Electronically Delivered

August 20, 2025

Licensee
Carechoice Homes LLC
1422 Trollhagen Drive
Fridley, MN 55421

RE: Project Number(s) SL38732016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 8, 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.

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

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. 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 addtion 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

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

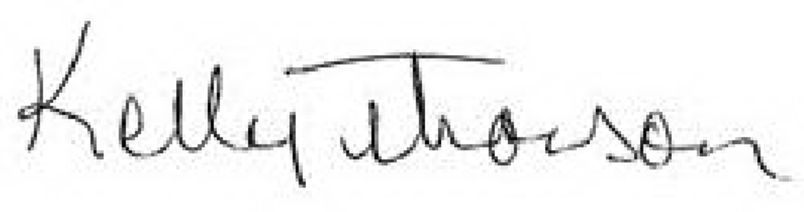
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms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



Kelly Thorson, Supervisor
State Evaluation Team
Email: Kelly.Thorson@state.mn.us
Telephone: 320-223-7336 Fax: 1-866-890-9290

KKM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38732	A. BUILDING: _____ B. WING _____	07/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECHOICE HOMES LLC	1422 TROLLHAGEN DRIVE FRIDLEY, MN 55421

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ***ATTENTION*** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL38732016 On July 7, 2025, through July 8, 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; all receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Licensing 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 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food	0 480		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38732	A. BUILDING: _____ B. WING _____	07/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECHOICE HOMES LLC	1422 TROLLHAGEN DRIVE FRIDLEY, MN 55421

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 480	Continued From page 1 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 allowed provided the facility keeps them clean	0 480		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38732	A. BUILDING: _____ B. WING _____	07/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECHOICE HOMES LLC	1422 TROLLHAGEN DRIVE FRIDLEY, MN 55421

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 480	Continued From page 2 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 the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated, July 8, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer	0 480		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38732	A. BUILDING: _____ B. WING _____	07/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECHOICE HOMES LLC	1422 TROLLHAGEN DRIVE FRIDLEY, MN 55421

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 480	Continued From page 3 to the FBEIR for any compliance dates.	0 480		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included a two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test, for one of one employee unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive	0 660		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38732	A. BUILDING: _____ B. WING _____	07/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECHOICE HOMES LLC	1422 TROLLHAGEN DRIVE FRIDLEY, MN 55421

(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
0 660	Continued From page 4 or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: The facility TB risk assessment was completed January 1, 2025, and indicated the facility was at a low risk for TB transmission. ULP-B was hired August 15, 2024, and provided direct care services to residents. ULP-B's record lacked a two-step TST or other evidence of TB screening such as a blood test. On July 7, 2025, at 1:25 p.m., clinical nurse supervisor (CNS)-A stated they skip the blood test and just do a chest x-ray to rule out TB for all employees The Minnesota Department of Health guidelines Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, and based on CDC guidelines, indicated a TB infection control program should include an annual facility TB risk assessment. The guidelines also indicated an employee may begin working with patients (residents) after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW starts working with patients. Baseline TB screening should be documented in the employee's record. The licensee's Tuberculosis Screening/Prevention policy dated August 1, 2021, indicated employees receive baseline TB screening upon hire to test for infection with M.	0 660		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38732	A. BUILDING: _____ B. WING _____	07/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECHOICE HOMES LLC	1422 TROLLHAGEN DRIVE FRIDLEY, MN 55421

(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
0 660	Continued From page 5 Tuberculosis. Baseline screening includes an assessment for TB history and current TB symptoms. An employee's history of BCG vaccination will be disregarded when administering and interpreting TST results. The baseline test may be either TST (two-step) or BAMT. Employees with written documentation of a previous positive TST or BAMT do not need a repeat TST or BAMT. Employees with a verbal, but undocumented, history of a previous positive TST or BAMT will undergo the same screening process as those without previous positive results. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
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 and interview, the licensee failed to comply with the requirements of Minnesota State Fire Code Rules, Chapter 7511. This had the potential to directly 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	0 775		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38732	A. BUILDING: _____ B. WING _____	07/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECHOICE HOMES LLC	1422 TROLLHAGEN DRIVE FRIDLEY, MN 55421

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 775	Continued From page 6 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: On July 8, 2025, at 10:50 a.m., the surveyor toured the facility with clinical nurse supervisor (CNS)-A. During the facility tour, the surveyor observed the following: SMOKING MATERIAL DISPOSAL In occupied resident sleeping room one, burnt cigarettes and ashes were disposed of on the top surfaces of a refrigerator and wood dresser, and inside a blue cup stored on the floor in the closet. In the closet, there were ashes on the hardwood floor and on a plastic tub that had been turned upside down. Additionally, the top surface of the hardwood floor in the closet had several burn marks. Improper smoking material disposal creates a fire hazard to all building occupants. During the facility tour interview, CNS-A verified the above listed smoking material disposal observations. CNS-A stated residents were instructed to smoke outside in the designated area and were not allowed to smoke in their rooms. EXTENSION CORDS In occupied resident sleeping room one, an extension cord was plugged into a wall outlet, routed under the door and into the closet to supply power. In occupied resident sleeping room two, an extension cord and power strip were daisy chained together. In the basement, two extension cords were used to supply power. During the facility tour interview, CNS-A verified the above listed extension cord observations and stated these extension cords would be removed. TIME PERIOD FOR CORRECTION: Two (2)	0 775		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38732	A. BUILDING: _____ B. WING _____	07/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECHOICE HOMES LLC	1422 TROLLHAGEN DRIVE FRIDLEY, MN 55421

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 775	Continued From page 7 days	0 775		
0 800 SS=E	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On July 8, 2025, at 10:50 a.m., the surveyor toured the facility with clinical nurse supervisor	0 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38732	A. BUILDING: _____ B. WING _____	07/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECHOICE HOMES LLC	1422 TROLLHAGEN DRIVE FRIDLEY, MN 55421

