Electronically Delivered

March 2, 2026

Licensee
Blissful Home Care Corporation
5643 Northport Drive
Brooklyn Center, MN 55429

RE: Project Number(s) SL39888016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on February 4, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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 . . ."

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

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

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,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: Jess.Schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

CLN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39888	A. BUILDING: _____ B. WING _____	02/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLISSFUL HOME CARE CORPORATION	5643 NORTHPORT DRIVE BROOKLYN CENTER, MN 55429

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments *****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: SL39888016-0 On February 2, 2026, through February 4, 2026, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were three (3) residents all receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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0 480	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are	0 480		

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

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0 480	Continued From page 3 TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 650 SS=D	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records included all required content for two of two employees (clinical nurse supervisor (CNS)-A, unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a	0 650		

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0 650	Continued From page 4 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: CNS-A CNS-A was hired August 1, 2025, to provide supervision to licensee's staff and residents. CNS-A's training transcript included seven (7) hours of dementia training completed on August 1-2, 2025. On February 3, 2026, at 11:30 a.m., owner/licensed assisted living director (O/LALD)-D stated CNS-A was supposed to bring her dementia training from her other employment at a hospital and said she would request that of CNS-A. On February 3, 2026, at 12:02 p.m., CNS-A approached surveyor with her laptop demonstrating dementia training was completed through her other employment amounting to 1.5 hours total completed September and October 2024 (within 18 months of employment). CNS-A stated she would include that transcript in her employment record. ULP-B ULP-B was hired August 21, 2024, to provide direct care to residents. On February 3, 2026, at 3:30 p.m., the surveyor	0 650		

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0 650	Continued From page 5 observed ULP-B working the evening shift (2:00 p.m. to 10:00 p.m.). ULP-B's record lacked documentation ULP-B was supervised within 30 days of performing delegated tasks, but ULP-B's record included supervision completed on August 21, 2025. On February 3, 2026, at 1:05 p.m., CNS-A stated she would complete a 30-day supervision but was not employed during this time. House manager (HM)-C stated their electronic health record (Residex) would prompt the nurse to complete supervision and they would be documented within that system. The licensee could not locate documented 30-day supervision. The licensee's 1.01 Assisted Living Statute and Rule Overview policy dated January 5, 2026, indicated supervisors and direct-care staff must have at least 8 hours of initial training within 120 working hours of start date and at least 2 hours of training annually. The licensee's 6.17 Supervision of Staff-Delegated Services policy dated January 5, 2026, indicated direct supervision of staff performing delegated tasks must be provided within 30 days after the date on which the individual began working for licensee and first performed the delegated tasks for residents and thereafter as needed based on performance. Documentation of supervision activities will be retained in the employee's record. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		

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0 730	Continued From page 6	0 730		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received	0 730		

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0 730	Continued From page 7 and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record included documentation of actions taken in response to medication refusals 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: R1 had diagnoses including otitis media (infection of air-filled space behind the eardrum), type 2 diabetes, and traumatic brain injury. R1's Service Plan (Waiver)-Addendum to Contract signed July 2, 2023, indicated R1 received assistance with medication administration twice daily. R1's medication list signed by the primary	0 730		

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0 730	Continued From page 8 provider February 18, 2025, included carbamazepine 200 milligrams (mg) by mouth twice daily (anticonvulsant). R1's medication administration record (MAR) dated January 1, 2026, through February 1, 2026, instructed to give atorvastatin (lowers cholesterol), losartan (lowers blood pressure), metformin (lowers blood sugar levels), multivitamin, omeprazole (treats excess stomach acid), acetaminophen (for pain), and levocetirizine (for allergies). The MARs lacked carbamazepine. R1's record lacked orders to discontinue carbamazepine. On February 3, 2026, at 1:05 p.m., owner/licensed assisted living director (O/LALD)-D stated R1 stopped taking carbamazepine and when they notified R1's psychiatrist, R1 refused to attend an appointment either in person or virtually when requested by the psychiatrist. O/LALD-D stated the psychiatrist would only extend the refill for a short period of time until R1 agreed to make an appointment, which he never did. Eventually the pharmacy stopped dispensing it so the licensee stopped giving it. O/LALD-D stated she could not provide any documentation showing the licensee contacted the psychiatrist informing them of R1's refusal to take the medication and any follow-up. On February 4, 2026, at 10:37 a.m., pharmacy technician (outside pharmacy) (PT)-G stated the pharmacy never received a discontinuation order for carbamazepine, but the script had never been renewed. The medication was last dispensed on June 17, 2025.	0 730		

