



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

July 22, 2026

Licensee

Sharons Faith Home Healthcare
3923 Globeflower Circle North
Brooklyn Park, MN 55443

RE: Project Number(s) SL41176001

Dear Licensee:

This is your **official notice** that you have been **granted your assisted living facility license**. Your license effective and expiration dates remain the same as on your provisional license. Your updated status will be listed on the license certificate at renewal and **this letter serves as proof** in the meantime. If you have not received a letter from us with information regarding renewing your license within 60 days prior to your expiration date, please contact us at (651) 201-5273 or by email at Health.assistedliving@state.mn.us.

The Minnesota Department of Health completed an initial survey on June 18, 2026, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

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

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. The Department of Health documents state correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Home Care Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance 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 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - \$500.00

St - 0 - 0810 - 144g.45 Subd. 2 (b-F) - Fire Protection And Physical Environment - \$500.00

The total amount you are assessed is \$1,000.00. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

Per 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 residents/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 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 the Department of Health 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 MDH 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.

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

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41176	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER SHARONS FAITH HOME HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 3923 GLOBEFLOWER CIRCLE NORTH BROOKLYN PARK, MN 55443		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(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: SL41176001-0 On June 15, 2026, through June 18, 2026, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were two residents; two receiving services under the Provisional Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
0 110 SS=C	144G.10 Subdivision 1a Assisted living director license required	0 110			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41176	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER SHARONS FAITH HOME HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 3923 GLOBEFLOWER CIRCLE NORTH BROOKLYN PARK, MN 55443			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 110	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 the licensed assisted living director (LALD) was listed as the Director of Record for the licensee through the Board of Executives for Long-Term Service and Supports (BELTSS) website. This had the potential to affect all the licensee's residents, staff, and visitors. This practice resulted in a level one violation (a violation that will cause only minimal impact on the residents and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On June 15, 2026, at 7:39 a.m., the BELTSS website indicated the health facility identification number (HFID) 41176 had a residency permit director that had an end date of June 2, 2026. The website did not list another LALD as the director of record for the licensee's HFID. On June 15, 2026, at 10:16 a.m., LALD/clinical nurse supervisor (LALD/CNS)-C confirmed they were the director of record for HFID 41176. LALD/CNS-C stated they were not aware they were not indicated as the director of record	0 110			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41176	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER SHARONS FAITH HOME HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 3923 GLOBEFLOWER CIRCLE NORTH BROOKLYN PARK, MN 55443			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 110	Continued From page 2 through the BELTSS website. LALD/CNS-C stated they now had their license to be the assisted living director and was listed with Minnesota Department of Health (MDH) so they were not sure why they were not listed as the director of record. On June 15, 2026, at 11:46 a.m., LALD/CNS-C confirmed their residency permit had expired on June 2, 2026. LALD/CNS-C stated they were licensed as an LALD a week prior to the expiration date; and they thought BELTSS would automatically update the director of record for the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110			
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	0 480			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41176	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER SHARONS FAITH HOME HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 3923 GLOBEFLOWER CIRCLE NORTH BROOKLYN PARK, MN 55443		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 480	Continued From page 3 removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are 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	0 480			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41176	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER SHARONS FAITH HOME HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 3923 GLOBEFLOWER CIRCLE NORTH BROOKLYN PARK, MN 55443			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 480	Continued From page 4 review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated June 15, 2026, 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			
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the	0 630			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41176	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER SHARONS FAITH HOME HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 3923 GLOBEFLOWER CIRCLE NORTH BROOKLYN PARK, MN 55443		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 630	Continued From page 5 abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for two of two residents (R2, R3). 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: R2 On June 16, 2026, at 8:04 a.m., the surveyor observed unlicensed personnel (ULP)-A assist R2 with medication administration. R2 was admitted to the licensee on February 13, 2025. R2's Service Plan - Modification dated June 16, 2026, was identified as the licensee's service plan, indicated R2 received assistance with medication administration. R2's IAPP dated May 19, 2026, indicated R2 had a history of agitation, physical and verbal aggression, socially and sexually inappropriateness, and a vulnerability of drug use.	0 630			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41176	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER SHARONS FAITH HOME HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 3923 GLOBEFLOWER CIRCLE NORTH BROOKLYN PARK, MN 55443		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 630	Continued From page 6 R2's IAPP lacked assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults and the person's risk of abusing other vulnerable adults. R2's Assessment dated May 19, 2026, under section Vulnerability, indicated R2 had no history of attempted suicide or thoughts of suicide; R2 was not a risk to abuse themselves; and had a current drug use. The assessment identified R2 had behaviors that included agitation, physical and verbal aggression, socially and sexually inappropriateness. The assessment lacked identification of the person's susceptibility to abuse by another individual, including other vulnerable adults and the person's risk of abusing other vulnerable adults. R3 On June 16, 2026, at 9:32 a.m., the surveyor observed ULP-A assist R3 with medication