



# STATE LICENSING COMPLIANCE REPORT

**Report #:** HL370132872C

**Date Concluded:** February 26, 2025

**Name, Address, and County of Facility**

**Investigated:**

New Life Care LLC  
4913 Winchester Lane North  
Brooklyn Center, Minnesota 55429  
Hennepin County

**Facility Type:** Assisted Living Facility (ALF)

**Evaluator's Name:** Nicole Myslicki, RN  
Special Investigator

The Minnesota Department of Health conducted a complaint investigation to determine compliance with state laws and rules governing the provision of care under Minnesota Statutes, Chapter 144G. The purpose of this complaint investigation was to review if facility policies and practices comply with applicable laws and rules. No maltreatment under Minnesota Statutes, Chapter 626 was alleged.

To view a copy of the correction orders, if any, please visit:

<https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html>, or call 651-201-4201 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached state form.

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>37013</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>02/20/2025</b>
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NAME OF PROVIDER OR SUPPLIER  <b>NEW LIFE CARE LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4913 WINCHESTER LANE NORTH BROOKLYN CENTER, MN 55429</b>
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0 000	<p><b>Initial Comments</b></p> <p>*****ATTENTION*****</p> <p><b>ASSISTED LIVING PROVIDER CORRECTION ORDER</b></p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation.</p> <p>Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance.</p> <p><b>INITIAL COMMENTS:</b></p> <p><b>#HL370132872C</b></p> <p>On February 20, 2025, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 3 residents receiving services under the provider's Assisted Living license.</p> <p>The following correction orders are issued for <b>#HL370132872C</b>, tag identification 0990, 1040, 1070.</p>	0 000	<p>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.</p> <p><b>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.</b></p> <p><b>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</b></p> <p><b>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.</b></p>	
0 990 SS=D	<b>144G.52 Subd. 2 Prerequisite to termination of a contract</b>	0 990		

Minnesota Department of Health  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

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0 990	<p>Continued From page 1</p> <p>(a) Before issuing a notice of termination of an assisted living contract, a facility must schedule and participate in a meeting with the resident and the resident's legal representative and designated representative. The purposes of the meeting are to:</p> <p>(1) explain in detail the reasons for the proposed termination; and</p> <p>(2) identify and offer reasonable accommodations or modifications, interventions, or alternatives to avoid the termination or enable the resident to remain in the facility, including but not limited to securing services from another provider of the resident's choosing that may allow the resident to avoid the termination. A facility is not required to offer accommodations, modifications, interventions, or alternatives that fundamentally alter the nature of the operation of the facility.</p> <p>(b) The meeting must be scheduled to take place at least seven days before a notice of termination is issued. The facility must make reasonable efforts to ensure that the resident, legal representative, and designated representative are able to attend the meeting.</p> <p>(c) The facility must notify the resident that the resident may invite family members, relevant health professionals, a representative of the Office of Ombudsman for Long-Term Care, a representative of the Office of Ombudsman for Mental Health and Developmental Disabilities, or other persons of the resident's choosing to participate in the meeting. For residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the facility must notify the resident's case manager of the meeting.</p> <p>(d) In the event of an emergency relocation under subdivision 9, where the facility intends to issue a notice of termination and an in-person meeting is</p>	0 990		

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0 990	<p>Continued From page 2</p> <p>impractical or impossible, the facility must use telephone, video, or other electronic means to conduct and participate in the meeting required under this subdivision and rules within Minnesota Rules, chapter 4659.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to identify and offer reasonable accommodations or modifications, interventions, or alternatives to avoid termination for one of one residents (R1) reviewed. Additionally, the licensee failed to schedule the pre-termination meeting at least seven days before issuing a notice of termination.</p> <p>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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).</p> <p>The findings include:</p> <p>R1 admitted to the licensee September 9, 2024. R1's diagnoses included post-traumatic stress disorder (PTSD) and anxiety. R1's planned services dated February 20, 2025, included assistance with medication administration and managing behaviors such as agitation, anxiety, and aggression.</p> <p>R1's Resident Contract for Assisted Living signed September 10, 2024, indicated the licensee may terminate the agreement by providing at least thirty (30) days' advanced written notice for not</p>	0 990		

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0 990	<p>Continued From page 3</p> <p>timely paying fees owed, or for failing to comply with any terms or conditions of the agreement. The contact did not address the requirements regarding a pre-termination meeting.</p> <p>R1's progress note dated November 21, 2024, at 7:27 p.m., indicated the licensee held a pre-termination meeting. The note indicated R1, R1's case managers, and a staff member met and agreed R1 would be relocated in two weeks to 30 days, moving out on or before December 21, 2024. The note did not identify any accommodations, modifications, interventions, or alternatives to avoid termination.</p> <p>R1's Pre-Termination Meeting Written Notice dated November 18, 2024, printed December 11, 2024, and signed by licensed assisted living director (LALD)-A November 21, 2024, did not identify any accommodations, modifications, interventions, or alternatives to avoid termination.</p> <p>R1's discharge care plan dated December 11, 2024, indicated the licensee terminated R1 due to physical aggression toward staff.</p> <p>During an interview February 21, 2025, at 1:37 p.m., LALD-A stated R1 did not want to remedy the situation. LALD-A stated they asked R1 to pay his rent and do everything they asked him to do, but he never said he would abide, pay, or make arrangements. LALD-A stated he gave R1 his 30 day notice at the pre-termination meeting.</p> <p>The licensee did not have a policy addressing this requirement under Minnesota Statute 144G.</p> <p>TIME PERIOD OF CORRECTION: Twenty-one (21) days</p>	0 990		