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0 730	Continued From page 9 The licensee's 2.38 Resident Record-Information and Content policy dated January 5, 2026, indicated the licensee would maintain appropriate and accurate records for each resident that received assisted living services. The resident record would include: -documentation of significant changes in the resident's status and incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; and -all records of communication pertinent to the resident's services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
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 training on the fire safety and evacuation plans	0 810		

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0 810	Continued From page 10 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: level 2 Widespread (F) Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical	0 810		

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0 810	Continued From page 11 Environment Inspection Report (PEIR) dated 2/3/2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty One (21) days	0 810		
01290 SS=D	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study was affiliated to the current health facility identification (HFID) number for one of one employee (unlicensed personnel (ULP)-F) shown to have worked with licensee's residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or	01290		

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01290	Continued From page 12 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: The licensee's undated Employee List did not include ULP-F as a current employee. The licensee's undated NETStudy 2.0 Roster (web-based system for submitting background study requests to the Department of Human Services (DHS)) for HFID 39888 did not show ULP-F was affiliated. The licensee's staff schedule dated January 29, 2026, through March 4, 2026, indicated ULP-F was scheduled to work: -January 30, at 2:00 p.m. to 10:00 p.m.; -January 31, at 2:00 p.m. to 6:00 a.m. (two shifts); -February 1, 6, 14, 15, 20, and 28, at 2:00 p.m. to 6:00 a.m. (two shifts); -February 8, and 22, at 10:00 p.m. to 6:00 a.m.; -February 13, and 27, at 2:00 p.m. to 10:00 p.m.; and -March 1, at 2:00 p.m. to 6:00 a.m. On February 4, 2026, at 1:03 p.m., via e-mail, owner/licensed assisted living director (O/LALD)-D indicated ULP-F began employment on September 14, 2023, to perform assisted living services. On February 2, 2026, at 2:47 p.m., the surveyor's supervisor provided ULP-F's "Person Summary" on DHS website, which indicated ULP-F was	01290		

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01290	Continued From page 13 affiliated to licensee's HFID 36839. During interview on February 3, 2026, at 2:30 p.m., O/LALD-D stated she completed background studies for all new hires and her process was to affiliate each person to each HFID right away and was not sure why ULP-F was missed. The licensee's 4.02 Background Studies policy dated January 5, 2026, indicated the licensee would conduct a Minnesota Department of Human Services Background Study on all employees and volunteers and contractors that worked with the licensee, and no employee would provide direct services and have independent direct contact with any residents until an acceptable result of the background study had been received. The policy lacked instruction regarding affiliating staff to more than one HFID. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (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	01620		

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01620	Continued From page 14 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 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.	01620		

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01620	Continued From page 15 This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to accurately assess a resident whether they required assistance with blood glucose monitoring 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: R1 was admitted for services on July 2, 2023, and had diagnoses including otitis media (infection of air-filled space behind the eardrum), type 2 diabetes, and traumatic brain injury. R1's Service Plan (Waiver)-Addendum to Contract signed July 2, 2023, indicated R1 received assistance with recording daily blood glucose (BG) and registered nurse (RN) supervision once weekly. R1's Individualized Treatment and Therapy Plan (ITTP)-As of Date last updated on January 10, 2025, indicated record blood glucose daily, "HHA [unlicensed personnel-ULP]-Wearing gloves and following agency procedure, check blood glucose and record. Notify RN if: If Blood Glucose is less than 70 or greater than 300." R1's Vital Sign-Blood Glucose record dated December 2, 2025, through February 2, 2026,	01620		