administration. R3 was admitted to the licensee on April 6, 2026. R3's Service Plan - Modification dated June 16, 2026, was identified as the licensee's service plan, indicated R3 received assistance with medication administration. R3's IAPP dated April 17, 2026, indicated R3 had a history of verbal aggression with periods of agitation and a vulnerability of drug use and/or history of drug use. R3's IAPP lacked assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults and the person's risk of abusing other vulnerable adults. R3's Assessment dated April 17, 2026, under	0 630			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41176	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER SHARONS FAITH HOME HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 3923 GLOBEFLOWER CIRCLE NORTH BROOKLYN PARK, MN 55443		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 630	Continued From page 7 section Vulnerability, indicated R3 had no known risk to abuse themselves and had a current drug use. The assessment identified R3 had behaviors that included a history of agitation and verbal aggression. The assessment lacked identification of the person's susceptibility to abuse by another individual, including other vulnerable adults and the person's risk of abusing other vulnerable adults. On June 16, 2026, at 9:13 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated the residents were supposed to all have an IAPP and the IAPP was to be tailored to the residents' need. The surveyor asked LALD/CNS-C if they knew of the required content needed for an IAPP; LALD/CNS-C stated the IAPP needed to include interventions based on their needs. LALD/CNS-C stated they did not know why the required content was not on the IAPP as it is included in the licensee's assessments. The surveyor observed LALD/CNS-C reviewing R2 and R3's assessments. After LALD/CNS-C reviewed R2 and R3's assessments, they confirmed the required content was not in the assessments. LALD/CNS-C then stated they were aware they needed to assess the susceptibility to abuse and the risk of abusing others but was not sure why it was not on the IAPP. The licensee's Vulnerable Adult policy dated May 9, 2025, indicated an assessment of vulnerability status of each resident would include susceptibility to abuse which included self-abuse, neglect, and risk of abuse by other individuals, including other vulnerable adults in the following areas: physical, verbal, sexual, financial exploitation, and self-abuse. Also, the assessment would include the risk of abusing	0 630			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41176	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER SHARONS FAITH HOME HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 3923 GLOBEFLOWER CIRCLE NORTH BROOKLYN PARK, MN 55443			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 630	Continued From page 8 other vulnerable adults within the residence. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630			
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 information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure staff records included all required content for two of two	0 650			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41176	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER SHARONS FAITH HOME HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 3923 GLOBEFLOWER CIRCLE NORTH BROOKLYN PARK, MN 55443			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 650	Continued From page 9 unlicensed personnel ((ULP)-A, 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 the potential to affect a large portion or all of the residents). The findings include: ULP-A On June 16, 2026, at 8:04 a.m., the surveyor observed ULP-A assist R2 with medication administration. ULP-A was hired on April 20, 2025. ULP-A's Clinical LMS - Orientation Checklist dated May 28, 2025, was authenticated by ULP-A and licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C to indicate training and evaluations were completed on May 28, 2025, for the following: - appropriate and safe techniques in personal hygiene and grooming to include hair care and bathing; care of teeth, gums, and oral prosthetic devices; care and use of hearing aids; and dressing and assisting with toileting; - standby assistance techniques and how to perform them; - reading and recording temperature, pulse, and respirations of the resident; - safe transfer techniques and ambulation; - range of motion; and - administering medications or treatment as required.	0 650			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41176	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER SHARONS FAITH HOME HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 3923 GLOBEFLOWER CIRCLE NORTH BROOKLYN PARK, MN 55443		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
0 650	Continued From page 10 ULP-A's record lacked documentation of the above competency evaluations by a registered nurse as follows: - appropriate and safe techniques in personal hygiene and grooming to include hair care and bathing; care of teeth, gums, and oral prosthetic devices; care and use of hearing aids; and dressing and assisting with toileting; - standby assistance techniques and how to perform them; - reading and recording temperature, pulse, and respirations of the resident; - safe transfer techniques and ambulation; - range of motion; and - administering medications or treatment as required. ULP-B ULP-B was hired on May 29, 2025. ULP-B's Clinical LMS - Orientation Checklist dated May 29, 2025, was authenticated by ULP-B and LALD/CNS-C to indicate training and evaluations were completed on May 29, 2025, for the following: - appropriate and safe techniques in personal hygiene and grooming to include hair care and bathing; care of teeth, gums, and oral prosthetic devices; care and use of hearing aids; and dressing and assisting with toileting; - standby assistance techniques and how to perform them; - reading and recording temperature, pulse, and respirations of the resident; - safe transfer techniques and ambulation; - range of motion; and - administering medications or treatment as required.	0 650			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41176	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER SHARONS FAITH HOME HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 3923 GLOBEFLOWER CIRCLE NORTH BROOKLYN PARK, MN 55443		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 650	Continued From page 11 ULP-B's record lacked documentation of the above competency evaluations by a registered nurse that included: - facility name, location, and license number; - the training methodology, such as classroom style, web-based training, video, or one-to-one training; - the total amount of time of the training and competency evaluation; - the evaluator's signature with a statement attesting that the employee successfully completed the training and competency evaluation; and - the staff person's signature with a statement attesting that the staff person successfully completed the training as described in the training documentation. On June 16, 2026, at 2:30 p.m., licensed assisted living director/ clinical nurse supervisor (LALD/CNS)-C stated they had shown the staff how to perform the procedures along with verbal instructions and then had the staff return the demonstration of the task to determine their competency but did not recall documentation of the competency evaluation as they utilized a check list as a guide for the training. LALD/CNS-C stated they were not aware of the documentation requirements for competency evaluations. The licensee's Personnel Records policy dated May 9, 2025, indicated personnel records for an employee would include all documents related to competency evaluations. Minnesota Administrative Rule 