(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
0 800	Continued From page 8 (CNS)-A. During the facility tour, the surveyor observed the following: - In the backyard, a broken branch was hanging down and still partially attached to a large tree, creating a safety risk to residents. During an interview on July 8, 2025, at 12:50 p.m., CNS-A stated the licensee had already scheduled a tree service to remove this branch. - In the basement resident bathroom, there was a hole in one ceiling tile, and several other ceiling tiles were water stained. - In the basement laundry room, plastic ceiling panels were broken and/or cracked. During the facility tour interview, CNS-A verified the above listed basement physical environment observations. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	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	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38732	A. BUILDING: _____ B. WING _____	07/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECHOICE HOMES LLC	1422 TROLLHAGEN DRIVE FRIDLEY, MN 55421

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 810	Continued From page 9 training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with required content, make the plan readily available, and provide required training and drills. This had the potential to directly 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) 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: FIRE SAFETY AND EVACUATION PLAN	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38732	A. BUILDING: _____ B. WING _____	07/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECHOICE HOMES LLC	1422 TROLLHAGEN DRIVE FRIDLEY, MN 55421

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 810	Continued From page 10 On July 8, 2025, at 10:50 a.m., the surveyor toured the facility with clinical nurse supervisor (CNS)-A. During the facility tour, the surveyor observed the following: - A written copy of the fire safety and evacuation plan (FSEP) was not posted in the facility. On July 8, 2025, the surveyor requested the written FSEP from clinical nurse supervisor (CNS)-A. CNS-A provided an emergency preparedness binder and stated the FSEP was kept in this binder. Record review of the available documentation in the binder indicated it did not include a written FSEP. The FSEP was not located in a central location for all accessibility. The FSEP floor plan failed to include the location and number of resident sleeping rooms and identify the emergency exits evident by the following: - Two resident sleeping rooms were located in the basement. The basement FSEP floor plan posted at the main entrance labeled one bedroom in the basement. - A FSEP floor plan for the main floor was not posted. Three resident sleeping rooms were located on the main floor. - Occupied resident sleeping room 2 was verbally identified by CNS-A. A room number identifier was not posted at the door. During the tour interview, CNS-A stated the door had recently been replaced and the room number had not yet been reinstalled. - Numbers were posted at the doors for resident sleeping rooms 1, 3, 4, and 5. The posted FSEP floor plan was lacking these resident room number labels. Resident room numbers are required to be included on the FSEP floor plan and correspond with the numbers installed at the resident room doors to provide efficient communication for exiting in the event of a fire or similar emergency.	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38732	A. BUILDING: _____ B. WING _____	07/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECHOICE HOMES LLC	1422 TROLLHAGEN DRIVE FRIDLEY, MN 55421

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 810	Continued From page 11 - Emergency exit doors were not labeled on the posted FSEP floor plan. Exit doors are required to be identified on the FSEP floor plan to direct the building occupants to these exits in the event of an emergency. During an interview on July 8, 2025, at 12:50 p.m., CNS-A verified the FSEP floor plan required revision and they were unable to locate a copy of the written FSEP procedures in the emergency preparedness binder. The licensee failed to develop a site specific FSEP with employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks evident by the lack of these procedures. The licensee failed to develop the FSEP with specific fire protection instructions for residents evident by a lack of these procedures. The licensee failed to develop the FSEP with specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents evident by a lack of these procedures. During an interview on July 8, 2025, at 12:50 p.m., CNS-A stated the FSEP had been developed, but they were unable to locate these procedures. TRAINING On July 8, 2025, clinical nurse supervisor (CNS)-A provided documentation on fire safety and evacuation training for residents and employees. Record review indicated the licensee failed to	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38732	A. BUILDING: _____ B. WING _____	07/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECHOICE HOMES LLC	1422 TROLLHAGEN DRIVE FRIDLEY, MN 55421

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 810	Continued From page 12 provide fire safety and evacuation training to residents at least once per year evident by a review of training records lacking the required frequency. Record review indicated the licensee failed to provide training to employees on the FSEP upon hire and at least twice per year evident by a review of training records lacking the required frequency. A fire safety and emergency evacuation training log for staff and resident training, dated April 8, 2024, was provided with three names recorded. No additional training records were provided. During an interview on July 8, 2025, at 12:50 p.m., CNS-A verified the training frequency was lacking. DRILLS On July 8, 2025, clinical nurse supervisor (CNS)-A provided documents on evacuation drills for the facility. During an interview on July 8, 2025, at 12:50 p.m., CNS-A stated they were having a hard time printing out all of the evacuation fire drill records and would email any remaining documentation. On July 9, 2025, CNS-A emailed the surveyor additional fire drill logs. Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month evident by a review of fire drill logs lacking the required frequency. Two fire drills were recorded in February 2025. Four fire drills were recorded in 2024, dated June, August, September, and December. The June and August 2024 drill logs did not include the shift or time of	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38732	A. BUILDING: _____ B. WING _____	07/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECHOICE HOMES LLC	1422 TROLLHAGEN DRIVE FRIDLEY, MN 55421

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 810	Continued From page 13 the drill. The September 16, 2024, drill log inappropriately listed staff actions as closing doors and sheltering in place for a building with no life safety systems or fire resistant construction type. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 830 SS=E	144G.45 Subd. 3 Local laws apply Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements, except a facility with a licensed resident capacity of six or fewer is exempt from rental licensing regulations imposed by any town, municipality, or county. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to obtain a building permit and submit a Minnesota Department of Health engineering services plan review application for facility construction projects. 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the	0 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38732	A. BUILDING: _____ B. WING _____	07/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECHOICE HOMES LLC	1422 TROLLHAGEN DRIVE FRIDLEY, MN 55421