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01620	Continued From page 16 indicated 31 out of 63 a blood glucose was not recorded because R1 refused/declined the service. R1's ongoing Assessment As of Date completed on September 4, 2025, and December 10, 2025, respectively, indicated R1 was a type two diabetic without insulin use. The assessments did not address whether R1 required assistance with blood glucose checks or monitoring. On February 3, 2026, at 1:05 p.m., CNS-A stated during weekly visits, she would ask R1 what his BG was that day and review the BG record. After reviewing R1's most recent nursing assessment together, owner/licensed assisted living director (O/LALD)-D stated the RN did not assess the level of assistance R1 needed with monitoring blood glucose levels. The licensee's 6.01 Assessments, Reviews & Monitoring policy dated January 5, 2026, indicated the nursing assessment would include all the elements of the uniform assessment tool as required. The licensee's 6.03 Uniform Assessment Tool policy dated January 5, 2026, indicated the licensee would use the uniform assessment tool that addressed all of the required elements including list of treatments, including type, frequency, and level of assistance needed. The Minnesota Administrative Rule 4659.0150 published electronically on August 11, 2021, indicated each facility must develop a uniform assessment tool to include all the required elements. No further information was provided.	01620		

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01620	Continued From page 17 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01760 SS=D	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 medications were accurately documented after administration for one of one resident (R1) receiving eye drops. 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).	01760		

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01760	Continued From page 18 The findings include: R1 had diagnoses including otitis media (infection of air-filled space behind the eardrum), type 2 diabetes, and traumatic brain injury. R1's Service Plan (Waiver)-Addendum to Contract signed July 2, 2023, indicated R1 received assistance with medication administration twice daily. On February 3, 2026, at 9:54 a.m., after unlicensed personnel (ULP)-E administered one medication to R3, the surveyor observed R1's medications within the medication cabinet and saw a box of Refresh Optive 0.5-0.9% eye drops containing a pharmacy label. The bottle still had the manufacturer's safety seal, indicating it had not been used. The pharmacy label indicated that the medication was dispensed on April 2, 2025. On February 3, 2026, at 10:05 a.m., house manager (HM)-C observed the box of Optive eye drops and stated R1 "refused those eye drops a lot." R1's medication administration record (MAR) dated January 1, 2026, through February 1, 2026, instructed to give Optive 0.5-0.9% drops, one drop into both eyes two times a day in AM (morning), and PM (night). On January 1, 2, 15, and 30, for AM time, the MAR showed blank boxes (no initials) and lacked an explanation whether the medication was refused, held, or missed. R1's record lacked a prescriber order for Optive 0.5-0.9% drops. On February 3, 2026, at 12:36 p.m., when asked	01760		

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01760	Continued From page 19 if R1's eye drops were being administered, ULP-E stated a bottle of eye drops was used up that morning. On February 4, 2026, at 10:37 a.m., pharmacy technician (outside pharmacy) (PT)-G stated R1's provider submitted to them a discontinuation order for Optive eye drops on October 14, 2025, and the last time the eye drops were filled was on September 18, 2025, for a one-month supply. PT-G stated there were no other eye drops prescribed for R1. On February 4, 2026, at 1:30 p.m., house manager (HM)-C and owner/licensed assisted living director (O/LALD)-D stated R1 had been receiving his eye drops and that he had multiple bottles available at one point because he had the ability to purchase them himself at other pharmacies. HM-C and O/LALD-D were not aware of the discontinuation order and would follow up on that. For the MAR, if there were blank boxes, it meant the ULP either skipped medication administration or R1 declined but staff should have indicated a reason. The licensee's 7.22 Medication & Treatment Record- Documentation & Refusal dated January 5, 2026, indicated the licensee would create and maintain a correct and accurate medication record for each resident receiving medication assistance or administration. if the medication was refused, staff should circle their initials and write a capital "R" in the same box on the MAR. If the medication was held, circle their initials and write a capital "H" in the same box on the MAR. Lastly, there was a designated area to document the reason for refusal, held, etc. No further information was provided.	01760		

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01760	Continued From page 20 TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be	01790		

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01790	Continued From page 21 labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) had provided training and ensured the unlicensed personnel (ULP) demonstrated competency to provide medications for residents having unplanned time away when the licensed nurse was not available for one of one employee (ULP-B). This had the potential to affect all residents who would need medications for an unplanned time away. This practice resulted in a level two violation (a	01790		

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01790	Continued From page 22 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During entrance conference on February 2, 2026, at 11:00 a.m., owner/licensed assisted living director (O/LALD)-D and clinical nurse supervisor (CNS)-A stated the licensee provided medication management services to residents. ULP-B's 2.35 Unplanned Time Away Meds Set Up training and competency form dated March 12, 2025, indicated house manager (HM)-C, who was not an RN, documented they completed the training with ULP-B. During interview with CNS-A, HM-C, and O/LALD-D, on February 3, 2026, at 1:05 p.m., HM-C stated she completed the training and competency for medication set up for unplanned leave of absence for all staff. All were not aware the RN was required to complete the training. The licensee's 7.01 Medication Management-Planned & Unplanned Time Away policy dated September 1, 2023, indicated a properly trained and competency-tested ULP may give the resident or resident's representative medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven (7) calendar days. No further information was provided.	01790		

