Electronically Delivered

January 27, 2026

Licensee
Care4u Home Care Services LLC
13704 Portland Avenue South
Burnsville, MN  55337

RE: Project Number(s) SL38633016

Dear Licensee:

On December 23, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on October 16, 2025. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

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

CLN

Electronically Delivered

November 17, 2025

Licensee
Care4u Home Care Services LLC
13704 Portland Avenue South
Burnsville, MN 55337

RE: Project Number(s) SL38633016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on October 16, 2025, 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:

**0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00**
**0780 - 144g.45 Subd. 2 (a) (1) - Fire Protection And Physical Environment - $500.00**
**0810 - 144g.45 Subd. 2 (b-F) - Fire Protection And Physical Environment - $1,000.00**

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $2,000.00**. 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 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,

Jodi Johnson, Supervisor
State Evaluation Team
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

JMD

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 38633 | A. BUILDING: _____ B. WING _____ | 10/16/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CARE4U HOME CARE SERVICES LLC | 13704 PORTLAND AVENUE SOUTH BURNSVILLE, MN 55337 |

| (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<br><br>*****ATTENTION*****<br><br>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.<br><br>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.<br><br>INITIAL COMMENTS:<br><br>SL38633016-0<br><br>On October 13, 2025, through October 16, 2025, 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 four residents; four receiving services under the 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.<br><br>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.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>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. | |
| 0 470 SS=F | 144G.41 Subdivision 1 Minimum requirements | 0 470 | | |

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| 0 470 | Continued From page 1<br><br>(11) develop and implement a staffing plan for determining its staffing level that:<br>(i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility;<br>(ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and<br>(iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility;<br>(12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be:<br>(i) awake;<br>(ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time;<br>(iii) capable of communicating with residents;<br>(iv) capable of providing or summoning the appropriate assistance; and<br>(v) capable of following directions;<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, the licensee failed to develop and implement a staffing plan to determine staffing levels to meet the needs of all residents; and failed to ensure the staffing schedule was posted in a central location accessible to staff, residents, volunteers, and the public according to MN rules 4659.0180, Subp. 4 | 0 470 | | |

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| 0 470 | Continued From page 2<br>(B).<br><br>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).<br><br>The findings include:<br><br>The Assisted Living licensee was licensed for a capacity of five residents with a current census of 4 residents receiving services.<br><br>During the entrance conference on October 13, 2025, at 9:30 a.m., agent (A)-A and assisted living director/registered nurse (ALD/RN)-B stated the usual staffing schedule for the facility was as follows:<br>- the RN was on call 24 hours per day and was onsite at varied times three to four days a week<br>- day and evening hours included three to four unlicensed personnel (ULP) working multiple different shifts.<br>- the night shift was staffed with one ULP.<br><br>On October 13, 2025, at 10:00 a.m., ALD/RN-B stated they had not developed a staffing plan for the facility and was not aware of the requirement.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 0 470 | | |

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| 0 480 SS=F | 144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services<br><br>(a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626.<br>(b) For an assisted living facility with a licensed capacity of ten or fewer residents:<br>(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;<br>(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;<br>(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;<br>(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;<br>(5) notwithstanding Minnesota Rules, parts | 0 480 | | |

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| 0 480 | Continued From page 4<br><br>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;<br>(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<br>(7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code.<br><br>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 or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).<br><br>The findings include:<br><br>Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated October 14, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 | 0 480 | | |

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| 0 480 | Continued From page 5<br>hours of the inspection.<br><br>TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates. | 0 480 | | |
| 0 500 SS=F | 144G.41 Subd. 2 Policies and procedures<br><br>Each assisted living facility must have policies and procedures in place to address the following and keep them current:<br>(1) requirements in section 626.557, reporting of maltreatment of vulnerable adults;<br>(2) conducting and handling background studies on employees;<br>(3) orientation, training, and competency evaluations of staff, and a process for evaluating staff performance;<br>(4) handling complaints regarding staff or services provided by staff;<br>(5) conducting initial evaluations of residents' needs and the providers' ability to provide those services;<br>(6) conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate;<br>(7) orientation to and implementation of the assisted living bill of rights;<br>(8) infection control practices;<br>(9) reminders for medications, treatments, or exercises, if provided;<br>(10) conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; | 0 500 | | |