(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
0 830	Continued From page 14 situation has occurred repeatedly; but is not found to be pervasive). The findings include: On July 8, 2025, at 10:50 a.m., the surveyor toured the facility with clinical nurse supervisor (CNS)-A. During the facility tour, the surveyor observed the following: - A ramp constructed of wood was installed on the exterior of the building, leading from the driveway up to the front door. During the facility tour interview, CNS-A stated the ramp had been installed three months ago, and a permit from the city was obtained for the project. - A new front door had been installed. - For occupied resident room 2, a new door measuring 42 inches in width was installed. - A new walk in shower and bathroom door, measuring 30 inches in width was installed. During the facility tour interview, CNS-A stated these new doors and the shower had recently been installed to make the building more accessible, and permits from the city were not required for these projects. During an interview on July 8, 2025, at 12:50 p.m., the surveyor requested a copy of the city building permit for the ramp from CNS-A. CNS-A stated they had not been able to locate the permit and would email this information to the surveyor no later than 10:00 a.m. on July 9, 2025. CNS-A stated they were not aware of any plan review requirements for these projects. No further information was received. TIME PERIOD FOR CORRECTION: Seven (7) days	0 830		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38732	A. BUILDING: _____ B. WING _____	07/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECHOICE HOMES LLC	1422 TROLLHAGEN DRIVE FRIDLEY, MN 55421

(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
01620	Continued From page 15 (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38732	A. BUILDING: _____ B. WING _____	07/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECHOICE HOMES LLC	1422 TROLLHAGEN DRIVE FRIDLEY, MN 55421

(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
01620	Continued From page 16 the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to ensure the registered nurse (RN) completed an ongoing reassessment and monitoring on or before day 90 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, 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: On July 7, 2025, at 10:30 a.m., during the entrance conference, clinical nurse supervisor (CNS)-A stated a registered nurse completed assessments upon admission, 14 days, every 90 days, and with changes in condition or incidents. R1 began receiving services on January 3, 2024. R1's record indicated a 90-day comprehensive nursing assessment was completed on March 18,	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38732	A. BUILDING: _____ B. WING _____	07/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECHOICE HOMES LLC	1422 TROLLHAGEN DRIVE FRIDLEY, MN 55421

(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
01620	Continued From page 17 2025. On July 8, 2025, at 2:03 p.m., clinical nurse supervisor (CNS)-A stated an assessment had been done on time for R1, but he did not close it in the electronic system, so it looked like it was late. CNS-A further stated the assessments for the other residents were completed on time. The licensee's Assessment and Reassessment policy dated August 1, 2021, indicated ongoing resident reassessments must be conducted by an RN and cannot exceed 90 days from the last date of assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility;	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38732	A. BUILDING: _____ B. WING _____	07/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECHOICE HOMES LLC	1422 TROLLHAGEN DRIVE FRIDLEY, MN 55421

(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
01650	Continued From page 18 (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure resident service plans included all the required content 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, 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 the residents). The findings include: R1's service plan dated January 3, 2025, indicated R1 received assistance with grooming, dressing, positioning, transfers, toileting, medication administration, and blood glucose monitoring. On July 8, 2025, at 9:05 a.m., the surveyor observed unlicensed personnel (ULP)-B	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38732	A. BUILDING: _____ B. WING _____	07/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECHOICE HOMES LLC	1422 TROLLHAGEN DRIVE FRIDLEY, MN 55421

(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
01650	Continued From page 19 administer medications to R1. R1's service plan lacked the following: -the action to be taken if the scheduled service cannot be provided -information and a method to contact the facility -the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in and emergency -the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters On July 8, 2025, at 2:04 p.m., clinical nurse supervisor (CNS)-A stated they did not realize the forms they were using for the service plan did not meet all the requirements and will start using the service plans in their electronic system. CNS-A further stated the same service plan forms were used for all the residents. The licensee's Service Plan policy dated August 1, 2021, indicated a service plan will include a contingency plan that includes the following: -action to be taken if the scheduled service cannot be provided -information and method for a resident to resident's representative to contact the facility -names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition -the identification of and information as to who has the authority to sign for the resident in an emergency	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38732	A. BUILDING: _____ B. WING _____	07/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECHOICE HOMES LLC	1422 TROLLHAGEN DRIVE FRIDLEY, MN 55421

(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
01650	Continued From page 20 -circumstances in which emergency medical services are not to be summoned and declarations made by the resident related to health care directives. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		
01760 SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure prescriber orders were transcribed accurately 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, but was not likely to	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38732	A. BUILDING: _____ B. WING _____	07/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECHOICE HOMES LLC	1422 TROLLHAGEN DRIVE FRIDLEY, MN 55421

(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
01760	Continued From page 21 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 the residents). The findings include: R1's service plan, dated January 3, 2025, indicated R1 received medication administration services. On July 8, 2025, at 9:05 a.m., the surveyor observed unlicensed personnel (ULP)-B administer medications to R1. R1's medication administration record (MAR) dated July 2025, included the following scheduled medications: -aripiprazole 20mg, take one tablet daily -bumetanide 0.5mg, take 1 tablet daily -buprenorphine patch apply 1 patch every 7 days -buspirone 10mg, take 1 tablet two times a day -Combivent Respimat inhale one puff by mouth four times a day -enoxaparin 120ml/0.8ml inject 0.8ml twice a day -famotidine 20mg take 1 tablet twice daily -ferrous sulfate 325mg, take one tablet every Monday, Wednesday, and Friday -fluticasone-umeclidin-vilanter, inhale one puff daily -lubiprostone 24mcg, take one capsule twice a day -Mounjaro 12.5mg, inject 12.5mg every 7 days -nicotine patch, apply one patch daily -nystatin powder, apply twice a day -oxybutynin 10mg, take one tablet daily -polyethylene glycol 17g, take 17g daily -portable oxygen use 2-3L of oxygen continuously - pregabalin 200mg, take 200mg three times a	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38732	A. BUILDING: _____ B. WING _____	07/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECHOICE HOMES LLC	1422 TROLLHAGEN DRIVE FRIDLEY, MN 55421

