STATE LICENSING COMPLIANCE REPORT

Report #: HL403945440C

Date Concluded: May 18, 2026

Name, Address, and County of Facility Investigated:
Nedka Care LLC
4856 Flag Avenue N.
New Hope, MN 55428
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Yolanda Dawson, 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40394	A. BUILDING: _____ B. WING _____	C 04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEDKA CARE LLC	4856 FLAG AVENUE NORTH NEW HOPE, MN 55428

(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 CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. 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. INITIAL COMMENTS: #HL403945440C On April 9, 2026, 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 2 residents receiving services under the provider's Assisted Living license. The following correction orders are issued for #HL403945440C, tag identification. 0110, 0330, 0470, 0650, 0660, 1430, 1460.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 110 SS=F	144G.10 Subdivision 1a Assisted living director license required	0 110		

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0 110	Continued From page 1 Each assisted living facility must employ an assisted living director who is licensed or permitted by the Board of Executives for Long Term Services and Supports and affiliated as the director of record with the board. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to ensure employment of a licensed assisted living director (LALD), licensed by the Board of Executives for Long Term Services and Supports (BELTSS). 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 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee held an Assisted Living Facility license effective on January 30, 2026. A complaint investigation was initiated on April 9, 2026 at the licensee's facility. The licensee did not have an LALD working at the facility at the time of the complaint investigation. On April 9, 2026, at 11:23 a.m., the owner/registered nurse (O)-A/RN was interviewed	0 110		

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0 110	Continued From page 2 and confirmed she did not currently employ a licensed assisted living director (LALD). O-A/RN stated she took the LALD certification exam but did not pass the LALD certification in December 2025. O-A stated she had previously employed LALD-B to serve as the LALD for the facility but LALD-B informed her two weeks ago that he no longer worked for her. O-A/RN stated the facility had hired LALD-B one year ago but did not have an employee file for him. O-A stated she had been looking for a replacement from the time LALD-B gave his notice to the present. On April 13, 2026, at 3:59p.m., LALD-B was interviewed and stated he was approached by O-A/RN regarding the LALD position in February 2025. LALD-B stated that while O-A/RN was checking BELTSS to verify his licensure, he decided he did not want the position. LALD-B stated he never accepted the position, had never been an employee of the facility, was never on the payroll, and had never been inside the facility. He stated he did not give her permission to use his name to obtain her license. LALD-B stated he did have his LALD license, but was never employed in this position at this facility. On April 30, 2026, at 1:06 p.m., a previous house manager/unlicensed personnel (ULP)-D from the facility stated he went into business with O-A/RN in January 2025. ULP-D stated he invested money, brought in the clients, and built up the facility, and when they started making money, O-A kicked him out of the business. When he went to the facility to talk with O-A/RN, she called the police and had him trespassed. ULP-D stated he referred LALD-B to be the facility's LALD in January of 2025. LALD-B wanted $2000 every two weeks for pay and O-A/RN said it was too much so LALD-B said he would work for $2000 a	0 110		

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0 110	Continued From page 3 month and she agreed but would not sign a contract with him. ULP-D stated LALD-B never worked at the facility because O-A/RN would not sign a contract. ULP-D stated O-A/RN utilized LALD-B's application information to apply for the facility license. ULP-D called LALD-B and informed him of what O-A/RN was doing. On May 1, 2026, at 11:25 p.m., the Minnesota Board of Executives for Long Term Services and Supports (BELTSS) website indicated O-A/RN did not hold a LALD license. LALD-B did have a license effective December 9, 2021, with an expiration date of October 31, 2026, however this license was not associated with the facility. No LALD was recorded with BELTSS as director of record for the licensee. On May 18, 2026, the Minnesota Department of Human Services (DHS) Background Net Study website identified LALD-B did not have a background study affiliated to the licensee. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
0 330 SS=F	144G.30 Subd. 4 Information provided by facility (a) The assisted living facility shall provide accurate and truthful information to the department during a survey, investigation, or other licensing activities. (b) Upon request of a surveyor, assisted living facilities shall within a reasonable period of time provide a list of current and past residents and their legal representatives and designated representatives that includes addresses and	0 330		

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0 330	Continued From page 4 telephone numbers and any other information requested about the services to residents. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide the Minnesota Department of Health (MDH) with accurate and truthful information during an investigation and other licensing activities. This had the potential to affect all residents of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: A complaint investigation was initiated on April 9, 2026. At the time of the complaint investigation, the facility did not employe a licensed assisted living director (LALD). On April 9, 2026, at 11:23 a.m., the owner/registered nurse (O)-A/RN confirmed no LALD was employed at the facility. O-A/RN stated licensed assisted living director (LALD)-B informed her two weeks ago that he no longer worked for her. O-A/RN stated she had hired LALD-B one year ago in January 2025.	0 330		