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| 0 500 | Continued From page 6<br><br>(11) ensuring that nurses and licensed health professionals have current and valid licenses to practice;<br>(12) medication and treatment management;<br>(13) delegation of tasks by registered nurses or licensed health professionals;<br>(14) supervision of registered nurses and licensed health professionals; and<br>(15) supervision of unlicensed personnel performing delegated tasks.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to develop and implement current policies and procedures as required.<br><br>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).<br><br>The findings include:<br><br>During the entrance conference on October 13, 2025, at 9:30 a.m., agent (A)-A and assisted living director/registered nurse (ALD/RN)-B stated they were aware of the assisted living regulations.<br><br>On October 13, 2025, at 2:15 p.m., the surveyor requested to review the licensee's policy manual.<br><br>On October 14, 2025, at 12:00 p.m., the surveyor | 0 500 | | |

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| 0 500 | Continued From page 7<br><br>received a large binder labeled Policy and Procedure Manual. In review of the binder, it was labeled Human Resources (HR) Manual and contained HR forms.<br><br>The licensee failed to ensure they had the required policies and procedures in place and kept current.<br><br>On October 14, 2025, at 12:30 p.m., agent (A)-A and assisted living director/registered nurse (ALD/RN)-B stated they thought they had purchased a policy and procedure manual and must have purchased the wrong thing.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 0 500 | | |
| 0 580 SS=F | 144G.42 Subd. 2 Quality management<br><br>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.<br><br>This MN Requirement is not met as evidenced by: | 0 580 | | |

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| 0 580 | Continued From page 8<br><br>Based on interview and record review, the licensee failed to engage in and maintain documentation of quality management activity appropriate to the size and relevant to the type of services provided by the assisted living. This had the potential to affect all residents receiving assisted living services.<br><br>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 or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).<br><br>The findings include:<br><br>During the entrance conference on October 13, 2025, at 9:30 a.m., agent (A)-A and assisted living director/registered nurse (ALD/RN)-B stated they were aware of the Assisted Living regulations. When asked about the licensee's quality management process, A-A and ALD/RN-B stated they do not have any formal process and have nothing in writing, but they meet regularly.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 0 580 | | |
| 0 660 SS=F | 144G.42 Subd. 9 Tuberculosis prevention and control<br><br>(a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current | 0 660 | | |

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| 0 660 | Continued From page 9<br><br>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.<br>(b) The facility must maintain written evidence of compliance with this subdivision.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure the provider established and maintained a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included completion of a facility TB risk assessment.<br><br>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 or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).<br><br>The findings include:<br><br>During the entrance conference on October 13, 2025, at 9:30 a.m., the surveyor asked for the facility TB risk assessment. Assisted living director/registered nurse (ALD/RN)-B stated the | 0 660 | | |

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| CARE4U HOME CARE SERVICES LLC | 13704 PORTLAND AVENUE SOUTH BURNSVILLE, MN 55337 |

| (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 |
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| 0 660 | Continued From page 10<br><br>TB risk assessment was completed when they first started and thought it was only required once.<br><br>The licensee's TB risk assessment provided was dated October 21, 2022, which indicated the TB risk level as low.<br><br>The MN Department of Health (MDH) Facility Tuberculosis (TB) Risk Assessment Instructions and Worksheet for Health Care Setting Licensed by MDH updated June 2023, indicated: Settings should perform a facility risk assessment on an annual basis.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 0 660 | | |
| 0 775 SS=F | 144G.45 Subd. 2. (a) Fire protection and physical environment<br><br>Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to comply with the current State Fire Code in Minnesota Rules, chapter 7511. This had the potential to directly affect all residents, staff, and visitors.<br><br>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 | 0 775 | | |

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| | 38633 | A. BUILDING: _____ B. WING _____ | 10/16/2025 |