(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
01760	Continued From page 22 day -tizanidine 4mg, take one tablet three times a day -venlafaxine ER 75mg, take one capsule daily -vitamin D3 take 3 capsules (3000u) daily -eszopiclone 2mg, take one tablet every night -insulin glargine 10units, inject 10u every evening -lithium 300mg, take one tablet daily -metformin ER 500mg, take 4 tablets at bedtime -metoprolol 10mg, take 1 tablet daily -omeprazole 20mg, take one tablet daily -rosuvastatin 20mg, take one tablet at bedtime -trazadone 150mg, take 1-2 tablets at bedtime R1's record indicated transcription errors for the following medications: -cholecalciferol (vitamin D3) 125mcg (5000 unit) capsule, take one capsule daily -trazadone 150mg tablet, take 2 tabs every night -insulin glargine 100u/ml (3ml), inject 10 units at bedtime while on prednisone for the next 5 days- dated April 30, 2025 -Mounjaro 15mg/0.5ml, inject 15mg every 7 days On July 8, 2025, at 2:10 p.m., clinical nurse supervisor (CNS)-A stated he knew there were some discrepancies between the orders and the MAR. The provider sends the orders to the pharmacy and changes are not always communicated with the facility. The pharmacy communicates the changes. R1 has a lot of appointments and does not communicate with us, and it can be hard to keep up with changes in orders. The licensee's Medication Orders policy dated August 1, 2021, indicated [the facility] will maintain a current written or electronically recorded prescription for all prescribed medications managed for the resident. Medication orders will be renewed at least every	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38732	A. BUILDING: _____ B. WING _____	07/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECHOICE HOMES LLC	1422 TROLLHAGEN DRIVE FRIDLEY, MN 55421

(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
01760	Continued From page 23 12 months or as required by the physician, the RN assessment and/or regulation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01760		
01820 SS=F	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain current medication orders 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, 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 the residents). The findings include: R1's service plan, dated January 3, 2025, indicated R1 received medication administration services. On July 8, 2025, at 9:05 a.m., the surveyor observed unlicensed personnel (ULP)-B	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38732	A. BUILDING: _____ B. WING _____	07/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECHOICE HOMES LLC	1422 TROLLHAGEN DRIVE FRIDLEY, MN 55421

(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
01820	Continued From page 24 administer medications to R1. R1's medication administration record (MAR) dated July 2025, included the following scheduled medications: -aripiprazole 20mg, take one tablet daily -bumetanide 0.5mg, take 1 tablet daily -buprenorphine patch apply 1 patch every 7 days -buspirone 10mg, take 1 tablet two times a day -Combivent Respimat inhale one puff by mouth four times a day -enoxaparin 120ml/0.8ml inject 0.8ml twice a day -famotidine 20mg take 1 tablet twice daily -ferrous sulfate 325mg, take one tablet every Monday, Wednesday, and Friday -fluticasone-umeclidin-vilanter, inhale one puff daily -lubiprostone 24mcg, take one capsule twice a day -Mounjaro 12.5mg, inject 12.5mg every 7 days -nicotine patch, apply one patch daily -nystatin powder, apply twice a day -oxybutynin 10mg, take one tablet daily -polyethylene glycol 17g, take 17g daily -portable oxygen use 2-3L of oxygen continuously - pregabalin 200mg, take 200mg three times a day -tizanidine 4mg, take one tablet three times a day -venlafaxine ER 75mg, take one capsule daily -vitamin D3 take 3 capsules (3000u) daily -eszopiclone 2mg, take one tablet every night -insulin glargine 10units, inject 10u every evening -lithium 300mg, take one tablet daily -metformin ER 500mg, take 4 tablets at bedtime -metoprolol 10mg, take 1 tablet daily -omeprazole 20mg, take one tablet daily -rosuvastatin 20mg, take one tablet at bedtime -trazadone 150mg, take 1-2 tablets at bedtime R1's record lacked signed provider orders for the	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38732	A. BUILDING: _____ B. WING _____	07/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECHOICE HOMES LLC	1422 TROLLHAGEN DRIVE FRIDLEY, MN 55421

(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
01820	Continued From page 25 following medications: -buprenorphine patch apply 1 patch every 7 days -buspirone 10mg, take 1 tablet two times a day -Combivent Respimat inhale one puff by mouth four times a day -fluticasone-umeclidin-vilanter, inhale one puff daily -lubiprostone 24mcg, take one capsule twice a day -nystatin powder, apply twice a day R1's record had expired provider orders for the following medications: -eszopiclone 2mg tablet- dated February 1, 2024 -metformin ER 500mg, take 4 tablets at bedtime- dated January 30, 2024 -metoprolol succinate ER 100mg- dated January 30, 2024 -enoxaparin 120mg/0.8ml inject 0.8ml twice daily- dated January 4, 2024 -cholecalciferol (vitamin D3) 125mcg (5000 unit) capsule, take one capsule daily dated January 30, 2024 -rosuvastatin 20mg, take one tablet at bedtime- dated January 30, 2024 -famotidine 20mg tablet, take 1 tablet twice daily- dated January 30, 2024 R1's record indicated transcription errors for the following medications: -cholecalciferol (vitamin D3) 125mcg (5000 unit) capsule, take one capsule daily -trazadone 150mg tablet, take 2 tabs every night -insulin glargine 100u/ml (3ml), inject 10 units at bedtime while on prednisone for the next 5 days- dated April 30, 2025 -Mounjaro 15mg/0.5ml, inject 15mg every 7 days On July 8, 2025, at 2:10 p.m., clinical nurse supervisor (CNS)-A stated he knew there were	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38732	A. BUILDING: _____ B. WING _____	07/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECHOICE HOMES LLC	1422 TROLLHAGEN DRIVE FRIDLEY, MN 55421