4659.0190, subpart 6, A., dated August 11, 2021, indicated the facility must maintain a record of staff training and competency required under this part and	0 650			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41176	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER SHARONS FAITH HOME HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 3923 GLOBEFLOWER CIRCLE NORTH BROOKLYN PARK, MN 55443			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 650	Continued From page 12 Minnesota Statutes, chapter 144G, that documents the following information for each competency evaluation, training, retraining, and orientation topic: - facility name, location, and license number; - name of the training topic or training program, and the training methodology, such as classroom style, web-based training, video, or one-to-one training; - date of the training and competency evaluation, and the total amount of time of the training and competency evaluation; - name and title of the instructor and the instructor's signature, and the name and title of the competency evaluator, if different from the instructor, and the evaluator's signature with a statement attesting that the employee successfully completed the training and competency evaluation; and - name and title of the staff person completing the training, and the staff person's signature with a statement attesting that the staff person successfully completed the training as described in the training documentation. 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	0 680			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41176	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER SHARONS FAITH HOME HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 3923 GLOBEFLOWER CIRCLE NORTH BROOKLYN PARK, MN 55443		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 680	Continued From page 13 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 available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	0 680			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41176	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER SHARONS FAITH HOME HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 3923 GLOBEFLOWER CIRCLE NORTH BROOKLYN PARK, MN 55443		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 680	Continued From page 14 The licensee's undated EPP lacked evidence of the following required content: - develop and maintain the EPP; - maintain and annual EPP updates; - EPP program patient population; - subsistence needs for staff and patients; - procedures for tracking of staff and patients; - policies and procedures for medical documents; - policies and procedures for volunteers; - arrangement with other facilities; - names and contact information; - emergency officials contact information; - methods for sharing information; - sharing information on occupancy/needs; and - emergency prep testing requirements. On June 17, 2026, at 10:35 a.m., during a review of the licensee's EPP, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated the licensee did not have a facility risk assessment completed. LALD/CNS-C stated they had not completed quarterly reviews of the licensee's missing person plan. LALD/CNS-C acknowledged the delegations of authority in the licensee's EPP was blank and did not identify which staff would assume specific roles. LALD/CNS-C stated the priority levels for the current residents were not accurate as the current residents were not considered high priority. LALD/CNS-C stated the licensee had back up emergency supplies for food and water onsite but did not have current policies and procedures for minimum food, water, pharmaceutical supplies; alternative sources of energy; or sewage/waste disposal. LALD/CNS-C confirmed the EPP did not have a policy and procedure for tracking staff and residents. LALD/CNS-C acknowledged the EPP indicated the use of volunteers indicated it was not applicable at this time; and did not have a policy	0 680			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41176	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER SHARONS FAITH HOME HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 3923 GLOBEFLOWER CIRCLE NORTH BROOKLYN PARK, MN 55443		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
0 680	Continued From page 15 and procedure to address the use of volunteers or other emergency staffing strategies. LALD/CNS-C stated the licensee did not have a written agreement in place with other facilities/providers to receive residents in the event of an emergency. LALD/CNS-C confirmed the licensee's EPP did not have contact information for staff and residents' physicians' information. LALD/CNS-C confirmed the licensee did not have documentation of the facility's analysis and response for staff drills. The licensee's Emergency Preparedness policy dated May 31, 2026, 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. The policy referenced CMS (Centers for Medicare and Medicaid Services) State Operations Manual (SOM) Appendix Z and MN Rules 4659.0100. Minnesota Administrative Rule 4659.0100 dated August 11, 2021, indicated assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.72, or successor requirements. This part referenced documents, specifications, methods, and standards in "State Operations Manual Appendix Z - Emergency Preparedness for All Provider and Certified Supplier Types: Interpretive Guidance." No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41176	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER SHARONS FAITH HOME HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 3923 GLOBEFLOWER CIRCLE NORTH BROOKLYN PARK, MN 55443		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 775	Continued From page 16	0 775			
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated June 16, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Two (2) days.	0 775			
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41176	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER SHARONS FAITH HOME HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 3923 GLOBEFLOWER CIRCLE NORTH BROOKLYN PARK, MN 55443		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 810	Continued From page 17 (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. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41176	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER SHARONS FAITH HOME HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 3923 GLOBEFLOWER CIRCLE NORTH BROOKLYN PARK, MN 55443			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 810	Continued From page 18 Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated June 16, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	0 810			
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living	0 970			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41176	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER SHARONS FAITH HOME HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 3923 GLOBEFLOWER CIRCLE NORTH BROOKLYN PARK, MN 55443			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 970	Continued From page 19 contract did not include language that waived the licensee's liability for health, safety, or personal property of a resident. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that will cause only minimal impact on the residents and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: The licensee's blank Assisted Living Contract dated 2023 read under Miscellaneous Provisions, Responsibilities, the resident agrees that resident shall be responsible for any personal injury or property damage (including, without limitation, damage to, or loss or theft of, automobiles or personal property of resident) suffered by the resident ...unless and to the extent that the injury or damage is caused by the negligence of the licensee or its employees or agents. On June 15, 2026, at 11:39 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C provided a blank assisted living contract to the surveyor; and stated the contract would be used for all residents. On June 16, 2026, at 12:58 p.m., LALD/CNS-C stated they were not aware the licensee's contract had a waiver of liability. LALD/CNS-C stated it was an oversight as the licensee had purchased the contract through a consulting company. No further information was provided.	0 970			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41176	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER SHARONS FAITH HOME HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 3923 GLOBEFLOWER CIRCLE NORTH BROOKLYN PARK, MN 55443		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 970	Continued From page 20	0 970			
