Electronically Delivered

April 29, 2026

Licensee
New Life Care LLC
4913 Winchester Lane North
Brooklyn Center, MN 55429

RE: Project Number(s) SL37013016

Dear Licensee:

On April 14, 2026, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on January 14, 2026. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the January 14, 2026 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on January 14, 2026, found not corrected at the time of the April 14, 2026, follow-up survey and/or subject to penalty assessment are as follows:

0810-Fire Protection And Physical Environment-144g.45 Subd. 2 (b-F) - $1,000.00

The details of the violations noted at the time of this follow-up survey completed on April 14, 2026 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **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
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders outlined on the state form; however, plans of correction are not required to be submitted for approval.

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.

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

REQUESTING A HEARING

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

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

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

We urge you to review these orders carefully. If you have questions, please contact Stephanie Jones de Palma at 651-201-4320.

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

Sincerely,

Stephanie Jones de Palma, Supervisor
State Evaluation Team
Email: stephanie.jones.de.palma@state.mn.us
Telephone: 651-201-4320 Fax: 1-866-890-9290

CLN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37013	A. BUILDING: _____ B. WING _____	R 04/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW LIFE CARE LLC	4913 WINCHESTER LANE NORTH BROOKLYN CENTER, MN 55429

(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 INITIAL COMMENTS SL37013016-1 On April 6, 2026, through April 14, 2026, the Department of Health conducted an on-site licensing order follow up survey on the above assisted living provider to follow-up on orders issued pursuant to a survey completed January 14, 2026. At the time of the follow-up survey there were two (2) residents receiving services under the assisted living license. As a result of the revisit the following tag was reissued 0810.	{0 000}		
{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:	{0 775}	Not reviewed during this survey	
{0 800} SS=C	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.	{0 800}		

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{0 800}	Continued From page 1 This MN Requirement is not met as evidenced by:	{0 800}	Not reviewed during this survey	
{0 810} SS=I	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (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.	{0 810}		

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{0 810}	Continued From page 2 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 three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated April 14, 2026, for the specific violations related the physical environment under Minnesota Statute 144G.	{0 810}		

Electronically Delivered

February 11, 2026

Licensee
New Life Care LLC
4913 Winchester Lane North
Brooklyn Center, MN 55429

RE: Project Number(s) SL37013016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 14, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. MDH documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

IMPOSITION OF FINES

In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement;
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;
Level 3: a fine of $1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 4: a fine of $3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 5: a fine of $5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

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

pursuant to this survey:

St - 0 - 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 - $1,000.00
St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - $1,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $2,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

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

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

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

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

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

If you have any questions, please contact me.

Sincerely,

Renee L. Anderson

Renee L. Anderson, Supervisor
State Evaluation Team
Email: Renee.L.Anderson@state.mn.us
Telephone: 651-201-5871 Fax: 1-866-890-9290

CLN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37013	A. BUILDING: _____ B. WING _____	01/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW LIFE CARE LLC	4913 WINCHESTER LANE NORTH BROOKLYN CENTER, MN 55429

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0 000	Initial Comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been 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: SL37013016-0 On January 12, 2026, through January 14, 2026, the Minnesota Department of Health conducted an initial survey at the above provider, and the following correction orders are issued. At the time of the survey, there were three residents, all of whom were receiving services under the provider's Assisted Living Facility license. An immediate correction order was identified on January 13, 2026, issued for SL37013016-0, tag identification 1290.	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 License 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 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 surveyors' 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.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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0 480	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before 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	0 480		

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated January 13, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.	0 480		

