

STATE LICENSING COMPLIANCE REPORT

Report #: #HL367913940C

Date Concluded: September 18, 2026

Name, Address, and County of Facility

Investigated:

Solution Home Care LLC
9037 Moorland Chase
Brooklyn Center, MN
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Erin Johnson-Crosby, RN
Special Investigator

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

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

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36791	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/27/2026
NAME OF PROVIDER OR SUPPLIER SOLUTION HOME CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 9037 MOORLAND CHASE BROOKLYN CENTER, MN 55443		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL367913940C On August 27, 2026, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were three residents receiving services under the provider's Assisted Living license. The following correction orders are issued for #HL367913940C, tag identification 0110, 0320, and 0800.	0 000			
0 110 SS=F	144G.10 Subdivision 1a Assisted living director license required 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	0 110			

Minnesota Department of Health

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

TITLE

(X6) DATE

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0 110	Continued From page 1 director of record with the board. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to ensure employment of a licensed assisted living director (LALD), licensed by the Board of Executives for Long Term Services and Supports (BELTSS). This had the potential to affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On August 27, 2026, at 10:05 a.m., unlicensed personnel (ULP)-A answered the door and would not let the investigator into the facility until she contacted management. ULP-A called LALD-C, and LALD-C informed ULP-A he was no longer employed by the licensee. At 10:13 a.m., Owner (O)-B answered the phone and told staff to let us in. On August 27, 2026, at 10:43 a.m., the investigator observed LALD-C's LALD license hanging on the facility wall. O-B was not aware LALD-C no longer worked for the licensee. O-B stated the last time she spoke to LALD-C was in July.	0 110	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		

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0 110	Continued From page 2 On August 26, 2026, at 4:55 p.m., the BELTSS website indicated LALD-D had been the director of record for the facility, from May 11, 2026, to June 20, 2026. No other LALD was recorded with BELTSS as director of record for the licensee. No further information was provided.	0 110	SUBDIVISION 1-3.		
0 320 SS=F	144G.30 Subdivision 1 Regulatory powers (a) The Department of Health is the exclusive state agency charged with the responsibility and duty of surveying and investigating all assisted living facilities required to be licensed under this chapter. The commissioner of health shall enforce all sections of this chapter and the rules adopted under this chapter. (b) The commissioner, upon request to the facility, must be given access to relevant information, records, incident reports, and other documents in the possession of the facility if the commissioner considers them necessary for the discharge of responsibilities. For purposes of surveys and investigations and securing information to determine compliance with licensure laws and rules, the commissioner need not present a release, waiver, or consent to the individual. The identities of residents must be kept private as defined in section 13.02, subdivision 12. This MN Requirement is not met as evidenced by: Based on interviews and record review, the licensee failed to provide access to relevant information and records, when the licensee failed to respond timely to requests for resident records to determine compliance with licensure laws and	0 320			

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0 320	Continued From page 3 rules. 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 August 27, 2026, at 11:15 a.m., Owner (O)-B stated all updated information for the residents would be in those binders. The current documents were not located in the binders and O-B stated the documents may be downstairs in a locked room that she did not have the key for. On August 27, 2026, at 11:48 a.m., the investigator questioned O-B on where service delivery documents were kept. O-B stated those records were kept in the basement and did not have the key. O-B then stated staff used a group text message to document services provided to the residents. On August 27, 2026, at 12:09 p.m., the investigator informed O-B we would need the most up to date assessments, customized living rate worksheets, support plans and service delivery records for all residents. On September 8, 2026, at 2:09 p.m., the investigator emailed O-B requesting the customized living rate worksheets, support plans, and service delivery record for all three residents.	0 320			

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0 320	Continued From page 4 On September 9, 2026, at 4:30 p.m., the investigator emailed O-B indicating the documents should be emailed no later than September 10, 2026, at 11:00 a.m. As of September 15, 2026, documents requested had not been provided. No further information provided	0 320			
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to affect more than a limited number of residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive	0 800			

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0 800	Continued From page 5 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: Licensing orders from a previous full survey dated March 6, 2025, indicated the closet space under the stairs in the basement, next to resident room five, had a mold-like substance growing on the walls. On August 27, 2026, at 11:08 a.m., Owner (O)-B stated there had been flooding that caused black mold in the basement. O-B stated flooding occurs every spring or summer and caused the mold. O-B and a Department of Human Service (DHS) investigator went to the basement to observe the physical environment. O-B stated she had reported the concerns many times to the landlord, and nothing had been done about it. On August 27, 2026, at 11:10 a.m., a DHS investigator took multiple pictures of the black mold like substances on the walls and ceilings in the basement. On August 27, 2026, at 11:18 a.m., the carpet in the living room, and stairway had dark/black stains all over the carpet. O-B stated the stains were probably from one of the residents. The investigators took multiple pictures of the carpet in the living room and stairway. No further information was provided.	0 800			