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0 330	Continued From page 5 On April 9, 2026, LALD-B's employee file was requested but not provided. O-A stated that she could not find it and thought he may have taken it with him when he quit. On April 13, 2026, at 3:59p.m., LALD-B was interviewed and stated he was approached by O-A/RN regarding the LALD position in February 2025. LALD-B stated that while O-A/RN was checking BELTSS to verify his licensure, he decided he did not want the position. LALD-B stated he never accepted the position, had never been an employee of the facility, was never on the payroll, and had never been inside the facility. He stated he did not give O-A/RN permission to use his name to obtain her license. LALD-B stated he did have hold LALD licensure, however was not employed in this position by the facility. On April 30, 2026, at 1:06 p.m., a previous house manager/unlicensed personnel (ULP)-D stated he went into business with O-A/RN in January 2025. ULP-D stated he referred LALD-B to be the facility's LALD in January of 2025. ULP-D stated LALD-B never worked at the facility because O-A would not sign a contract with him. ULP-D stated O-A/RN utilized LALD-B's application information to apply for the facility licensE so ULP-D called LALD-B and informed him of O-A/RN's actions. A review of the licensee's application for renewal completed by O-A/RN on January 10, 2025 listed LALD-B as the current LALD. O-A/RN signed and attested that the information submitted was true, correct, and complete and would notify MDH in writing of any changes in information as required. A review of the licensee's application for licensure renewal completed by O-A/RN on January 5, 2026 identified LALD-B as the director of record.	0 330		

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0 330	Continued From page 6 O-A/RN signed and attested that the information submitted was true, correct, and complete and would notify MDH in writing of any changes in information as required. On May 1, 2026, at 11:25 p.m., the Minnesota Board of Executives for Long Term Supports and Services (BELTSS) website indicated O-A/RN did not hold LALD licensure. No director of record was associated with the facility. LALD-B did hold an active LALD license effective December 9, 2021, with an expiration date of October 31, 2026, however this license was not associated with the facility. On May 18, 2026, the Minnesota Department of Human Services (DHS) Background Net Study website identified LALD-B did not have a background study affiliated to the licensee. 144G.30 Subd 4 The assisted living facility shall provide accurate and truthful information to the department during a survey, investigation, or other licensing activities. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 330		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable	0 470		

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0 470	Continued From page 7 unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a staffing plan was developed and implemented to determining its staffing level that includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that	0 470		

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0 470	Continued From page 8 has affected or has the potential to affect a large portion or all of the residents). The findings include: A complaint investigation was initiated on April 9, 2026. On April 9, 2026, at 8:30 a.m., upon entry to facility it was observed that there was not a staffing schedule posted. Two residents resided at the facility at the time of the complaint investigation. On April 9, 2026, at 1:00 p.m., the owner/registered nurse (O)-A/RN was interviewed and stated there were only two residents living in the facility and three employees; herself, and two home health aides. O-A/RN stated because of this small number they do not use a staffing plan or schedule and communicated the plan verbally to eachother. A staff posting and staffing plan was requested but not provided. The licensee policy titled "Staffing and Scheduling" dated August 1, 2021, indicated the clinical nurse supervisor will develop and implement a written staffing plan that provides an adequate number of qualified direct-care staff to meet the residents' needs 24-hours a day, seven-days a week. The daily work schedule must be posted, after redacting direct-care staff members' resident assignments, at the beginning of each work shift in a central location in each building of a facility or campus, accessible to staff, residents, volunteers, and the public. The facility shall not disclose any information that is protected by law from public disclosure.	0 470		

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0 470	Continued From page 9 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included baseline TB testing for one of three employees unlicensed personnel (ULP-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 660		

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0 660	Continued From page 10 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: A complaint investigation was initiated on April 9, 2026 at the licensee's facility. Two residents resided at the facility and ULP-C was working at the time of the complaint investigation. ULP-C's employee record was requested for review. ULP-C's employee record indicated ULP-C was hired on September 23, 2025, and began providing direct care services to licensee's residents. ULP-C's employee record lacked evidence of TB clearance verification. A request was made for O-A/RN to provide ULP-C's TB clearance verification, but no verification was provided. On April 9, 2026, at 11:30 a.m., owner/registered nurse (O)-A/RN stated she had TB clearance verification for ULP-C; however, she was unable to provide the document. The licensee's policy titled "Employee Records) dated August 1, 2021, indicated for individuals providing assisted living services, verification that required health screenings for tuberculosis (TB) have taken place and the dates of those screenings. (recommended to keep medical information in a separate employee medical file).	0 660		