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure.	01470			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41176	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER SHARONS FAITH HOME HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 3923 GLOBEFLOWER CIRCLE NORTH BROOKLYN PARK, MN 55443		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01470	Continued From page 21 (b) In addition to the topics in paragraph (a), orientation 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 the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide orientation to assisted living licensing requirements and regulations prior to providing services for two of two unlicensed personnel ((ULP)-A, 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	01470			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41176	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER SHARONS FAITH HOME HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 3923 GLOBEFLOWER CIRCLE NORTH BROOKLYN PARK, MN 55443		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01470	Continued From page 22 failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-A On June 16, 2026, at 8:04 a.m., the surveyor observed ULP-A assist R2 with medication administration. ULP-A was hired on April 20, 2025. ULP-A's personnel record lacked evidence of orientation training that included the following: - overview of Assisted Living Statutes; - handling of resident complaints, reporting of complaints, where to report; and - review of types of assisted living services the employee will provide and provider's scope of license. ULP-B ULP-B was hired on May 29, 2025. ULP-B's personnel record lacked evidence of orientation training that included the following: - overview of Assisted Living Statutes; - handling of resident complaints, reporting of complaints, where to report; and - review of types of assisted living services the employee will provide and provider's scope of license. On June 16, 2026, at 3:40 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated it was an oversight with not having the missing items with orientation. LALD/CNS-C stated they would just assign classes from the licensee's Residex LMS (learning management system) however,	01470			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41176	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER SHARONS FAITH HOME HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 3923 GLOBEFLOWER CIRCLE NORTH BROOKLYN PARK, MN 55443			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01470	Continued From page 23 LALD/CNS-C confirmed they were not able to find a course that included the missing content. The licensee's Staff Orientation and Education policy dated May 9, 2025, indicated all staff who provided assisted living services would complete orientation which included the following topics: - overview of Assisted Living Statutes; - handling of resident complaints, reporting of complaints, where to report; and - review of types of assisted living services the employee will provide and provider's scope of license. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470			
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan	01640			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41176	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER SHARONS FAITH HOME HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 3923 GLOBEFLOWER CIRCLE NORTH BROOKLYN PARK, MN 55443		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01640	Continued From page 24 must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a current service plan was completed within fourteen days of starting services; and failed to obtain a signature or other authentication by the licensee to document agreement of services to be provided for two of two residents (R2, R3) that were receiving services. 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: R2 On June 16, 2026, at 8:04 a.m., the surveyor observed unlicensed personnel (ULP)-A assist R2 with medication administration. R2 was admitted to the licensee on February 13, 2025. R2's Assisted Living Contract was signed on February 13, 2025.	01640			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41176	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER SHARONS FAITH HOME HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 3923 GLOBEFLOWER CIRCLE NORTH BROOKLYN PARK, MN 55443		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01640	Continued From page 25 R2's Service Plan - Modification dated June 16, 2026, was identified as the licensee's service plan, indicated R2 received assistance with medication administration. R2's service plan lacked a signature or other authentication by the licensee; and lacked the following required content of a service plan: - the fees for services; - the schedule and methods of monitoring assessments of the resident; - the schedule and methods of monitoring staff providing services; and - a contingency plan that included: - the action to be taken if the scheduled service cannot be provided; - information and a method to contact the facility; - the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and - the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. R2's Addendum to Contract - Waiver - MN dated June 16, 2026, was identified as a service plan the licensee could utilize after the initiation of survey, indicated R2 received assistance with medication administration but lacked a signature or other authentication by the licensee. R2's record lacked evidence of a service plan prior to the initiation of survey. R3 On June 16, 2026, at 9:32 a.m., the surveyor	01640			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41176	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER SHARONS FAITH HOME HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 3923 GLOBEFLOWER CIRCLE NORTH BROOKLYN PARK, MN 55443		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01640	Continued From page 26 observed ULP-A assist R3 with medication administration. R3 was admitted to the licensee on April 6, 2026. R3's Assisted Living Contract was signed on April 4, 2026. R3's Service Plan - Modification dated June 16, 2026, was identified as the licensee's service plan, indicated R3 received assistance with medication administration. R3's service plan lacked a signature or other authentication by the licensee; and lacked the following required content of a service plan: - the fees for services; - the schedule and methods of monitoring assessments of the resident; - the schedule and methods of monitoring staff providing services; and - a contingency plan that included: - the action to be taken if the scheduled service cannot be provided; - information and a method to contact the facility; - the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and - the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. R3's Addendum to Contract - Waiver - MN dated June 16, 2026, was identified as a