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| 0 775 | Continued From page 11<br><br>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).<br><br>Findings include:<br><br>On October 16, 2025, from 11:30 a.m. to 2:30 p.m., the surveyor toured the facility with administrator (A)-A. During the tour, the surveyor observed:<br><br>LOCKS:<br>The basement exit door was equipped with a lockable handle, a deadbolt, and a flip style night latch. Doors from individual dwelling or sleeping units of Group R occupancies having an occupant load of ten or less are permitted to be equipped with a night latch, dead bolt, or security chain, provided such devices are openable from the inside without the use of a key or tool.<br><br>EXTERIOR OUTLET:<br>In the rear of the house, an exterior outlet with excess supply line was lying in a pile of leaves and not secure to the house. Duct tape was also found wrapped around a section of the line. A-A stated the line had been there since purchase of the house.<br><br>During a facility tour on October 16, 2025, at 1:30 p.m., A-A, verified the above listed observations while accompanying on the tour.<br><br>TIME PERIOD FOR CORRECTION: Two (2) day. | 0 775 | | |

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| 0 780 | Continued From page 12 | 0 780 | | |
| 0 780 SS=F | 144G.45 Subd. 2 (a) (1) Fire protection and physical environment<br><br>(a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:<br>(1) for dwellings or sleeping units, as defined in the State Fire Code:<br>(i) provide smoke alarms in each room used for sleeping purposes;<br>(ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms;<br>(iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics;<br>(iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and<br>(v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated;<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to provide smoke alarms that were interconnected so that the actuation of one alarm caused all alarms in the dwelling unit to actuate. This had the potential to directly affect all | 0 780 | | |

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| 0 780 | Continued From page 13<br>residents, staff, and visitors.<br><br>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).<br><br>Findings include:<br><br>INTERCONNECTION:<br>On October 16, 2025, from 11:30 a.m. to 2:30 p.m., the surveyor toured the facility with the administrator (A)-A. During the tour, the surveyor observed:<br><br>Facility has hard-wired smoke alarms in the common areas of the main and basement levels that was not interconnected with separate battery alarms located in bedrooms and other common areas of the facility. Provider was using separate battery powered system for interconnection; Facility should maintain one detection system. Smoke alarms were not interconnected so activation of one alarm activates all alarms throughout the facility.<br><br>During a facility tour on October 16, 2025, at 1:30 p.m., A-A, verified the above listed observations while accompanying on the tour.<br><br>TIME PERIOD FOR CORRECTION: Two (2) day | 0 780 | | |
| 0 810 SS=I | 144G.45 Subd. 2 (b-f) Fire protection and physical environment | 0 810 | | |

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| 0 810 | Continued From page 14<br><br>(b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:<br>(1) location and number of resident sleeping rooms;<br>(2) staff actions to be taken in the event of a fire or similar emergency;<br>(3) fire protection procedures necessary for residents; and<br>(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.<br>(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.<br>(d) Fire safety and evacuation plans shall be readily available at all times within the facility.<br>(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.<br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record | 0 810 | | |

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| 0 810 | Continued From page 15<br><br>review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training. This had the potential to directly affect all residents, staff, and visitors.<br><br>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).<br><br>The findings include:<br><br>On October 16, 2025, from 11:30 a.m. to 2:30 p.m., with administrator (A)-A. Surveyor asked for the documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility.<br><br>FIRE SAFETY AND EVACUATION PLAN:<br>The licensee failed to have a FSEP. A-A stated that they thought the emergency preparedness plan was the FSEP. Facility purchased an emergency preparedness plan from a vendor which did not include a FSEP.<br><br>STAFF ACTIONS:<br>Record review of the available documentation indicated that the licensee did not have specific employee actions for this facility to be taken in the event of a fire or similar emergency located within the plan.<br><br>RESIDENT ACTIONS:<br>Record review of the available documentation | 0 810 | | |

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| 0 810 | Continued From page 16<br><br>indicated that the licensee did not have detailed fire protection procedures necessary for residents located within the plan.<br><br>UNIQUE AND UNUSUAL RESIDENT NEEDS:<br>Record review of the available documentation indicated that the fire safety and evacuation plan did not include procedures for employees in regard to resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation.<br><br>On October 16, 2025, at 1:30 p.m., A-A stated they understood the areas of their policy that were incomplete and would work on bringing them into compliance.<br><br>TRAINING:<br>Record review of the available documentation indicated that employees did not receive training upon initial hire and twice per year thereafter on the facility fire safety and evacuation plan.<br><br>Record review of the available documentation indicated that the licensee did not provide training to residents who are capable of self-evacuation on the proper actions to be taken in the event of a fire in regard to movement, evacuation, and relocation.<br><br>On October 16, 2025, at 1:30 p.m., A-A stated they understood the requirements for training staff and would implement a training program that was compliant with statute requirements.<br><br>DRILLS<br>Record review of the available documentation did not indicate that evacuation drills had been | 0 810 | | |