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01790	Continued From page 23 TIME PERIOD FOR CORRECTION: Seven (7) days	01790		
01820 SS=D	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 ensure written or electronically recorded prescriptions were maintained for one of two residents (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: R1 was admitted for services on July 2, 2023, with diagnoses including otitis media (infection of air-filled space behind the eardrum), type 2 diabetes, and traumatic brain injury. R1's Service Plan (Waiver)-Addendum to Contract signed July 2, 2023, indicated R1 received medication administration twice daily.	01820		

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01820	Continued From page 24 On February 3, 2026, at 9:54 a.m., after unlicensed personnel (ULP)-E administer one medication to R3, the surveyor observed R1's medications within the medication cabinet and saw a box of Refresh Optive 0.5-0.9% eye drops. The bottle still had the manufacturer's safety seal, indicating it had not been used. The pharmacy label indicated it was dispensed on April 2, 2025. R1's medication administration record (MAR) dated January 1, 2026, through February 1, 2026, instructed to give Optive 0.5-0.9% drops-place one drop into both eyes two times a day at AM (morning), and PM (night). R1's record included prescriber orders signed February 18, 2025, included atorvastatin (lowers cholesterol), carbamazepine (anticonvulsant), losartan (lowers blood pressure), metformin (lowers blood sugar levels), multivitamin, omeprazole (treats excess stomach acid), acetaminophen (for pain), and levocetirizine (for allergies). R1's record lacked a prescriber order for Optive 0.5-0.9% drops. On February 3, 2026, at 12:36 p.m., ULP-E stated a bottle of eye drops was used up that morning and that explained why there was an unopened bottle. On February 3, 2026, at 1:05 p.m., the surveyor requested the licensee provide orders for Optive eye drops. On February 4, 2026, at 10:37 a.m., pharmacy technician (outside pharmacy) (PT)-G stated the provider submitted a discontinuation order for	01820		

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01820	Continued From page 25 Optive eye drops to the pharmacy on October 14, 2025, and the last time the eye drops were filled was on September 18, 2025, for a one-month supply. PT-G stated there were no other eye drops prescribed for R1. On February 4, 2026, at 1:30 p.m., HM-C and owner/licensed assisted living director (O/LALD)-D stated R1 had been receiving his eye drops and that he had multiple bottles available at one point because he had the ability to purchase them himself from pharmacies like Walgreens. HM-C and O/LALD-D were not aware of the discontinuation order and would follow up on that. They did not provide the order as requested. The licensee's 7.17 Medication & Treatment Orders-Receiving policy dated January 5, 2026, indicated the licensee would obtain all medication orders either in writing, verbally, or electronically by an authorized prescriber. All orders must be in the resident's record. The licensee 7.20 Medication & Treatment Orders policy dated January 5, 2026, indicated a current, written prescriber's order must be obtained for any medication administration provided to a resident. The licensed nurse will review all medication orders for progress, effectiveness and necessity on a regular basis and with resident change of condition. No further information was provided. TIME PERIOD FOR CORRECTIION: Seven (7) days	01820		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39888	A. BUILDING: _____ B. WING _____	02/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLISSFUL HOME CARE CORPORATION	5643 NORTHPORT DRIVE BROOKLYN CENTER, MN 55429

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01940	Continued From page 26 For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that 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 interview and record review, the licensee failed to provide a current treatment and therapy management plan for one of one resident (R1) who received assistance with treatments. This practice resulted in a level two violation (a	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39888	A. BUILDING: _____ B. WING _____	02/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLISSFUL HOME CARE CORPORATION	5643 NORTHPORT DRIVE BROOKLYN CENTER, MN 55429