service plan the licensee could utilize after the initiation of survey, indicated R3 received assistance with	01640			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41176	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER SHARONS FAITH HOME HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 3923 GLOBEFLOWER CIRCLE NORTH BROOKLYN PARK, MN 55443		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01640	Continued From page 27 medication administration but lacked a signature or other authentication by the licensee. R3's record lacked evidence of a service plan prior to the initiation of survey. On June 16, 2026, at 8:27 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated they used the residents support plan from the county case manager as the residents' service plan. LALD/CNS-C stated the Service Plan - Modification listed all services a resident would receive from the licensee; however, the residents did not sign the Service Plan - Modification. LALD/CNS-C stated R2 had signed their support plan with the county case manager. On June 16, 2026, at 8:56 a.m., LALD/CNS-C stated the licensee did not have a support plan from the county for R3. LALD/CNS-C stated they created a generic document that indicated what services R3 received from the licensee based on their assessment which was identified as the Service Plan - Modification. On June 16, 2026, at 12:19 p.m., LALD/CNS-C confirmed the licensee's service plan was the Service Plan - Modification they had provided to the surveyor used in conjunction to with the county assessment. LALD/CNS-C stated the licensee did not have a service plan for R3. LALD/CNS-C had asked the surveyor what the required content was for a service plan. On June 16, 2026, at 1:59 p.m., LALD/CNS-C stated they had found a document titled, Addendum to Contract - Waiver - MN for the service plan in their electronic record system but confirmed they had not previously used the	01640			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41176	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER SHARONS FAITH HOME HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 3923 GLOBEFLOWER CIRCLE NORTH BROOKLYN PARK, MN 55443		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01640	Continued From page 28 document as service plan. LALD/CNS-C confirmed the licensee did not have any signatures on the service plans. The licensee's Service Plan policy dated May 9, 2025, indicated an individualized service plan would be implemented for all residents; and the service plan would be finalized no later than fourteen days after the date services were first provided. Also, the service plan would be signed by a representative from the licensee and the resident or resident's representative to indicate agreement with the services provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640			
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, a registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions;	01730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41176	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER SHARONS FAITH HOME HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 3923 GLOBEFLOWER CIRCLE NORTH BROOKLYN PARK, MN 55443		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01730	Continued From page 29 (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an individualized medication management plan with the required content for two of two residents (R2, R3). 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	01730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41176	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER SHARONS FAITH HOME HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 3923 GLOBEFLOWER CIRCLE NORTH BROOKLYN PARK, MN 55443		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01730	Continued From page 30 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: R2 On June 16, 2026, at 8:04 a.m., the surveyor observed unlicensed personnel (ULP)-A assist R2 with medication administration that included checking the resident's medication record, preparing the medication, administering the medication to the resident, and documenting the administration. R2 was admitted to the licensee on February 13, 2025. R2's Service Plan - Modification dated June 16, 2026, was identified as the licensee's service plan, indicated R2 received assistance with medication administration. R2's Assessment dated May 19, 2026, under section Medications, indicated R2 needed reminders to take medications; and staff were to remind R2 when to take medications. Also, under the Medications section, indicated trained staff were to set up medications at scheduled times, including insulin; and R2 was able to self-administer their insulin injections in the presence of staff after checking blood glucose. R2's assessment did not indicate if R2 could administer medications other than insulin; and did not include the specific needs for medication administration other than insulin. R2's Individualized Medication Management Plan dated May 19, 2026, under section Medication	01730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41176	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER SHARONS FAITH HOME HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 3923 GLOBEFLOWER CIRCLE NORTH BROOKLYN PARK, MN 55443		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01730	Continued From page 31 Administration, indicated staff were to remind R2 when medications were due; and an outside pharmacy prepared (set up) R2's medications. R2's record lacked evidence of the following required content: - documentation of specific resident instructions related to the administration of medications; and - identification of medication management tasks that may be delegated to unlicensed personnel. R3 On June 16, 2026, at 9:32 a.m., the surveyor observed ULP-A assist R3 with medication administration of oral medications that included checking the resident's medication record, preparing the medication, administering the medication to the resident, and documenting the administration. R3 was admitted to the licensee on April 6, 2026. R3's Service Plan - Modification dated June 16, 2026, was identified as the licensee's service plan, indicated R3 received assistance with medication administration. R3's Individualized Medication Management Plan dated April 17, 2026, indicated that staff were to remind R3 when medications were due; the pharmacy prepared medications in monthly pill packs (multi-dose blister packs that organize medications by day and time); the RN reviewed the medication list and packaged medications for any discrepancies; and trained staff were to set up medications at scheduled times. R3's record lacked evidence of the following required content: - documentation of specific resident instructions	01730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41176	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER SHARONS FAITH HOME HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 3923 GLOBEFLOWER CIRCLE NORTH BROOKLYN PARK, MN 55443		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01730	Continued From page 32 related to the administration of medications; and - identification of medication management tasks that may be delegated to unlicensed personnel. On June 17, 2026, at 2:32 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated the records did not have clear instructions for the medication management needs for R2 and R3 as they needed assistance with medication administration. LALD/CNS-C confirmed the records did not indicate the delegated medication tasks for the unlicensed staff. LALD/CNS-C stated they were aware of the required content but did not know why the information was not included in the records. The licensee's Service Plan for Medication