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| 0 810 | Continued From page 17<br>conducted twice per year per shift and least once every other month as required.<br><br>On October 16, 2025, at 1:30 p.m., A-A, stated there were no additional documented drills for the facility and would implement fire drills that comply with statute requirements.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 0 810 | | |
| 01690 SS=F | 144G.71 Subdivision 1 Medication management services<br><br>(a) This section applies only to assisted living facilities that provide medication management services.<br>(b) An assisted living facility that provides medication management services must develop, implement, and maintain current written medication management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse, licensed health professional, or pharmacist consistent with current practice standards and guidelines.<br>(c) The written policies and procedures must address requesting and receiving prescriptions for medications; preparing and giving medications; verifying that prescription drugs are administered as prescribed; documenting medication management activities; controlling and storing medications; monitoring and evaluating medication use; resolving medication errors; communicating with the prescriber, pharmacist, and resident and legal and designated representatives; disposing of unused medications; and educating residents and legal and designated representatives about | 01690 | | |

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| 01690 | Continued From page 18<br><br>medications. When controlled substances are being managed, the policies and procedures must also identify how the provider will ensure security and accountability for the overall management, control, and disposition of those substances in compliance with state and federal regulations and with subdivision 23.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to develop, implement, and maintain current medication management policies and procedures under the supervision and direction of a registered nurse (RN) consistent with current practice standards and guidelines.<br><br>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).<br><br>The findings include:<br><br>During the entrance conference on October 13, 2025, at 9:30 a.m., agent (A)-A and assisted living director/registered nurse (ALD/RN)-B stated the licensee provided medication management services to the licensee's residents.<br><br>The licensee failed to ensure they had medication policies and procedures in place and kept current. | 01690 | | |

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| 01690 | Continued From page 19<br><br>On October 14, 2025, at 7:40 a.m., the surveyor observed unlicensed personnel (ULP)-C administering morning medications to R4.<br><br>On October 14, 2025, at 12:00 p.m., the surveyor received a large binder labeled Policy and Procedure Manual. In review of the binder, it was labeled Human Resources (HR) Manual containing HR forms, but it did not include any medication policies.<br><br>On October 14, 2025, at 12:30 p.m., agent (A)-A and assisted living director/registered nurse (ALD/RN)-B stated they thought they had purchased a policy and procedure manual and must have purchased the wrong thing.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01690 | | |
| 01880 SS=F | 144G.71 Subd. 19 Storage of medications<br><br>An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure the medication refrigerator maintained an acceptable temperature to ensure the medications were stored according to manufacturer's recommendations. | 01880 | | |

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| 01880 | Continued From page 20<br><br>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 or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).<br><br>The findings include:<br><br>On October 13, 2025, at 10:30 a.m. during the facility tour with agent (A)-A and assisted living director/registered nurse (ALD/RN)-B included a review of the medication refrigerator located at the locked nurse's station. The current temperature of the medication refrigerator was 44 degrees Fahrenheit (F).<br><br>The refrigerator contained the following medication:<br>- one unopened box of Ozempic two milligram(mg) pens for R4.<br>- one Lantus 100 units/milliliter (ml) insulin pen for R4<br>- six Novolog 100 units/ml insulin pens for R4<br><br>On October 14, 2025, at 7:40 a.m., the surveyor observed unlicensed personnel (ULP)-C administering morning diabetic medication to R4.<br><br>On October 14, 2025, at 9:00 a.m., the surveyor asked to review the temperature logs and A-A stated they check the temperature daily but do not have a formal process to record temperatures or have anyone specifically checking it.<br><br>The manufacturer's instructions for Lantus insulin | 01880 | | |