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0 660	Continued From page 11 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
01430 SS=D	144G.62 Subd. 3 Supervision of staff (a) Staff who only provide assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), must be supervised periodically where the services are being provided to verify that the work is being performed competently and to identify problems and solutions to address issues relating to the staff's ability to provide the services. The supervision of the unlicensed personnel must be done by staff of the facility having the authority, skills, and ability to provide the supervision of unlicensed personnel and who can implement changes as needed, and train staff. (b) Supervision includes direct observation of unlicensed personnel while the unlicensed personnel are providing the services and may also include indirect methods of gaining input such as gathering feedback from the resident. Supervisory review of staff must be provided at a frequency based on the staff person's competency and performance. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure documentation of direct supervision of unlicensed personnel (ULP) for one of three employees (ULP-C) with employee records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or	01430		

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01430	Continued From page 12 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: A complaint investigation was initiated on April 9, 2026 at the licensee's facility. Two residents resided at the facility and ULP-C was working at the time of the complaint investigation. ULP-C's employee record was requested for review. ULP-C's employee record indicated ULP-C was hired on September 23, 2025, and began providing direct care services to licensee's residents. ULP-C's employee record lacked documentation of direct supervision to verify the ULP performed competently and to identify problems and solutions to address issues relating to the staff's ability to provide the services. On April 9, 2026, at 11:30 a.m., owner/registered nurse (O)-A/RN who was employed as the facility Clinical Nurse Supervisor (CNS) confirmed the requested records did not exist for ULP-C. The licensee's Clinical Nurse Supervisor job description dated June 2021, indicated the following: Supervision of other nursing and unlicensed personnel. -Supervises, orients and competency tests	01430		

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NEDKA CARE LLC	4856 FLAG AVENUE NORTH NEW HOPE, MN 55428

(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
01430	Continued From page 13 unlicensed staff to assisted living and to each client's individual needs. -Gives input and/or helps perform annual evaluations for nursing and unlicensed personnel staff. -Supervises, disciplines, and terminates unlicensed personnel. -Coordinates staff education to include at least 8 hours of in-services per year. -Meets with staff as needed. -Provides health and medication training to all new employees as well as continued education for all staff and documents such training to assure compliance with state, federal and local regulations -Assures that staff clearly understands and follow all assisted living procedures. -Monitors compliance of monthly resident treatments as schedule. No further information was provided. TIME PERIOD FOR CORRECTION: Seven days	01430		
01460 SS=D	144G.63 Subdivision 1 Orientation of staff and supervisors (a) All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility, except as provided in paragraph (b). (b) A staff person is not required to repeat the	01460		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40394	A. BUILDING: _____ B. WING _____	C 04/09/2026

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01460	Continued From page 14 orientation required under subdivision 2 if the staff person transfers from one licensed assisted living facility to another facility operated by the same licensee or by a licensee affiliated with the same corporate organization as the licensee of the first facility, or to another facility managed by the same entity managing the first facility. The facility to which the staff person transfers must document that the staff person completed the orientation at the prior facility. The facility to which the staff person transfers must nonetheless provide the transferred staff person with supplemental orientation specific to the facility and document that the supplemental orientation was provided. The supplemental orientation must include the types of assisted living services the staff person will be providing, the facility's category of licensure, and the facility's emergency procedures. A staff person cannot transfer to an assisted living facility with dementia care without satisfying the additional training requirements under section 144G.83. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to ensure orientation, training, and competence evaluations were completed as required prior to providing direct care services for one of one unlicensed personnel (ULP-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the	01460		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01460	Continued From page 15 situation has occurred only occasionally). The findings include: A complaint investigation was initiated on April 9, 2026 at the licensee's facility. Two residents resided at the facility and ULP-C was working at the time of the complaint investigation. ULP-C's employee record was requested for review. ULP-C's employee record indicated ULP-C was hired on September 23, 2025, and began providing direct care services to licensee's residents. ULP-C's record lacked evidence of orientation to assisted living, training, and competence evaluations. Also, there was no evidence of completed online training. On April 9, 2026, at 11:30 p.m., owner/registered nurse (O)-A/RN stated she aware ULP-C's competencies had not been completed, and ULP-C was working on completing the required training. The licensee policy titled "Competency Training Evaluations" dated August 1, 2021, indicated when a registered nurse or licensed health professional staff of Nedka Care delegates tasks, prior to the delegation of services they must make certain the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each client and are able to demonstrate the ability to competently follow the procedures and perform the tasks. No further information was provided.	01460		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01460	Continued From page 16 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01460		