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0 480	Continued From page 3 TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post in a conspicuous place information about the licensee's grievance procedure with the required content. 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	0 550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 550	Continued From page 4 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On January 12, 2026, at 1:20 p.m., during a self-guided facility tour, the surveyor observed the licensee lacked a posting in a conspicuous place, of the grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. In addition, there was no evidence of posting in the common area, the contact information for the state, applicable regional Office of Ombudsman for Long-Term Care (OOLTC), the Office of Ombudsman for Mental Health and Developmental Disabilities (OMHDD), and information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC). On January 12, 2026, at 1:30 p.m., licensed assisted living director (LALD)-A stated licensee's office was previously located in the downstairs basement of the facility and surveyor would find the required postings at that location. On January 12, 2026, at 1:35 p.m., surveyor and LALD-A completed a walk-through of the facilities basement, and licensee lacked posting the information noted above, in a conspicuous place. On January 12, 2026, at 1:37 p.m., LALD-A stated licensee was unaware the required posting noted above was no longer located on the basement wall. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 550		

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0 550	Continued From page 5 (21) days	0 550		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to engage in and maintain documentation of quality management activity appropriate to the size of the facility and relevant to the type of services provided. This had the potential to affect all residents. 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:	0 580		

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NEW LIFE CARE LLC	4913 WINCHESTER LANE NORTH BROOKLYN CENTER, MN 55429

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0 580	Continued From page 6 The licensee lacked documentation of quality management activities to ensure safe and competent services provided to residents. On January 13, 2026, at 9:30 a.m., licensed assisted living director (LALD)-A stated licensee had been working on an employee incentive program for its employees; however, was unable to provide documentation for the discussion. Furthermore, LALD-A stated they had meeting to discuss things happening within the facility but were unaware of the requirement to document the quality improvement activities, as well as maintaining the documentation for a period of two years. The licensee's Quality Management Project policy dated November 9, 2021, indicated the licensee would have at least one documented quality management project in place at all times, and retain records of such projects for at least two years. Furthermore, identified staff would use data collected from logged resident complaints, outcomes from Minnesota Department of Health (MDH) surveys or investigations, outcomes from resident satisfaction surveys, or other sources of data, select at least one area to focus on in the form of a quality improvement initiative. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 580		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a	0 660		

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	37013	A. BUILDING: _____ B. WING _____	01/14/2026

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0 660	Continued From page 7 comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included TB symptom screening and TB baseline testing no greater than 90 days prior to hire date for two of two employees (unlicensed personnel (ULP)-C, ULP-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	0 660		

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0 660	Continued From page 8 The licensee's Facility TB Risk Assessment dated March 19, 2025, lacked the facility risk setting for TB transmission. ULP-C ULP-C was hired on June 10, 2025, and provided direct care and services for residents of the facility. ULP-C's employee record included TB history and symptom screening dated December 3, 2025, and a first-step tuberculin skin test (TST) dated June 24, 2025; however, lacked documentation of a second-step TST, as required. On January 12, 2026, at 2:25 p.m., ULP-C was observed administering medications to R1. ULP-D ULP-D was hired October 25, 2024, and provided direct care and services for residents of the facility. ULP-D's employee record included a first-step TST dated September 2, 2024; however, lacked TB history and symptom screening, and second-step TST, as required. On January 13, 2026, at 9:00 a.m., licensed assisted living director (LALD)-A stated both ULP's lacked second-step TB testing and ULP-D lacked TB symptom screening. LALD-A further stated he was unaware of the TB requirements; therefore, did not have either employee complete second-step TB testing. The licensee's Tuberculosis Screening policy dated November 9, 2021, indicated that staff whose essential job functions required working	0 660		

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0 660	Continued From page 9 within the same air space of [assisted living residents] would be screened and tested for tuberculosis prior to the staff being exposed to [residents]. Furthermore, new staff would be screened for active signs of TB using the baseline TB screening tool for health care workers (HCW's). In addition, new staff would have an IGRA (blood test) or a two-step Mantoux conducted with results documented on the baseline TB screening tool for HCW's, and TB screening results would be kept in each employee's medical file. The Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013 noted training was required at the time of hire and included: pathogenesis, signs symptoms, and the licensee's infection control plan. In addition, baseline screening for all health care workers (HCW) included a history and symptom screen and testing for the presence of TB infection. The regulations noted a blood test should include the date of the test. According to the regulations, if HCW had documentation for latent TB, that documentation could be substituted for documentation of a previous positive TST or blood test. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
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	0 680		