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| 01880 | Continued From page 21<br><br>pens dated December 2019, indicated before opening, store the insulin pens in the refrigerator (36-46 degrees Fahrenheit (F)). Do not allow the Lantus to freeze.<br><br>The manufacturer's instructions for Novolog insulin pens dated June 2021, indicated before opening, store the insulin pens in the refrigerator (36-46 degrees F). Do not allow the Novolog to freeze.<br><br>The manufacturer's instructions for Ozempic dated October 2025, indicated prior to first use, Ozempic pens should be refrigerated at 36 degrees to 46 degrees F. Do not allow pen to freeze.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01880 | | |
| 01890 SS=D | 144G.71 Subd. 20 Prescription drugs<br><br>A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure medications were maintained bearing the original prescription label with legible information including the expiration date for time sensitive medications for | 01890 | | |

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| 01890 | Continued From page 22<br>one of one resident (R4).<br><br>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).<br><br>The findings include:<br><br>On October 14, 2025, at 7:40 a.m., the surveyor observed unlicensed personnel (ULP)-C preparing R4's Ozempic medication and stated the pen did not have an open date and should have.<br><br>On October 14, 2025, at 11:15 a.m., assisted living director/registered nurse (ALD/RN)-B stated that insulin pens should be marked with the date they were opened, and would need to reinforce that retraining with staff.<br><br>The manufacturer's instructions for Ozempic dated October 2025, indicated that after first use of the Ozempic pen, the pen can be stored for 56 days.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01890 | | |
| 01910 SS=D | 144G.71 Subd. 22 Disposition of medications<br><br>(a) Any current medications being managed by the assisted living facility must be provided to the | 01910 | | |

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| 01910 | Continued From page 23<br><br>resident when the resident's service plan ends or 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.<br>(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.<br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed upon discharge, to document in the resident's record the disposition of the medication including the medication's prescription number (Rx), as applicable, and to whom the medications were given for one of one discharged resident (R1).<br><br>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). | 01910 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 38633 | A. BUILDING: _____ B. WING _____ | 10/16/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CARE4U HOME CARE SERVICES LLC | 13704 PORTLAND AVENUE SOUTH BURNSVILLE, MN 55337 |

| (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 |
|---|---|---|---|---|
| 01910 | Continued From page 24<br>The findings include:<br><br>R1 was admitted to the facility on April 13, 2022, and was discharged to another assisted living facility on September 25, 2025.<br><br>R1's care plan dated July 9, 2025, indicated R1 received assist with medication administration.<br><br>R1's record included a Disposition of Medications form dated September 25, 2025, that included the medication name and dosage, but it did not include the quantity or Rx number as required.<br><br>On October 13, 2025, at 2:15 p.m., assistant living director/registered nurse (ALD/RN)-B stated R1's disposition form did not include Rx number or quantity because he did not think it was needed since it was included on the medication packets sent with the resident.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01910 | | |
| 01930 SS=F | 144G.72 Subd. 2 Policies and procedures<br><br>(a) An assisted living facility that provides treatment and therapy management services must develop, implement, and maintain up-to-date written treatment or therapy management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse or appropriate licensed health professional consistent with current practice standards and guidelines.<br>(b) The written policies and procedures must | 01930 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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|---|---|---|---|---|
| 01930 | Continued From page 25<br><br>address requesting and receiving orders or prescriptions for treatments or therapies, providing the treatment or therapy, documenting treatment or therapy activities, educating and communicating with residents about treatments or therapies they are receiving, monitoring and evaluating the treatment or therapy, and communicating with the prescriber.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to develop, implement, and maintain up-to-date written treatment or therapy management policies and procedures.<br><br>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).<br><br>The findings include:<br><br>During the entrance conference on October 13, 2025, at 9:30 a.m., agent (A)-A and assisted living director/registered nurse (ALD/RN)-B stated the licensee provided treatment management services to the licensee's residents.<br><br>The licensee failed to ensure they had treatment policies and procedures in place and kept current that were facility specific, to include the following required topics:<br>- requesting and receiving orders or prescriptions | 01930 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 38633 | A. BUILDING: _____ B. WING _____ | 10/16/2025 |

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| CARE4U HOME CARE SERVICES LLC | 13704 PORTLAND AVENUE SOUTH BURNSVILLE, MN 55337 |

