicated, "All staff that perform direct care services at [licensee] will complete at least eight (8) hours of annual training for each 12 months of employment." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34713	A. BUILDING: _____ B. WING _____	10/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST CHOICE HOME CARE LLC	821 20TH AVENUE NE MINNEAPOLIS, MN 55418

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01530	Continued From page 32	01530		
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 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	01530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34713	A. BUILDING: _____ B. WING _____	10/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST CHOICE HOME CARE LLC	821 20TH AVENUE NE MINNEAPOLIS, MN 55418

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01530	Continued From page 33 and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure direct care staff received the required two hours of initial training on mental illness and de-escalation topics for two of two employees (clinical nurse supervisor (CNS-A), unlicensed personnel (ULP)-B). This had the potential to affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: CNS-A CNS-A was hired January 1, 2019, and provided supervision of staff and provided direct care services to the residents. CNS-A's records lacked documentation CNS-A completed the required two hours of initial training on mental illness and de-escalation topics which became effective July 1, 2025.	01530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34713	A. BUILDING: _____ B. WING _____	10/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST CHOICE HOME CARE LLC	821 20TH AVENUE NE MINNEAPOLIS, MN 55418

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01530	Continued From page 34 ULP-B ULP-B was hired March 1, 2020, to provide direct care services to the residents of the facility. ULP-B's records lacked documentation ULP-B completed the required two hours of initial training on mental illness and de-escalation topics which became effective July 1, 2025. During interview on October 23, 2025, at 12:30 p.m., licensed assisted living director (LALD)-C acknowledged ULP-B and CNS-A's records were missing documentation of the required two hours of initial training on mental illness and de-escalation topics which became effective July 1, 2025. Also, LALD-C stated they were not aware of training and planned to ensure that all staff completed the training. The licensee's 5.03 Dementia Training policy dated August 1, 2021, indicated direct care staff and supervisors must satisfy eight hours of initial training for dementia, however, the policy did not include two hours of mental health and de-escalation training to be completed by July 1, 2025. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		

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

BEST CHOICE HOME CARE LLC
821 20TH AVENUE NE
Minneapolis, MN 55418
Hennepin County
Parcel:

Phone:

License Info

License: HFID 34713

Risk:
License:
Expires on:
CFPM: ALIA ABDI NAMUS
CFPM #: 109074; Exp: 10/5/2027

Inspection Info

Report Number: F1029251238
Inspection Type: Full - Single
Date: 10/21/2025 Time: 10:15:48 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 1
Total Priority 2 Orders: 3
Total Priority 3 Orders: 6
Delivery:

New Order: 3-300C Protection from Contamination: equipment/utensils, consumers
3-307.11 *Priority Level: Priority 3 CFP#: 39*
MN Rule 4626.0337 Protect food from miscellaneous sources of contamination.
COMMENT: PAINT FLECKING OFF HOOD OVER RANGE BURNERS. REPAIR OR REPLACE.
Comply By: 10/24/2025 Originally Issued On: 10/21/2025

! **New Order: 3-500B Microbial Control: hot and cold holding**
3-501.16A2 *Priority Level: Priority 1 CFP#: 22*
MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.
COMMENT: OPENED JAR OF SALSA IN CABINET. STAFF INDICATED A CLIENT PLACED THE SALSA IN THE CABINET. ENSURE TCS ITEMS ARE HELD UNDER MECHANICAL REFRIGERATION AND ITEMS INVOLVED IN THE FOOD AND BEVERAGE SERVICE ARE MONITORED BY THE PERSON IN CHARGE TO PREVENT FOODBORNE ILLNESS RISK FACTORS.
Comply By: 10/21/2025 Originally Issued On: 10/21/2025

New Order: 3-500C Microbial Control: date marking
3-501.17B *Priority Level: Priority 2 CFP#: 23*
MN Rule 4626.0400B Mark the refrigerated, ready-to-eat, TCS food prepared and packaged in a processing plant and opened and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded. The date must not exceed the manufacturer's use-by-date.
COMMENT: OPENED SHREDDED CHEESE WITHOUT DATE MARK. ITEM KNOWN TO BE WITHIN 7 DAY USE WINDOW. DATE MARK REQUIRED ITEMS AND DISCARD AFTER 7 DAYS.
Comply By: 10/21/2025 Originally Issued On: 10/21/2025

New Order: 4-100 Equipment Construction Materials
4-101.18 *Priority Level: Priority 3 CFP#: 47*
MN Rule 4626.0493 Discontinue using cleaning aids or utensils that can scratch or scour the nonstick coating of pots, pans, griddles, cookie sheets, waffle makers and other cookware.
COMMENT: NONSTICK COOKING VESSELS WITH NONSTICK COATING MISSING IN AREAS. REMOVE FROM USE AND ONLY USE CLEANING AND COOKING ITEMS ON NONSTICK COOKWARE THAT WILL NOT SCRAPE OFF NONSTICK COATING.
Comply By: 10/21/2025 Originally Issued On: 10/21/2025