Management policy dated May 9, 2025, indicated the licensee would prepare and document a medication management plan that included identification of medication management tasks that may be delegated to unlicensed personnel. The policy did not include the required content to include documentation of specific resident instructions related to the administration of medications. Also, the policy indicated the medication management plan would be kept current and updated with any changes. Minnesota Statute 144G.08, subd 38, defines Medication Administration as performing a set of tasks that included the following: - checking the resident's medication record; - preparing the medication as necessary; - administering the medication to the resident; - documenting the administration or reason for not administering the medication; and - reporting to a registered nurse or appropriate licensed health professional any concerns about the medication, the resident, or the resident's	01730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41176	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER SHARONS FAITH HOME HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 3923 GLOBEFLOWER CIRCLE NORTH BROOKLYN PARK, MN 55443		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01730	Continued From page 33 refusal to take the medication. Minnesota Statute 144G.08, subd 57, defines Reminder as providing a verbal or visual reminder to a resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730			
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures	01790			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41176	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER SHARONS FAITH HOME HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 3923 GLOBEFLOWER CIRCLE NORTH BROOKLYN PARK, MN 55443		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01790	Continued From page 34 regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) developed written procedures for the unlicensed personnel (ULP) to provide medications for residents having unplanned time	01790			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41176	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER SHARONS FAITH HOME HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 3923 GLOBEFLOWER CIRCLE NORTH BROOKLYN PARK, MN 55443		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01790	Continued From page 35 away when the licensed nurse was not available. This had the potential to affect all residents who would need medications for an unplanned time away. 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: On June 16, 2026, at 3:14 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated the licensee had not written a procedure/protocol for the delegation of ULPs to provide medications to residents that had an unplanned time away from the facility. LALD/CNS-C stated the staff have a form they print from the licensee's electronic record in which then they have the resident sign for the medications. LALD/CNS-C stated they had not had to delegate the task of sending medications with a resident for an unplanned time away yet. After the surveyor reviewed the licensee's policy, LALD/CNS-C agreed the licensee should create a procedure/protocol for ULPs to follow; and they would need to complete a competency evaluation for all staff. The licensee's Medication Management Plan for Residents Away from Home policy dated May 9, 2025, indicated the RN could delegate to ULP if the RN had developed written procedures/protocols that included the following:	01790			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41176	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER SHARONS FAITH HOME HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 3923 GLOBEFLOWER CIRCLE NORTH BROOKLYN PARK, MN 55443		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01790	Continued From page 36 - special instructions regarding controlled substances; - type of container to be used for the medications appropriate to the facility's medication system; - how the containers should be labeled; - written information about the medications to be provided; - documentation requirements; - how the RN should be notified that the medications were provided to the resident and whether the RN should be notified before the medications are given; and - medications may be set up for the length of the anticipated absence, not to exceed seven days. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790			
01940 SS=F	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that	01940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41176	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER SHARONS FAITH HOME HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 3923 GLOBEFLOWER CIRCLE NORTH BROOKLYN PARK, MN 55443		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01940	Continued From page 37 will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of two residents (R2) with a treatment. 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: On June 16, 2026, at 8:04 a.m., the surveyor observed unlicensed personnel (ULP)-A assist R2 with medication administration. R2 was admitted to the licensee on February 13,	01940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41176	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER SHARONS FAITH HOME HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 3923 GLOBEFLOWER CIRCLE NORTH BROOKLYN PARK, MN 55443		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01940	Continued From page 38 2025. R2's Service Plan - Modification dated June 16, 2026, was identified as the licensee's service plan, indicated R2 received assistance with blood glucose two times per day and equipment care - diabetes every fifteen days. R2's order dated February 13, 2026, indicated R2 was to use a Freestyle Libre 3 Plus to check blood sugars and to change the Freestyle Libre 3 Plus Sensor every fifteen days. R2's record lacked evidence of an individualized treatment and therapy management plan for changing R2's Freestyle Libre 3 Plus sensor that included the following: - a statement of the type of services that will be provided; - documentation of specific resident instructions relating to the treatments or therapy administration; - identification of treatment or therapy tasks that will be delegated to unlicensed personnel; - procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and - any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy were administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. On June 17, 2026, at 1:12 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated only LALD/CNS-C and unlicensed personnel (ULP)-A would change R2's Freestyle Libre 3 Plus sensor as R2 was very	01940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41176	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER SHARONS FAITH HOME HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 3923 GLOBEFLOWER CIRCLE NORTH BROOKLYN PARK, MN 55443		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01940	Continued From page 39 particular with his sensor. LALD/CNS-C confirmed R2's service plan indicated equipment care - diabetes every fifteen days was for R2's treatment for changing of the Freestyle Libre 3 Plus sensor. On June 17, 2026, at 1:50 p.m., LALD/CNS-C stated the licensee did not have any of the required content of an individualized treatment and therapy management plan for R2's Freestyle Libre 3 Plus sensor in R2's record. LALD/CNS-C stated they knew a treatment plan needed to include a description of the treatment, frequency of the treatment, the discipline who would perform the treatment, and instructions to perform the treatment. On June 18, 2026, at 9:53 a.m., ULP-A stated they had performed R2's treatment of changing the Freestyle Libre 3 Plus Sensor and had been trained by the nurse before they were able to perform the task. The licensee's Treatment and Therapy Management policy dated May 9, 2025, indicated the registered nurse would prepare an individualized treatment or therapy management plan for each resident with an ordered treatment or therapy service that addressed the following: - type of service to be provided; - procedures for documentation of treatments or therapies; - procedures for monitoring treatments or therapies to prevent possible complications or adverse reactions; - identification of treatment or therapy tasks delegated to unlicensed personnel; and - procedures for notification to the RN or licensed health professional when a problem arises related to the treatment or therapy service.	01940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41176	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER SHARONS FAITH HOME HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 3923 GLOBEFLOWER CIRCLE NORTH BROOKLYN PARK, MN 55443		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01940	Continued From page 40 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940			