(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
01820	Continued From page 26 some discrepancies between the orders and the MAR. The provider sends the orders to the pharmacy and changes are not always communicated with the facility. The pharmacy communicates the changes. R1 has a lot of appointments and does not communicate with us, and it can be hard to keep up with changes in orders. The licensee's Medication Orders policy dated August 1, 2021, indicated [the facility] will maintain a current written or electronically recorded prescription for all prescribed medications managed for the resident. Medication orders will be renewed at least every 12 months or as required by the physician, the RN assessment and/or regulation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01820		
01830 SS=F	144G.71 Subd. 14 Renewal of prescriptions Prescriptions must be renewed at least every 12 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter 152. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure prescriptions were renewed at least every 12 months for one of one resident (R1).	01830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38732	A. BUILDING: _____ B. WING _____	07/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECHOICE HOMES LLC	1422 TROLLHAGEN DRIVE FRIDLEY, MN 55421

(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
01830	Continued From page 27 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 the residents). The findings include: R1 began receiving services on January 3, 2024. R1's service plan, dated January 3, 2025, indicated R1 received medication administration services. On July 8, 2025, at 9:05 a.m., the surveyor observed unlicensed personnel (ULP)-B administer medications to R1. R1's medication administration record (MAR) dated July 2025, included the following scheduled medications: -aripiprazole 20mg, take one tablet daily -bumetanide 0.5mg, take 1 tablet daily -buprenorphine patch apply 1 patch every 7 days -buspirone 10mg, take 1 tablet two times a day -Combivent Respimat inhale one puff by mouth four times a day -enoxaparin 120ml/0.8ml inject 0.8ml twice a day -famotidine 20mg take 1 tablet twice daily -ferrous sulfate 325mg, take one tablet every Monday, Wednesday, and Friday -fluticasone-umeclidin-vilanter, inhale one puff daily -lubiprostone 24mcg, take one capsule twice a day -Mounjaro 12.5mg, inject 12.5mg every 7 days	01830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38732	A. BUILDING: _____ B. WING _____	07/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECHOICE HOMES LLC	1422 TROLLHAGEN DRIVE FRIDLEY, MN 55421

(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
01830	Continued From page 28 -nicotine patch, apply one patch daily -nystatin powder, apply twice a day -oxybutynin 10mg, take one tablet daily -polyethylene glycol 17g, take 17g daily -portable oxygen use 2-3L of oxygen continuously - pregabalin 200mg, take 200mg three times a day -tizanidine 4mg, take one tablet three times a day -venlafaxine ER 75mg, take one capsule daily -vitamin D3 take 3 capsules (3000u) daily -eszopiclone 2mg, take one tablet every night -insulin glargine 10units, inject 10u every evening -lithium 300mg, take one tablet daily -metformin ER 500mg, take 4 tablets at bedtime -metoprolol 10mg, take 1 tablet daily -omeprazole 20mg, take one tablet daily -rosuvastatin 20mg, take one tablet at bedtime -trazadone 150mg, take 1-2 tablets at bedtime R1's record lacked signed provider orders for the following medications: -buprenorphine patch apply 1 patch every 7 days -buspirone 10mg, take 1 tablet two times a day -Combivent Respimat inhale one puff by mouth four times a day -fluticasone-umeclidin-vilanter, inhale one puff daily -lubiprostone 24mcg, take one capsule twice a day -nystatin powder, apply twice a day R1's record had expired provider orders for the following medications: -eszopiclone 2mg tablet- dated February 1, 2024 -metformin ER 500mg, take 4 tablets at bedtime- dated January 30, 2024 -metoprolol succinate ER 100mg- dated January 30, 2024 -enoxaparin 120mg/0.8ml inject 0.8ml twice daily- dated January 4, 2024	01830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38732	A. BUILDING: _____ B. WING _____	07/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECHOICE HOMES LLC	1422 TROLLHAGEN DRIVE FRIDLEY, MN 55421

(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
01830	Continued From page 29 -cholecalciferol (vitamin D3) 125mcg (5000 unit) capsule, take one capsule daily dated January 30, 2024 -rosuvastatin 20mg, take one tablet at bedtime-dated January 30, 2024 -famotidine 20mg tablet, take 1 tablet twice daily-dated January 30, 2024 On July 8, 2025, at 2:10 p.m., clinical nurse supervisor (CNS)-A stated he knew there were some discrepancies between the orders and the MAR. The provider sends the orders to the pharmacy and changes are not always communicated with the facility. The pharmacy communicates the changes. R1 has a lot of appointments and does not communicate with us, and it can be hard to keep up with changes in orders. The licensee's Medication Orders policy dated August 1, 2021, indicated [the facility] will maintain a current written or electronically recorded prescription for all prescribed medications managed for the resident. Medication orders will be renewed at least every 12 months or as required by the physician, the RN assessment and/or regulation. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01830		
01940 SS=F	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38732	A. BUILDING: _____ B. WING _____	07/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECHOICE HOMES LLC	1422 TROLLHAGEN DRIVE FRIDLEY, MN 55421

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01940	Continued From page 30 services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop a treatment or therapy management plan to include the required content 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, but was not likely to	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38732	A. BUILDING: _____ B. WING _____	07/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECHOICE HOMES LLC	1422 TROLLHAGEN DRIVE FRIDLEY, MN 55421

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01940	Continued From page 31 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 the residents). The findings include: R1 was admitted on January 3, 2024. On July 8, 2025, at 9:05 a.m., the surveyor observed unlicensed personnel (ULP)-B administer medications to R1. R1's service plan dated January 3, 2025, indicated R1 received services including but not limited to assistance with activities of daily living, medication administration, catheter care, blood glucose monitoring, and repositioning. R1's comprehensive nursing assessment dated March 18, 2025, indicated R1 needed assistance with transfers, repositioning, oxygen management, medication administration, catheter care, and blood glucose monitoring. R1's record lacked evidence of an individualized treatment or therapy management plan which included the following for assistance with blood glucose monitoring and oxygen management: -a statement of the type of services that will be provided - documentation of specific resident instructions relating to the treatments or therapy administered -identification of treatment or therapy tasks that will be delegated to unlicensed personnel -procedures for notifying a registered nurse or licensed health professional when a problem arises related to the treatment or therapy service -any resident-specific requirements relating to	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38732	A. BUILDING: _____ B. WING _____	07/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECHOICE HOMES LLC	1422 TROLLHAGEN DRIVE FRIDLEY, MN 55421