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0 680	Continued From page 10 contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually 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 have a written emergency preparedness (EP) plan that included all required content. 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 potential to affect a large portion or all of the residents).	0 680		

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0 680	Continued From page 11 The findings include: The licensee's EP plan dated October 16, 2025, lacked the following requirements: - missing resident plan reviewed quarterly; - develop policy and procedures which address development and arrangements with other facilities or providers to receive residents in the event continuity of services cannot be provided; and - must conduct and document exercises to test the EP plan at least twice per year including unannounced staff drills using the EP plan. On January 12, 2026, at 1:40 p.m., licensed assisted living director (LALD)-A and surveyor reviewed licensee's EP binger together. LALD-A stated licensee's EP binder lacked the information noted above. LALD-A further stated he was unaware fire drills could not be utilized as table-top or full-scale EP exercises. In addition, LALD-A stated licensee had made verbal arrangements with other facilities in the event of an emergency; however, lacked documentation of any such arrangements with other facilities. The license's Emergency Preparedness Plan-Appendix Z compliance policy dated November 9, 2021, indicated [licensee] would have an effective and compliant EP plan in place. Furthermore, the EP plan would be aligned with the Centers for Medicare and Medicaid Services State Operations Manual Appendix Z, which would provide interpretive guidance for EP for all providers and certified supplier types. Moreover, the EP plan would be in writing, reviewed annually, and would include all the required elements of appendix Z	0 680		

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0 680	Continued From page 12 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
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 January 13, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7)	0 775		

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0 775	Continued From page 13 days	0 775		
0 800 SS=C	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, 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 one violation (a violation that will cause only minimal impact on the resident 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: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated January 13, 2026, for the specific violations related the physical environment under Minnesota Statute 144G.	0 800		

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0 800	Continued From page 14 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
0 810 SS=I	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (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.	0 810		

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0 810	Continued From page 15 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 three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated January 13, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 920 SS=C	144G.50 Subd. 2 (c) Contract information (c) The contract must include: (1) a disclosure of the category of assisted living facility license held by the facility and, if the facility is not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license; (2) a description of all the terms and conditions of	0 920		

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0 920	Continued From page 16 the contract, including a description of and any limitations to the housing or assisted living services to be provided for the contracted amount; (3) a delineation of the cost and nature of any other services to be provided for an additional fee; (4) a delineation and description of any additional fees the resident may be required to pay if the resident's condition changes during the term of the contract; (5) a delineation of the grounds under which the resident may be transferred or have housing or services terminated or be subject to an emergency relocation; (6) billing and payment procedures and requirements; and (7) disclosure of the facility's ability to provide specialized diets. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written assisted living contract with the required content for two of two residents (R1, R3). This practice resulted in a level one violation (a violation that has no potential to cause more than a 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 potential to affect a large portion or all of the residents). The findings include: R1 R1 admitted to the licensee on September 5,	0 920		

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0 920	Continued From page 17 2025, and began receiving assisted living services. R1's service plan-addendum to contract dated September 6, 2025, indicated R1 received services which included assistance with medication administration, behavior management, and housekeeping services. R3 R3 admitted to the licensee on January 30, 2025, and began receiving assisted living services. R3's service plan dated January 30, 2025, indicated R3 received services which included assistance with medication administration, behavior management, housekeeping, laundry assistance, and socialization. R1, and R3's records included a Resident Contract for Assisting Living dated January 12, 2026, and February 1, 2025, respectively. The contract lacked a disclosure of the licensee's ability to provide specialized diets. On January 13, 2026, at 10:54 a.m., licensed assisted living director (LALD)-A stated they had an outside consultant assist with the drafting of the current contract, and he was not aware the contract was missing information. LALD-A further stated the contract R1 and R3 signed was the contract licensee had been using for all the residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 920		

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0 950	Continued From page 18	0 950		
0 950 SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide the required verbatim notice for designation of representative in writing, before or at the time of execution of an assisted living contract, for two of two residents (R1, R3).	0 950		