New Order: 4-100 Equipment Construction Materials
4-101.19 *Priority Level: Priority 3 CFP#: 47*
MN Rule 4626.0495 Remove non-food-contact surfaces of equipment that are exposed to splash, spillage, or other food soiling, or that require frequent cleaning, that are not constructed of a corrosion-resistant, non-absorbent, and smooth material.
COMMENT: DRAWERS AND CABINETRY WITH LAMINATE MISSING ON WOOD/MDF IN AREAS. REPAIR OR REPLACE TO MAKE NON-ABSORBENT AND EASILY CLEANABLE. STAFF NOTED THAT THE KITCHEN WAS UNDERGOING AN FULL REMODEL WITHIN THE NEXT FEW DAYS AND ALL OF THE DRAWERS AND CABINETRY WOULD BE REPLACED.
Comply By: 10/24/2025 Originally Issued On: 10/21/2025

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 MIN/MAX THERMOMETER OR THERMAL STICKERS. PROVIDE MEANS OF VERIFYING DISHWASHER SANITZING TEMPERATURES.
Comply By: 10/24/2025 Originally Issued On: 10/21/2025

New Order: 4-600 Cleaning Equipment and Utensils
4-603.12 *Priority Level: Priority 3 CFP#: 48*
MN Rule 4626.0865 Flush, scrape, scrub, or soak utensils and equipment to remove food debris before washing.
COMMENT: RESIDUE ON UTENSILS IN DRAWER. ENSURE EQUIPMENT AND UTENSILS ARE EFFECTIVELY CLEANED PRIOR TO SANITIZING AND PROTECTED FROM CONTAMINATION AFTER STORAGE.
Comply By: 10/21/2025 Originally Issued On: 10/21/2025

New Order: 6-300 Physical Facility Numbers and Capacities
6-301.14A *Priority Level: Priority 3 CFP#: 10*
MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands.
COMMENT: NO HANDWASHING SIGN IN TOILET ROOM. ENSURE HANDWASHING SIGNS ARE AT ALL SINKS WHERE STAFF WASH THEIR HANDS. HANDWASHING SIGN PROVIDED TO ESTABLISHMENT DURING INSPECTION.
Comply By: 10/21/2025 Originally Issued On: 10/21/2025

New Order: 6-500 Physical Facility Maintenance/Operation and Pest Control
6-501.111C *Priority Level: Priority 2 CFP#: 38*
MN Rule 4626.1565C Use approved trapping devices or other means of pest control when pests are found.
COMMENT: RODENT DROPPINGS IN LOWER CABINETS AND UNDER SINK. REMOVE AND DISINFECT. INCREASE PEST CONTROL MEASURES TO REDUCE AND ELIMINATE PEST POPULATION.
Comply By: 10/21/2025 Originally Issued On: 10/21/2025

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: DEBRIS AND FOOD RESIDUES IN DRAWERS AND CABINETRY. CLEAN AND MAINTAIN CLEAN.
Comply By: 10/21/2025 Originally Issued On: 10/21/2025

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 F1029251238 from 10/21/2025

Trevor McCliment

ALIA NAMUS
PERSON IN CHARGE

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

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

Temperature Observations/Recordings

Establishment Info

BEST CHOICE HOME CARE LLC
Minneapolis
County/Group: Hennepin County

Inspection Info

Report Number: F1029251238
Inspection Type: Full
Date: 10/21/2025
Time: 10:15:48 AM

New Record: **Product/Item/Unit:** SALSA**; Temperature Process:** Ambient Air
Location: CABINET at 69 Degrees F.
Comment:
Violation Issued?: Yes

New Record: **Product/Item/Unit:** NACHO CHEESE**; Temperature Process:** Cold-Holding
Location: REFRIGERATOR DOOR at 38 Degrees F.
Comment:
Violation Issued?: No

New Record: **Product/Item/Unit:** MILK**; Temperature Process:** Cold-Holding
Location: REFRIGERATOR CAVITY at 33 Degrees F.
Comment:
Violation Issued?: No

New Record: **Product/Item/Unit:** INTERNAL THERMOMETER**; Temperature Process:** Cold-Holding
Location: REFRIGERATOR at 35 Degrees F.
Comment:
Violation Issued?: No

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

Sanitizer Observations/Recordings

Establishment Info

BEST CHOICE HOME CARE LLC
Minneapolis
County/Group: Hennepin County

Inspection Info

Report Number: F1029251238
Inspection Type: Full
Date: 10/21/2025
Time: 10:15:48 AM

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Greater Than 150 Degrees F.
Comment:
Violation Issued?: No