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|---|---|---|---|---|
| 01930 | Continued From page 26<br><br>for treatments or therapies.<br>- providing the treatment or therapy.<br>- documenting treatment or therapy activities.<br>- educating and communicating with residents about treatments or therapies they are receiving.<br>- monitoring and evaluating the treatment or therapy; and<br>- communicating with the prescriber.<br><br>On October 14, 2025, at 12:00 p.m., the surveyor received a large binder labeled Policy and Procedure Manual. In review of the binder, it was labeled Human Resources (HR) Manual containing HR forms, and it did not contain any treatment policies.<br><br>On October 14, 2025, at 12:30 p.m., agent (A)-A and assisted living director/registered nurse (ALD/RN)-B stated they thought they had purchased a policy and procedure manual and must have purchased the wrong thing.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01930 | | |

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

CARE4U HOME CARE SERVICES LLC
13704 PORTLAND AVENUE SOUTH
Burnsville, MN 55337
Dakota County
Parcel:

Phone:

## License Info

License: HFID 38633

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

## Inspection Info

Report Number: F1005251165
Inspection Type: Full - Single
Date: 10/14/2025 Time: 10:30 AM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 1
Total Priority 3 Orders: 0
Delivery: Emailed

**New Order: 4-300 Equipment Numbers and Capacities**
4-302.13B *Priority Level: Priority 2 CFP#: 48*
*MN Rule 4626.0710B* Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.
COMMENT: THERE IS NO DEVICE ON SITE TO MEASURE THE UTENSIL SURFACE TEMPERATURE IN THE DISH MACHINE. PROVIDE TEMPERATURE STRIPS OR A MAXIMUM REGISTERING THERMOMETER TO VERIFY THAT THE UTENSIL SURFACE TEMPERATURE IS 160 DEGREES F OR ABOVE.
*Comply By: 10/21/2025 Originally Issued On: 10/14/2025*

# Food & Beverage General Comment

INSPECTION COMPLETED WITH STAFF AND REVIEWED WITH HRD NURSING EVALUATOR TRACEY FEARON.

INSPECTOR LEFT THERMOLABELS ON SITE AND AFTER INSPECTION OPERATOR SENT INSPECTOR A PICTURE OF THE TEMPERATURE STRIP THEY RAN THROUGH THEIR DISHWASHER, WHICH SHOWED IT PROVIDED A UTENSIL SURFACE TEMPERATURE OF 160+ DEGREES F.

DISCUSSED DATE MARKING, GLOVE USE, COOKING TEMPERATURES, CROSS-CONTAMINATION, AND EMPLOYEE ILLNESS.

KITCHEN IS RESIDENTIAL AND FOOD IS PREPARED FOR SAME DAY SERVICE.

CABINETS ARE WOOD WITH HOLLOW BASE AND COUNTERS ARE LAMINATE. ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT SUCH A TIME THEY ARE FOUND TO BE A CONCERN OR RISK OF CONTAMINATION, THEY WILL BE ORDERED TO BE REPLACED AND BROUGHT UP TO CODE.

**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 F1005251165 from 10/14/2025**

SOTHY NGUN VONG
OWNER

Jessica Davis, REHS
Public Health Sanitarian 3
651-201-3961
jessica.davis@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

CARE4U HOME CARE SERVICES LLC
Burnsville
County/Group: Dakota County

## Inspection Info

Report Number: F1005251165
Inspection Type: Full
Date: 10/14/2025
Time: 10:30 AM

**Equipment Temperature: Product/Item/Unit:** AMBIENT**; Temperature Process:** Cold-Holding
**Location:** Refrigerator at 41 Degrees F.
Comment:
*Violation Issued?: No*

**Food Temperature: Product/Item/Unit:** MILK**; Temperature Process:** Cold-Holding
**Location:** Refrigerator 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

CARE4U HOME CARE SERVICES LLC
Burnsville
County/Group: Dakota County

## Inspection Info

Report Number: F1005251165
Inspection Type: Full
Date: 10/14/2025
Time: 10:30 AM

**Sanitizing Equipment:** **Product:** Hot Water**; Sanitizing Process:** Dishwasher
**Location:** **Greater Than** 160 Degrees F.
Comment: At least 160 F as indicated by Thermolabel
*Violation Issued?: No*