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0 950	Continued From page 19 This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident 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 potential to affect a large portion or all of the residents). The findings include: R1 R1 admitted to the licensee on September 5, 2025, and began receiving assisted living services. R1's service plan-addendum to contract dated September 6, 2025, indicated R1 received services which included assistance with medication administration, behavior management, and housekeeping services. R3 R3 admitted to the licensee on January 30, 2025, and began receiving assisted living services. R3's service plan dated January 30, 2025, indicated R3 received services which included assistance with medication administration, behavior management, housekeeping, laundry assistance, and socialization. R1, and R3's records included a Resident Contract for Assisting Living dated January 12, 2026, and February 1, 2025, respectively. R1 and R3's contracts lacked the following verbatim notice, on a document separate from the contract: "RIGHT TO DESIGNATE A	0 950		

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0 950	Continued From page 20 REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." Moreover, there was also no documentation showing R1 and R3 refused or indicated a designated representative. On January 13, 2026, at 10:50 a.m., licensed assisted living director (LALD)-A stated R1 and R3's contracts lacked the right to designate a representative notice. LALD-A further stated he was under the understanding that if a resident declined choosing a designated representative, there was nothing further licensee was required to complete; therefore, licensee had not required resident's to initial that area of the contract. In addition, LALD-A stated the contract R1 and R3 signed was the contract licensee had been using for all the residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 950		
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	0 970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37013	A. BUILDING: _____ B. WING _____	01/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW LIFE CARE LLC	4913 WINCHESTER LANE NORTH BROOKLYN CENTER, MN 55429

(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 21 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 contract did not include language waiving the facility'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 has no potential to cause more than a minimal impact on the resident 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 potential to affect a large portion or all of the residents). The findings include: R1 R1 admitted to the licensee on September 5, 2025, and began receiving assisted living services. R1's service plan-addendum to contract dated September 6, 2025, indicated R1 received services which included assistance with medication administration, behavior management, and housekeeping services. R3 R3 admitted to the licensee on January 30, 2025, and began receiving assisted living services.	0 970		

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	37013	A. BUILDING: _____ B. WING _____	01/14/2026

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NEW LIFE CARE LLC	4913 WINCHESTER LANE NORTH BROOKLYN CENTER, MN 55429

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0 970	Continued From page 22 R3's service plan dated January 30, 2025, indicated R3 received services which included assistance with medication administration, behavior management, housekeeping, laundry assistance, and socialization. R1, and R3's records included a Resident Contract for Assisting Living dated January 12, 2026, and February 1, 2025, respectively. The contracts included the following language indicating a waiver of the licensee's responsibility for the health and safety or personal property of the residents. Section 24. "Provisions Related to Liability" A. Damage of Injury to Resident of Resident's Property [Licensee] would not be responsible for any damage or injury suffered by you, your property, your guests or their property that was not caused by us. Furthermore, licensee's insurance may not cover the loss of your personal property and the incidental and consequential damages arising from the loss of such property. Moreover, resident's personal property includes but is not limited to dentures, glasses and hearing aids. On January 13, 2026, at 11:07 a.m., licensed assisted living director (LALD)-A stated he was responsible to ensure licensee's contract did not include the liability language noted above. LALD-A further stated he thought he removed the lability language from the contract; however, could not explain why the liability language was still on the contract. In addition, LALD-A stated the contract R1 and R3 signed was the contract licensee had been using for all the residents. No further information was provided.	0 970		

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NEW LIFE CARE LLC	4913 WINCHESTER LANE NORTH BROOKLYN CENTER, MN 55429

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0 970	Continued From page 23 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01060 SS=D	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter	01060		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW LIFE CARE LLC	4913 WINCHESTER LANE NORTH BROOKLYN CENTER, MN 55429