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01940	Continued From page 32 documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. -a written statement of the treatment or therapy included in the service plan On July 8, 2025, at 2:27 p.m., clinical nurse supervisor (CNS)-A stated there were aware of the requirements of the treatment and therapy plans and not having plans in place for the unlicensed staff to follow was an oversight on his part. The licensee's Treatment and Therapy Management policy dated August 1, 2021, indicated the RN or licensed professional will prepare an individualized treatment or therapy management plan for each resident receiving ordered or prescribed treatments or therapy services, which addresses: -type of service to be provided -procedures for documenting treatments or therapies -procedures for monitoring treatments or therapies to prevent possible complications or adverse reactions -identification of treatment or therapy tasks delegated to unlicensed personnel -procedures for notifying the RN or licensed health professional when a problem arises related to the treatment or therapy service No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38732	A. BUILDING: _____ B. WING _____	07/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECHOICE HOMES LLC	1422 TROLLHAGEN DRIVE FRIDLEY, MN 55421

(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
01970	Continued From page 33	01970		
01970 SS=F	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure up-to-date written or electronically recorded orders were maintained for one of one resident (R1) receiving treatments. 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 the residents). The findings include: R1 was admitted on January 3, 2024. On July 8, 2025, at 9:05 a.m., the surveyor observed unlicensed personnel (ULP)-B administer medications to R1. R1's service plan dated January 3, 2025, indicated R1 received services including but not limited to assistance with activities of daily living, medication administration, catheter care, blood	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38732	A. BUILDING: _____ B. WING _____	07/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECHOICE HOMES LLC	1422 TROLLHAGEN DRIVE FRIDLEY, MN 55421

(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
01970	Continued From page 34 glucose monitoring, and repositioning. R1's comprehensive nursing assessment dated March 18, 2025, indicated R1 needed assistance with transfers, repositioning, oxygen management, medication administration, catheter care, and blood glucose monitoring. R1's record included a letter from the provider dated May 13, 2024, which indicated please check blood sugar 3 times a day for diabetes. R1's record lacked an order regarding oxygen management. On July 8, 2025, at 2:10 p.m., clinical nurse supervisor (CNS)-A stated they have a hard time getting signed provider orders for R1. The licensee's Prescriber's Orders policy dated August 1, 2021, indicated written orders from an authorized prescriber will be obtained for all medications and treatments with which the assisted living facility assists residents. Medication and treatment orders will be renewed at least every year or when changes occur. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		
02310 SS=F	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38732	A. BUILDING: _____ B. WING _____	07/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECHOICE HOMES LLC	1422 TROLLHAGEN DRIVE FRIDLEY, MN 55421

(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
02310	Continued From page 35 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the care and services were provided according to acceptable health care and medical, or nursing standards for one of one resident (R1) with hospital-style bed rails. 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). The findings include: On July 7, 2025, at 11:00 a.m., the surveyor observed R1's bilateral bed rails attached to the hospital bed. R1 was admitted and began receiving services on January 3, 2024. R1's service plan dated January 3, 2025, indicated R1 received assistance with dressing, bathing, toileting, medication administration, transfers, and positioning. R1's assessment dated March 18, 2025, lacked bed rail measurements that were completed and documented. On July 8, 2025, at 2:12 p.m., clinical nurse supervisor (CNS)-A stated he knew he was supposed to measure the bed rails but forgot.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38732	A. BUILDING: _____ B. WING _____	07/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECHOICE HOMES LLC	1422 TROLLHAGEN DRIVE FRIDLEY, MN 55421

(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
02310	Continued From page 36 The Food and Drug Administration's (FDA) A Guide to Bed Safety Bed Rails in Hospitals Nursing Homes and Home Health Care dated June 21, 2006, indicated the following information: "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) last updated April 3, 2024, indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail - The resident's bed rail use/need assessment - Risk vs. benefits discussion (individualized to each resident's risks) - The resident's preferences - Installation and use according to manufacturer's	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38732	A. BUILDING: _____ B. WING _____	07/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECHOICE HOMES LLC	1422 TROLLHAGEN DRIVE FRIDLEY, MN 55421

(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
02310	Continued From page 37 guidelines - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". Additionally, the MDH website indicated for hospital-style bed rails, the licensee must include in their documentation, the bed rail measurements and that the bed rail has not shifted and is securely attached to the bed frame per manufacturer recommendations. The licensee's Side Rail Use policy dated August 1, 2021, indicated the registered nurse is responsible to ensure that the side rails in use are of a safe design and properly maintained. The need for side rails will be reassessed and documented as needed, but not less that every 90 days. No further information provided. TIME PERIOD FOR CORRECTION: Two (2) days	02310		

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

CareChoice Homes LLC
1422 Trollhagen Drive
Fridley, MN 55421
Anoka County
Parcel:

Phone:

License Info

License: HFID 38732

Risk:
License:
Expires on:
CFPM: Soleiman N. Duqow
CFPM #: 108592; Exp: 09/27/2027

Inspection Info

Report Number: F1021251076
Inspection Type: Follow-up - Single
Date: 7/21/2025 Time: 10:04:42 AM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 1
Total Priority 2 Orders: 2
Total Priority 3 Orders: 0
Delivery: Mailed

Previous Order: 4-300 Equipment Numbers and Capacities
4-302.13A *Priority Level: Priority 2 CFP#: 48*
MN Rule 4626.0710A Provide a readily accessible temperature measuring device for measuring the washing and sanitizing temperatures in manual warewashing operations.
COMMENT: ESTABLISHMENT DOES NOT HAVE A MEASURING DEVICE THAT INDICATES THE FINAL UTENSIL SURFACE TEMPERATURE IN RESIDENTIAL DISH MACHINE. A PROVIDE.