02320 SS=F	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure unlicensed personnel (ULP) followed appropriate medication administration procedures for one of one employee (ULP-A). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-A was hired by the licensee on April 20, 2025, to perform assisted living services to	02320			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41176	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER SHARONS FAITH HOME HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 3923 GLOBEFLOWER CIRCLE NORTH BROOKLYN PARK, MN 55443		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
02320	Continued From page 41 residents. On June 16, 2026, at 8:04 a.m., the surveyor observed ULP-A assist R2 with medication administration. During the observation, the surveyor observed ULP-A document the medications were administered before giving the medications to R2 for administration. Also, the surveyor observed ULP-A give the prepared medications to R2 and then walked away without observing R2 taking the medications. Licensed assisted living/clinical nurse supervisor (LALC/CNS)-C was also present for the medication administration; and had observed R2 administer the prepared medications. On June 16, 2026, at 9:32 a.m., the surveyor observed ULP-A assist R3 with medication administration. During the observation, the surveyor observed ULP-A document the medications were administered before giving the medications to R3 for administration. Also, the surveyor observed ULP-A give the prepared medications to R3 and then walked away without observing R3 taking the medications as ULP-A went into the kitchen to get a paper towel; and then they walked into the living room to get a topical medication from the medication cabinet. On June 16, 2026, at 9:12 a.m., LALD/CNS-C stated they expected staff to observe the resident taking all medications when they assisted a resident with medication administration; and staff were to document the medication administration after the task was completed. LALD/CNS-C stated the licensee had not had any issues with residents not taking medications as scheduled; however, they would need to provide re-teaching on the medication administration process.	02320			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41176	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER SHARONS FAITH HOME HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 3923 GLOBEFLOWER CIRCLE NORTH BROOKLYN PARK, MN 55443			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
02320	Continued From page 42 On June 16, 2026, at 9:41 a.m., ULP-A stated their job duties included medication administration. ULP-A stated the nurse had trained and observed medication administration before they were able to perform the task on their own. ULP-A stated they should have documented the medication administration after they provided the medications to the residents as that was how they were trained. ULP-A confirmed they did give R2 their medications and had not observed R2 taking the medications. ULP-A stated they had given R3 their medications in the preset package from the pharmacy, however R3 was opening the package of medications while ULP-A was getting the topical cream from the medication cabinet in the other room. ULP-A stated R3 had not actually taken their medications until ULP-A was by R2 after getting the topical cream. On June 16, 2026, at 2:30 p.m., LALD/CNS-C stated they had completed a competency evaluation on medication administration for ULP-A; and had determined ULP-A was competent to perform medication administration. The licensee's Medication Documentation policy dated May 9, 2025, indicated documentation of medication administration would be completed promptly. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320			
02430 SS=F	144G.91 Subd. 15 Confidentiality of records (a) Residents have the right to have personal, financial, health, and medical information kept	02430			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41176	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER SHARONS FAITH HOME HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 3923 GLOBEFLOWER CIRCLE NORTH BROOKLYN PARK, MN 55443		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
02430	Continued From page 43 private, to approve or refuse release of information to any outside party, and to be advised of the assisted living facility's policies and procedures regarding disclosure of the information. Residents must be notified when personal records are requested by any outside party. (b) Residents have the right to access their own records. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure residents' personal health and medical information was kept private when the licensee used Whats App to communicate in a group chat for changes in residents' condition, medications, and treatment needs. This had the potential to affect all residents residing at the assisted living 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: On June 15, 2026, at 10:57 a.m., during the entrance conference, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated the licensee used Whats App to communicate in a group chat for changes in residents' condition, medications, and treatment needs.	02430			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41176	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER SHARONS FAITH HOME HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 3923 GLOBEFLOWER CIRCLE NORTH BROOKLYN PARK, MN 55443			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
02430	Continued From page 44 On June 16, 2026, at 12:07 p.m., unlicensed personnel (ULP)-A stated the licensee used the Whats App to communicate "pretty much everything" which may include any type of schedule information such as resident medical appointments, any concerns or updates on events that happened during the shifts that included resident status or condition changes. ULP-A briefly showed the surveyor the group chat in Whats App, the surveyor observed resident names, resident medical appointments with the dates, times, and locations. The licensee's Privacy of Protected Health Information policy dated May 9, 2025, indicated the licensee would protect the privacy of its residents' personal health information. Also, the policy indicated protected health information would not be discussed on cell phones in public areas. The licensee's Resident Confidentiality policy dated May 31, 2026, indicated employees must never use a cell phone or personal device to share resident information (text, image, or updates). No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02430			