(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
01060	Continued From page 24 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide the resident, legal representative, and designated representative with all required content after an emergency relocation for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1 was admitted to the licensee on September 5, 2025, and began receiving assisted living services. R1's service plan-addendum to contract dated September 6, 2025, indicated R1 received services which included assistance with medication administration, behavior management, and housekeeping services. R1's change in condition assessment completed	01060		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01060	Continued From page 25 on November 20, 2025, indicated R1 was admitted to the hospital's mental health unit on November 13, 2025, secondary to suicidal ideations and concerns for his mental-health safety. R1 was discharged back to the assisted living facility on November 20, 2025, which was seven days after the hospital admission. R1's hospital discharge summary dated November 20, 2025, at 2:12 p.m., indicated R1 was admitted to the hospital on November 12, 2025, and returned to the facility on November 20, 2025. R1's record lacked evidence that the resident or their representative was provided with a written notice that contained, at a minimum: - the reason for relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the Office of Ombudsman for Long-Term Care (OOLTC) and the Office of Ombudsman for Mental Health and Developmental Disabilities (OMHDD); - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and - a statement that, if the facility refuses to provide housing or services after relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the residents may submit an appeal. R1's record lacked evidence that the above written notice was delivered as soon as practicable to: - the resident;	01060		

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01060	Continued From page 26 - for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and - the Office of Ombudsman for Long-Term Care when the resident had been relocated and had not returned to the facility within four days. On January 13, 2025, at 12:00 p.m., licensed assisted living director (LALD)-A stated when licensee's residents are sent to the hospital, they usually only stay one day. LALD-A further stated licensee had notified the police regarding R1's hospitalization. Moreover, LALD-A stated he was unaware of all the required content that needed to be completed when a resident was sent to the hospital. The licensee's Emergency Relocation policy dated November 9, 2025, indicated licensee would in the event of an emergency relocation, [licensee] would provide a written notice that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the Office of Ombudsman for Long-Term Care; - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known, and; - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal. Furthermore, the notice required would be delivered as soon as practicable to: - the resident; - the resident's legal representative;	01060		

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01060	Continued From page 27 - the resident's designated representative; - if the resident was receiving home and community-based services, the resident's case manager; and - if the resident was relocated and had not returned to the licensee within four (4) days, the OOLTC. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure all employees had a cleared Department of Human Services (DHS) background study for one of	01290	An immediate order was identified on January 13, 2026, issued for SL37013016-0, tag identification 1290. The licensee took action to address the	

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01290	Continued From page 28 thirteen employees (clinical nurse supervisor (CNS)-B). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: CNS-B was hired on July 15, 2022, to provide direct cares and services to residents; as well as supervision to current employees. The licensee's Current Employee Roster dated January 12, 2026, indicated CNS-B was a current employee for the licensee. On January 13, 2026, the Minnesota Board of Nursing database indicated CNS-B was licensed as a registered nurse (RN) on July 30, 2009. On January 13, 2026, the licensee's DHS NETStudy 2.0 background study roster indicated CNS-B had a background study completed under COVID-19 waiver that expired December 31, 2022. CNS-B's record lacked evidence of a current, cleared background study affiliated with the licensee. On January 13, 2026, at 3:00 p.m., licensed assisted living director (LALD)-A stated because the licensee's NETStudy 2.0 roster indicated CNS-B's determination status was "eligible", he	01290	immediate risk.	

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01290	Continued From page 29 was unaware there was anything further the needed to be completed for CNS-B; therefore, CNS-B had not been sent for fingerprinting. The DHS website for Background Studies updated February 18, 2025, indicated, "The Minnesota Department of Human Services (DHS) requires background studies for people who work in certain health and human services programs, and in childcare settings if they provide care or have direct contact with vulnerable populations. DHS also completes background studies on others, such as people planning to provide foster care or adopt. Minnesota statutes direct the background study process for entities required to initiate background studies." It further indicated, "DHS temporarily modified background studies during the COVID-19 pandemic. Those modifications ended Jan. 1, 2023. Learn more about the return to fully compliant studies." The licensee's Background Studies policy dated November 9, 2021, indicated licensee would conduct a Minnesota DHS background study on all employees, volunteers, and contractors. Furthermore, no employee would provide direct services or have independent, direct contact, with any residents, until acceptable results of the background study had been received. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01290		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or	01910		