Comply By: 7/15/2025 Originally Issued On: 7/8/2025

Previous Order: 4-300 Equipment Numbers and Capacities
4-302.14 *Priority Level: Priority 2 CFP#: 48*
MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.
COMMENT: NO TEST KIT ON-SITE TO MEASURE THE CONCENTRATION OF SANITIZER. INFORMATION SENT WITH REPORT.
Comply By: 7/14/2025 Originally Issued On: 7/8/2025

! **Previous Order: 4-700 Sanitizing Equipment and Utensils**
4-702.11 *Priority Level: Priority 1 CFP#: 16*
MN Rule 4626.0900 Sanitize utensils and food contact surfaces of equipment before use, after cleaning.
COMMENT: ESTABLISHMENT USES LEMON-SCENTED WIPES TO CLEAN AND SANITIZE SURFACES; HOWEVER, AN APPROVED FOOD CONTACT SURFACE SANITIZER IS NOT AVAILABLE ON-SITE. INFORMATION SENT WITH REPORT.
Comply By: 7/8/2025 Originally Issued On: 7/8/2025

Food & Beverage General Comment

Today's follow-up was to address and clear previously written orders from a full inspection conducted on 7/8/25. 8 out of 11 orders were cleared from the report.

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 F1021251076 from 7/21/2025

Melissa Dawson

Miduaga Bekelcho
Registered Nurse (RN)

Melissa Ramos,
Public Health Sanitarian 3
651-201-4495
melissa.ramos@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

CareChoice Homes LLC
Fridley
County/Group: Anoka County

Inspection Info

Report Number: F1021251076
Inspection Type: Follow-up
Date: 7/21/2025
Time: 10:04:42 AM

Food Temperature: Product/Item/Unit: Milk **; Temperature Process:** Cold-Holding
Location: Kitchen Refrigerator at 39 Degrees F.
Comment:
Violation Issued?: No

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

Equipment Temperature: Product/Item/Unit: Upright Cooler, Upstairs **; Temperature Process:** Ambient Air
Location: Kitchen Refrigerator at 40 Degrees F.
Comment:
Violation Issued?: No

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

CareChoice Homes LLC
1422 Trollhagen Drive
Fridley, MN 55421
Anoka County
Parcel:

Phone:

License Info

License: HFID 38732

Risk:
License:
Expires on:
CFPM: Soleiman N. Duqow
CFPM #: 108592; Exp: 09/27/2027

Inspection Info

Report Number: F1021251065
Inspection Type: Full - Single
Date: 7/8/2025 Time: 12:31 PM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 2
Total Priority 2 Orders: 4
Total Priority 3 Orders: 5
Delivery: Emailed

! New Order: 2-200 Employee Health

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

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

COMMENT: NO EMPLOYEE ILLNESS LOG ON-SITE. DISCUSSED EMPLOYEE ILLNESS POLICY AND RECORDING WITH REGISTERED NURSE. AN EMPLOYEE ILLNESS LOG SENT WITH REPORT.

Comply By: 7/8/2025 Originally Issued On: 7/8/2025

New Order: 3-500A Microbial Control: cooling

3-501.13ABC *Priority Level: Priority 3 CFP#: 35*

MN Rule 4626.0380ABC Thaw TCS food by one of the following methods: 1. under mechanical refrigeration that maintains the food temperature at 41 degrees F (4 degrees C) or less; 2. completely submerged under running water at 70 degrees F (21 degrees C) or less with a velocity to remove loose particles on an overflow and the food is maintained at 41 degrees F (5 degrees C) or less; 3. in a microwave oven or; 4. as part of the cooking process.

COMMENT: STAFF WERE THAWING RAW TILAPIA FILLETS PACKAGED IN REDUCED OXYGEN (ROP) AT ROOM TEMPERATURE. PER CONVERSATION WITH STAFF, THE TILAPIA IS GOING TO BE USED FOR DINNER SERVICE TODAY. INSTRUCTED STAFF TO FINISH THAWING THE FROZEN TILAPIA FILLETS IN THE UPRIGHT COOLER. CORRECTED ON-SITE.

Comply By: 7/8/2025 Originally Issued On: 7/8/2025

New Order: 3-500A Microbial Control: cooling

3-501.13E *Priority Level: Priority 3 CFP#: 35*

MN Rule 4626.0380E Remove frozen fish from the reduced oxygen package prior to thawing under refrigeration or immediately after thawing if using the running water method of thawing.

COMMENT: A FEW FROZEN REDUCED OXYGEN PACKAGED (ROP) TILAPIA FILLETS WERE FOUND THAWING AT ROOM TEMPERATURE IN THE HANDWASHING SINK. THE TILAPIA FILLETS WERE STILL FROZEN, AND STAFF WERE INSTRUCTED TO CUT OPEN THE PACKAGES BEFORE STORING THEM IN THE UPRIGHT COOLER TO COMPLETE THAWING.CORRECTED ON-SITE.

Comply By: 7/8/2025 Originally Issued On: 7/8/2025

New Order: 4-200 Equipment Design and Construction
4-204.112A *Priority Level: Priority 3 CFP#: 36*
MN Rule 4626.0620A Provide a temperature measuring device located in the warmest part of mechanically refrigerated units and coolest part of hot food storage units that are capable of measuring air temperature or a simulated product temperature.
COMMENT: THE DOWNSTAIRS UPRIGHT COOLER CONTAINED A THERMOMETER DESIGNED FOR HOT HOLDING EQUIPMENT, RATHER THAN ONE INTENDED FOR COLD HOLDING UNITS. PROVIDE A THERMOMETER IN THE WARMEST PART OF THE COOLER AS DESCRIBED IN THE RULE ABOVE.
Comply By: 7/15/2025 Originally Issued On: 7/8/2025

New Order: 4-300 Equipment Numbers and Capacities
4-302.13A *Priority Level: Priority 2 CFP#: 48*
MN Rule 4626.0710A Provide a readily accessible temperature measuring device for measuring the washing and sanitizing temperatures in manual warewashing operations.
COMMENT: ESTABLISHMENT DOES NOT HAVE A MEASURING DEVICE THAT INDICATES THE FINAL UTENSIL SURFACE TEMPERATURE IN RESIDENTIAL DISH MACHINE. A PROVIDE.