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01040	Continued From page 4	01040		
01040 SS=D	<p><b>144G.52 Subd. 7 Notice of contract termination required</b></p> <p>(a) A facility terminating a contract must issue a written notice of termination according to this section. The facility must also send a copy of the termination notice to the Office of Ombudsman for Long-Term Care and, for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, to the resident's case manager, as soon as practicable after providing notice to the resident. A facility may terminate an assisted living contract only as permitted under subdivisions 3, 4, and 5.</p> <p>(b) A facility terminating a contract under subdivision 3 or 4 must provide a written termination notice at least 30 days before the effective date of the termination to the resident, legal representative, and designated representative.</p> <p>(c) A facility terminating a contract under subdivision 5 must provide a written termination notice at least 15 days before the effective date of the termination to the resident, legal representative, and designated representative.</p> <p>(d) If a resident moves out of a facility or cancels services received from the facility, nothing in this section prohibits a facility from enforcing against the resident any notice periods with which the resident must comply under the assisted living contract.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to issue a written notice of termination to one of one residents (R1) reviewed, Ombudsman for Long-Term Care, and</p>	01040		

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01040	<p>Continued From page 5</p> <p>case manager.</p> <p>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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).</p> <p>The findings include:</p> <p>R1 admitted to the licensee September 9, 2024. R1's diagnoses included post-traumatic stress disorder (PTSD) and anxiety. R1's planned services dated February 20, 2025, included assistance with medication administration and managing behaviors such as agitation, anxiety, and aggression.</p> <p>R1's Resident Contract for Assisted Living, signed September 10, 2024, indicated the licensee may terminate the agreement by providing at least thirty (30) days' advanced written notice for not timely paying fees owed, or for failing to comply with any terms or conditions of the agreement.</p> <p>R1's progress note dated November 21, 2024, at 7:27 p.m., indicated the licensee held a pre-termination meeting. The note indicated R1, R1's case managers, and a staff member met and agreed R1 would be relocated in two weeks to 30 days, moving out on or before December 21, 2024. The note did not identify any accommodations, modifications, interventions, or alternatives to avoid termination.</p> <p>R1's record lacked a written termination notice</p>	01040		

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01040	<p>Continued From page 6</p> <p>and lacked documentation a copy of the written termination notice was provided to R1, R1's case manager and the Ombudsman.</p> <p>R1's discharge care plan dated December 11, 2024, indicated the licensee terminated R1 due to physical aggression toward staff.</p> <p>During an interview on February 21, 2025, at 1:37 p.m., licensed assisted living director (LALD)-A stated the licensee did not provide a copy of the written notice of termination to the Ombudsman for Long-Term Care, and he did not know if he provided it to R1's case managers. LALD-A the case managers knew what happened in the meeting, and everyone knew the termination date. LALD-A stated they wrote the termination notice, but R1 never wanted to sign or accept any documentation from the licensee.</p> <p>The licensee failed to provide documentation of a written notice of termination.</p> <p>The licensee did not have a policy addressing this requirement under Minnesota Statute 144G.</p> <p>TIME PERIOD OF CORRECTION: Twenty-one (21) days</p>	01040		
01070 SS=D	<p>144G.52 Subd. 10 Right to return</p> <p>If a resident is absent from a facility for any reason, including an emergency relocation, the facility shall not refuse to allow a resident to return if a termination of housing has not been effectuated.</p> <p>This MN Requirement is not met as evidenced by:</p>	01070		

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01070	<p>Continued From page 7</p> <p>Based on interview and record review, the licensee failed to allow one of one residents (R1) to return to the facility after a hospitalization.</p> <p>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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).</p> <p>The findings include:</p> <p>R1 admitted to the licensee September 9, 2024. R1's diagnoses included post-traumatic stress disorder (PTSD) and anxiety. R1's planned services dated February 20, 2025, included assistance with medication administration and managing behaviors such as agitation, anxiety, and aggression.</p> <p>R1's Resident Contract for Assisted Living signed September 10, 2024, indicated a resident may be removed from the premises in an emergency if needed to meet urgent medical needs or if the resident posed an imminent risk to the health or safety of another resident or a staff member. The contract indicated emergency relocation did not constitute a termination of the agreement.</p> <p>An incident report dated December 8, 2024, at 3:35 p.m., indicated R1 pushed a staff member. The staff member called 911, and R1 transferred to a mental health hospital for further evaluation.</p> <p>A progress note dated December 10, 2024, at 6:13 p.m., indicated R1 had been at a mental health hospital following the incident with a staff</p>	01070		

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01070	<p>Continued From page 8</p> <p>member. The registered nurse (RN) had not been informed of R1's discharge from the hospital. R1 returned to the licensee and forcefully opened the facility door and went into his room. The licensed assisted living director (LALD) attempted to explain to R1 he no longer lived at the licensee. Then the LALD called 911 and discussed the situation with law enforcement and R1. R1 left the licensee, taking some of his belongings and medications.</p> <p>R1's discharge care plan dated December 11, 2024, indicated the licensee terminated R1 due to physical aggression toward staff.</p> <p>R1's medical record included a progress note dated December 18, 2024, at 3:44 p.m., which indicated R1 pushed a staff member. Staff called 911, and emergency medical services (EMS) took R1 to a hospital. A nurse from the hospital called to request R1 return. LALD-A informed the nurse R1 could not return.</p> <p>During an interview on February 21, 2025, at 1:37 p.m., LALD-A stated before being taken to the hospital after pushing a staff member, the licensee notified R1 they were discharging him.</p> <p>The licensee did not have a policy addressing this requirement under Minnesota Statute 144G.</p> <p>TIME PERIOD OF CORRECTION: Seven (7) days</p>	01070		