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01910	Continued From page 30 medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide documentation in the resident's record regarding the disposition of medication to include prescription number if applicable, and quantity of medications that were given upon discharge from the facility, for one of one discharged resident (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include:	01910		

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01910	Continued From page 31 R4's Discharge/Transfer Summary dated August 1, 2025, indicated R4 was admitted to the licensee's facility on July 3, 2025, and received services, which included registered nurse (RN) supervision of medication setup which was completed by Genoa pharmacy, and medication administration twice daily, by the licensee's home health aide (HHA). R4's undated active medication list at time of discharge included bupropion hydrochloride (XL) 150 milligram (mg) (indicated for depression), ferrous sulfate 325 mg (indicated for iron deficiency), olanzapine 10 mg (indicated for mood disorder), and sertraline 100 mg (indicated for depression). Furthermore, R4's active medication list indicated medications were given to R4 upon discharge. R4's record lacked evidence of documentation of R4's disposition of medications to include prescription number if applicable, and quantity given to R4 for bupropion hydrochloride (XL) 150 milligram (mg), ferrous sulfate 325 mg, olanzapine 10 mg, and sertraline 100 mg upon discharge from the facility. On January 12, 2026, at 12:00 p.m., licensed assisted living director (LALD)-A stated he was aware that medications given to resident's upon discharge would be counted and documented; however, due to R4's ride picking him up prior to LALD-A's arrival to the facility, on the date of discharge, R4 was given his medications without facility staff having the ability to count them before R4 left. The licensee's Medication Disposal policy dated November 9, 2024, indicated staff of [licensee]	01910		

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01910	Continued From page 32 would dispose of any medication, as needed, in a proper way including following the guidelines of the Minnesota Board of Pharmacy. Furthermore, upon disposition, the facility would document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

NEW LIFE CARE LLC
4913 WINCHESTER LANE NORTH
Brooklyn Center, MN 55429
Hennepin County
Parcel:

Phone:

License Info

License: HFID 37013

Risk:
License:
Expires on:
CFPM:
CFPM #: ; Exp:

Inspection Info

Report Number: F7963261011
Inspection Type: Full - Single
Date: 1/13/2026 Time: 10:05:47 AM
Duration: minutes
Announced Inspection: Yes
Total Priority 1 Orders: 1
Total Priority 2 Orders: 0
Total Priority 3 Orders: 3
Delivery: Emailed

New Order: 2-100 Supervision
2-102.12AMN *Priority Level: Priority 3 CFP#: 2*
MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.
COMMENT: A FOOD SAFETY CLASS HAS BEEN TAKEN BUT THE ESTABLISHMENT HAS NOT APPLIED FOR REQUIRED CERTIFIED FOOD MANAGER CERTIFICATE FROM THE STATE. INSTRUCTIONS SEND WITH REPORT.
Comply By: 1/13/2026 Originally Issued On: 1/13/2026

! **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: RAW SHELL EGGS STORED ABOVE READY TO EAT FOODS IN REFRIGERATOR. STORE EGGS IN A NONPOROUS CONTAINER OR MOVE TO THE LOWEST SHELF.
Comply By: 1/13/2026 Originally Issued On: 1/13/2026

New Order: 4-200 Equipment Design and Construction
4-202.16 *Priority Level: Priority 3 CFP#: 47*
MN Rule 4626.0540 Provide non-food contact surfaces that are free of unnecessary ledges, projections and crevices and are designed and constructed to allow easy cleaning.
COMMENT: PAINT IS WEARING OFF OF KITCHEN CABINETS. RESURFACE CABINETS SO THE SURFACE IS SMOOTH AND EASILY CLEANABLE.
Comply By: 3/13/2026 Originally Issued On: 1/13/2026

New Order: 6-500 Physical Facility Maintenance/Operation and Pest Control
6-501.12A *Priority Level: Priority 3 CFP#: 55*
MN Rule 4626.1520A Clean and maintain all physical facilities clean.
COMMENT: KITCHEN NEEDS A GENERAL CLEAN INCLUDING COUNTERTOPS, FLOORS (ESPECIALLY UNDER EQUIPMENT) AND APPLIANCES.
Comply By: 1/27/2026 Originally Issued On: 1/13/2026