Comply By: 7/15/2025 Originally Issued On: 7/8/2025

New Order: 4-300 Equipment Numbers and Capacities
4-302.14 *Priority Level: Priority 2 CFP#: 48*
MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.
COMMENT: NO TEST KIT ON-SITE TO MEASURE THE CONCENTRATION OF SANITIZER. INFORMATION SENT WITH REPORT.
Comply By: 7/14/2025 Originally Issued On: 7/8/2025

New Order: 4-500 Equipment Maintenance and Operation
4-501.11AB *Priority Level: Priority 3 CFP#: 47*
MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.
COMMENT: THE KITCHEN WHIRLPOOL REFRIGERATOR IS NOT WORKING. STAFF HAD ALREADY RELOCATED ALL FOOD ITEMS TO OTHER COLD STORAGE EQUIPMENT. ESTABLISHMENT HAS TWO OTHER UPRIGHT COOLERS ON-SITE. REPAIR OR REPLACE THE WHIRLPOOL KITCHEN REFRIGERATOR.
Comply By: 7/22/2025 Originally Issued On: 7/8/2025

New Order: 4-600 Cleaning Equipment and Utensils
4-601.11A *Priority Level: Priority 2 CFP#: 16*
MN Rule 4626.0840A Equipment food-contact surfaces and utensils must be clean to sight and touch.
COMMENT: THE FOOD THERMOMETER PROBE HAD DRIED FOOD DEBRIS ON IT. STAFF WERE ADVISED THAT THE PROBE SHOULD BE CLEANED AND SANITIZED BEFORE AND AFTER EACH USE. STAFF WILL USE ALCOHOL WIPES TO SANITIZE PROBE.
Comply By: 7/8/2025 Originally Issued On: 7/8/2025

! **New Order: 4-700 Sanitizing Equipment and Utensils**
4-702.11 *Priority Level: Priority 1 CFP#: 16*
MN Rule 4626.0900 Sanitize utensils and food contact surfaces of equipment before use, after cleaning.
COMMENT: ESTABLISHMENT USES LEMON-SCENTED WIPES TO CLEAN AND SANITIZE SURFACES; HOWEVER, AN APPROVED FOOD CONTACT SURFACE SANITIZER IS NOT AVAILABLE ON-SITE. INFORMATION SENT WITH REPORT.
Comply By: 7/8/2025 Originally Issued On: 7/8/2025

New Order: 5-200C Plumbing: Maintenance, fixture location
5-205.11AB *Priority Level: Priority 2 CFP#: 10*
MN Rule 4626.1110AB The handwashing sink must be accessible at all times for employee use, and must be used only for handwashing.
COMMENT: A CONTAINER WITH FROZEN REDUCED OXYGEN PACKAGED (ROP) TILAPIAS WAS FOUND INSIDE THE HANDWASHING SINK COMPARTMENT IN THE KITCHEN. STAFF REMOVED THE FROZEN TILAPIAS TO THE UPRIGHT COOLER. CORRECTED ON-SITE. COMPLY WITH RULE ABOVE.
Comply By: 7/8/2025 Originally Issued On: 7/8/2025

New Order: 6-300 Physical Facility Numbers and Capacities
6-301.14A *Priority Level: Priority 3 CFP#: 10*
MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands.
COMMENT: HANDWASHING SINKS IN THE KITCHEN AND IN THE BATHROOMS ARE MISSING A HANDWASHING SIGN/POSTER THAT REMINDS FOOD EMPLOYEES TO WASH THEIR HANDS BEFORE RETURNING TO WORK. PROVIDE AS DESCRIBED IN RULE ABOVE.

Comply By: 7/10/2025 Originally Issued On: 7/8/2025

Food & Beverage General Comment

All findings on this report were discussed with Registered Nurse (RN), Miduaga Bekelcho.

This establishment is a residential home. Currently, there are 4 clients with a maximum number of 5 clients.
.
Per conversation with RN, food is made for same-day service. No leftovers are kept.

The kitchen has residential equipment, wood cabinets, laminate countertops, painted drywall and vinyl flooring. Equipment and physical facility items will be monitored at future inspections.

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 F1021251065 from 7/8/2025

Melissa Ramos

Miduaga Bekelcho
Registered Nurse (RN)

Melissa Ramos,
Public Health Sanitarian 3
651-201-4495
melissa.ramos@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

CareChoice Homes LLC
Fridley
County/Group: Anoka County

Inspection Info

Report Number: F1021251065
Inspection Type: Full
Date: 7/8/2025
Time: 12:31 PM

Food Temperature: Product/Item/Unit: Milk **; Temperature Process:** Cold-Holding
Location: Upright Cooler, Upstairs at 39 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Shredded Cheese **; Temperature Process:** Cold-Holding
Location: Upright Cooler, Upstairs at 40 Degrees F.
Comment:
Violation Issued?: No

Equipment Temperature: Product/Item/Unit: Upright Cooler, Upstairs **; Temperature Process:** Ambient Air
Location: Upright Cooler, Upstairs at 37 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Sliced Deli Meat **; Temperature Process:** Cold-Holding
Location: Upright Cooler, Downstairs at 40 Degrees F.
Comment:
Violation Issued?: No

Equipment Temperature: Product/Item/Unit: Upright Cooler, Downstairs **; Temperature Process:** Ambient Air
Location: Upright Cooler, Downstairs at 39 Degrees F.
Comment:
Violation Issued?: No