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

Page: 1

Establishment Info

Sharons Faith Home Healthcare
3923 GLOBEFLOWER CIRCLE NORTH
Brooklyn Park, MN 55443
Hennepin County
Parcel:

Phone:

License Info

License: HFID 41176

Risk:
License:
Expires on:
CFPM: Ronesha Rochelle Jackson
CFPM #: 55546; Exp: 1/28/2028

Inspection Info

Report Number: F8041261082
Inspection Type: Full - Single
Date: 6/15/2026 Time: 1:30 PM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 3
Total Priority 2 Orders: 0
Total Priority 3 Orders: 1
Delivery: Emailed

! New Order: 2-200 Employee Health

2-201.11C Priority Level: Priority 1 CFP#: 3

MN Rule 4626.0040C The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority at the specific request of the regulatory authority.

COMMENT: FACILITY DOES NOT HAVE AN EMPLOYEE ILLNESS LOG. EXCLUSION AND LOGGING REQUIREMENTS REVIEWED WITH PIC. MDH LOG FORM SENT WITH REPORT.

Comply By: 6/15/2026 Originally Issued On: 6/15/2026

! New Order: 3-300B Protection from Contamination: cross-contamination, eggs

3-302.11A(1) Priority Level: Priority 1 CFP#: 15

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

COMMENT: PACKAGE OF RAW BACON IN REFRIGERATOR DRAWER STORED NEXT TO PRODUCE. PRODUCE WAS MOVED TO ANOTHER SHELF IN COOLER ABOVE RAW BACON. CORRECTED ON SITE.

Comply By: 6/15/2026 Originally Issued On: 6/15/2026

New Order: 4-200 Equipment Design and Construction

4-201.11GMN Priority Level: Priority 3 CFP#: 47

MN Rule 4626.0506G Discontinue serving TCS foods that are held for more than same-day service in an adult or child care center or boarding establishment or provide equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

COMMENT: FACILITY HAS A RESIDENTIAL KITCHEN AND IS SAVING SOME LEFTOVERS FROM MEAL SERVICE SUCH AS RICE AND SAUSAGE WITH CABBAGE. DISCUSSED PREPARING ALL FOOD FOR SAME DAY SERVICE WITH PIC.

Comply By: 6/15/2026 Originally Issued On: 6/15/2026

! New Order: 4-700 Sanitizing Equipment and Utensils

4-702.11 Priority Level: Priority 1 CFP#: 16

MN Rule 4626.0900 Sanitize utensils and food contact surfaces of equipment before use, after cleaning.

COMMENT: PER OPERATOR, SOMETIMES DISHES ARE WASHED IN THE TWO BASIN SINK WITHOUT A SANITIZE STEP. ENSURE ALL EQUIPMENT AND DISHES ARE CLEANED AND SANITIZED IN THE APPROVED UNDERCOUNTER DISHWASHER.

Comply By: 6/15/2026 Originally Issued On: 6/15/2026

Food & Beverage General Comment

Inspection was completed with Ronesha Jackson. Rhawnie Quinehan was the HRD nurse evaluator.

Facility has a residential kitchen. Kitchen has a smooth ceiling, vinyl flooring and wood cabinets with with a hollow base and a solid surface countertop.
countertop.

Establishment has a dish machine with a sani rinse cycle that achieved a utensil surface temperature of at least 160F. There is a two basin sink and a separate handwashing sink in the kitchen. There is a chest freezer in the basement.

Discussed the following:

- Employee illness policy and logging requirements
 - Reporting foodborne illness complaints to the health dept.
 - Handwashing
 - Date marking
 - Glove-use and bare hand contact
 - Proper food storage
 - Vomit clean-up procedures
 - Restrictions concerning serving a highly susceptible population
 - CFPM requirement
-

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 F8041261082 from 6/15/2026

Ronesha Jackson
Owner



Sarah Conboy,
Public Health Sanitarian Supervisor
651-201-3984
sarah.conboy@state.mn.us



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

Temperature Observations/Recordings

Page: 1

Establishment Info	Inspection Info
Sharons Faith Home Healthcare	Report Number: F8041261082
Brooklyn Park	Inspection Type: Full
County/Group: Hennepin County	Date: 6/15/2026
	Time: 1:30 PM

Food Temperature: **Product/Item/Unit:** HAM; **Temperature Process:** Cold-Holding

Location: KITCHEN COOLER at 41 Degrees F.

Comment:

Violation Issued?: No

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL41176001-0	Date: June 16, 2026
Facility Name: Sharons Faith Home Healthcare	
Facility Address: 3923 Globe Flower Circle N, Brooklyn Park, Mn 55443	

☒ **TAG IDENTIFICATION: 0775**

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Two (2) days

1. Each assisted living facility must comply with the provisions of the Minnesota State Fire Code (MSFC) in Minnesota Rules chapter 7511. [Minn. Stat. 144G.45 subd. 2]
2. Where smoking is permitted, suitable noncombustible ashtrays or match receivers shall be provided on each table and at other appropriate locations. [Minn. Stat. 144G.45 subd. 2; MSFC 310.6]

Comments: On the deck for resident room 3 there was a plastic bottle that was being used as an ashtray.

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Twenty One (21) days

1. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that include employee actions to be taken in the event of a fire or similar emergency. [Minn. Stat. 144G.45 subd.2]

Comments: The FSEP failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The provided FSEP was from a third-party provider and had not been updated to the specific facility.

2. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that include fire protection procedures necessary for residents. [Minn. Stat. 144G.45 subd.2]

Comments: The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency.

3. Evacuation drills are required for employees 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. [Minn. Stat. 144G.45 subd.2]

Comments: Licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C provided drill records that showed drills were performed on 12/29/25, and 4/17/26. No other drill documentation was provided.