Food & Beverage General Comment

MET WITH MDH NURSE SURVEYOR RHONDA MAKELA AND ESTABLISHMENT REPRESENTATIVE ABDASALEM HASSEN.
THIS IS A RESIDENTIAL HOME USING SAME-DAY FOOD SERVICE.
A DISHWASHER MUST BE USED FOR WASHING AND SANITIZING ALL UTENSILS AND EQUIPMENT.

KITCHEN HAS PAINTED CABINETS, SOLID SURFACE COUNTERTOPS, POPCORN CEILING AND CERAMIC TILE FLOOR.

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 F7963261011 from 1/13/2026

Abdusalam Hassen
PIC

Peggy Spadafore,
Public Health Sanitarian Supervisor
651-201-3979
peggy.spadafore@state.mn.us

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

Temperature Observations/Recordings

Establishment Info

NEW LIFE CARE LLC
Brooklyn Center
County/Group: Hennepin County

Inspection Info

Report Number: F7963261011
Inspection Type: Full
Date: 1/13/2026
Time: 10:05:47 AM

Food Temperature: Product/Item/Unit: MILK**; Temperature Process:**
Location: at 41 Degrees F.
Comment:
Violation Issued?: No

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

Sanitizer Observations/Recordings

Establishment Info

NEW LIFE CARE LLC
Brooklyn Center
County/Group: Hennepin County

Inspection Info

Report Number: F7963261011
Inspection Type: Full
Date: 1/13/2026
Time: 10:05:47 AM

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:**
Location: DISHWASHER RINSE **Equal To** 160 Degrees F.
Comment:
Violation Issued?: No

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ASSISTED LIVING | ASSISTED LIVING WITH DEMENTIA CARE

Project No: SL37013016-0	**Date:** 1/13/2026
Facility Name: NEW LIFE CARE LLC	
Facility Address: 4913 WINCHESTER LANE NORTH, BROOKLYN CENTER, MN 55429	

☒ **TAG IDENTIFICATION: 0775**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Seven (7) 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]

   Comments: The electrical panel was blocked and inaccessible. A minimum of 30" wide x 36" deep and 78" in height shall be provided in front of electrical the electrical panel [MSFC 604.3].

2. The means of egress shall be maintained free of obstructions or impediments to full instant use in case of fire or other emergency. [Minn. Stat. 144G.45 subd. 2; MSFC 1031.2]

   Comments: The deck is being used as a designated exit. The egress route was not clear of snow.

3. Occupancy separations shall be provided in Group I and Group R occupancies. These separations shall be constructed and maintained in accordance with the Building Code. Existing wood lathe and plaster in good condition or ½ inch gypsum wall board is acceptable where one-hour occupancy separations are required. [Minn. Stat. 144G.45 subd. 2; MSFC 1105.2]

   Comments: The garage attic access fire separation was not installed in its designated location.

☒ **TAG IDENTIFICATION: 0800**

SCOPE/ SEVERITY: Level 1; Widespread **TIME PERIOD OF CORRECTION:** Twenty One (21) days

1. The physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment are 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. [Minn. Stat. 144G.45 subd.2]

   Comments: The grout in the main level bathroom was missing in areas.

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 3; Widespread **TIME PERIOD OF CORRECTION:** Twenty One (21) days

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

   Comments: Licensed Assisted Living Director (LALD)-A stated no policy for residents is in place.

2. Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. [Minn. Stat. 144G.45 subd.2]

   Comments: LALD-A stated that staff training was done on a third-party web-based platform and not on the licensee's written FSEP.

3. 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. [Minn. Stat. 144G.45 subd.2]

   Comments: LALD-A stated no training for residents had been offered.

4. 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: Review of the evacuation drill log indicated drills were performed on 1-20-25, 9-1-25, and 11-17-25. These drills were performed with the day shift staff only.