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01940	Continued From page 27 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: R1 had diagnoses including otitis media (infection of air-filled space behind the eardrum), type 2 diabetes, and traumatic brain injury. R1's Service Plan (Waiver)-Addendum to Contract signed July 2, 2023, indicated R1 received assistance with recording daily blood glucose (BG) and registered nurse (RN) supervision once weekly. R1's Assessment As of Date completed by clinical nurse supervisor (CNS)-A on December 10, 2025, indicated R1 was a type two diabetic without insulin use. R1's Individualized Treatment and Therapy Plan (ITTP)-As of Date last updated on January 10, 2025, indicated record blood glucose daily, "HHA [unlicensed personnel-ULP]-Wearing gloves and following agency procedure, check blood glucose and record. Notify RN if: If Blood Glucose is less than 70 or greater than 300." On February 3, 2026, at 1:05 p.m., CNS-A stated during weekly visits, she would ask R1 what his BG was that day and review the BG record. After reviewing R1's ITTP together, owner/licensed assisted living director (O/LALD)-D stated R1 checked his own BG using needle lancets and	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39888	A. BUILDING: _____ B. WING _____	02/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLISSFUL HOME CARE CORPORATION	5643 NORTHPORT DRIVE BROOKLYN CENTER, MN 55429

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01940	Continued From page 28 strips he obtained on his own because the pharmacy the facility used did not cover it. O/LALD-D and CNS-A stated R1's ITTP was not up to date nor accurate. They both said they would get his plan updated. The licensee's 7.05 Treatment & Therapy Management Plan dated January 5, 2026, indicated the licensee would develop and maintain a current individualized treatment and therapy management record for reach resident and updated when there were any changes. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		

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

Blissful Home Care Inc.
5643 Northport Drive
Brooklyn Center, MN 55429
Hennepin County
Parcel:

Phone:

License Info

License: 0042970

Risk:
License: -1
Expires on: 12/31/2024
CFPM: LUCY A. FALLAH
CFPM #: 124943; Exp: 9-9-2027

Inspection Info

Report Number: F1062261018
Inspection Type: Full - Single
Date: 2/2/2026 Time: 10:30 am
Duration: minutes
Announced Inspection: Yes
Total Priority 1 Orders: 1
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

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

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

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

COMMENT: OBSERVED RAW SHELL EGGS HELD IN REFRIGERATOR OVER READY-TO-EAT FOODS SUCH AS PRODUCE DURING INSPECTION. ENSURE RAW ANIMAL PROTEINS ARE STORED SUCH THAT RISK OF CONTAMINATION TO RTE FOODS IS MINIMIZED.

Comply By: 2/2/2026 Originally Issued On: 2/2/2026

Food & Beverage General Comment

COMPLETED WITH ANNA BOHNEN HRD.

TILED WALLS. WOOD FLOOR, LAMINATE COUNTERTOPS IN KITCHEN. DISCUSSED WASHING MACHINE TESTING, LEFTOVER PROHIBITIONS AND COOK TEMPS.

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 F1062261018 from 2/2/2026

LUCY FALLAH
OPERATOR

Nicholas Streeter, RS
Public Health Sanitarian 2
nicholas.streeter@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

Blissful Home Care Inc.
Brooklyn Center
County/Group: Hennepin County

Inspection Info

Report Number: F1062261018
Inspection Type: Full
Date: 2/2/2026
Time: 10:30 am

Food Temperature: Product/Item/Unit: AMERICAN CHEESE**; Temperature Process:** Cold-Holding
Location: RESIDENTIAL REFRIGERATOR at 41 Degrees F.
Comment: TEMP TAKEN FROM OUTSIDE OF PACKAGE
Violation Issued?: No

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

Sanitizer Observations/Recordings

Establishment Info

Blissful Home Care Inc.
Brooklyn Center
County/Group: Hennepin County

Inspection Info

Report Number: F1062261018
Inspection Type: Full
Date: 2/2/2026
Time: 10:30 am

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Kitchen **Greater Than** 170 Degrees F.
Comment:
Violation Issued?: No

Sanitizing Chemical: **Product:** Chlorine**; Sanitizing Process:** Spray Bottle
Location: Kitchen **Equal To** 200 PPM
Comment:
Violation Issued?: No

Physical Environment Inspection Report

ASSISTED LIVING | ASSISTED LIVING WITH DEMENTIA CARE

Project No: SL39888016	**Date:** 2/3/2026
Facility Name: Blissful Care Services LLC	
Facility Address: 5643 Northport Dr, Brooklyn Center MN 55429	

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Twenty One (21) days

1. Each assisted living facility shall develop and maintain fire safety and evacuation plans that include the location and number of resident rooms. [Minn. Stat. 144G.45 subd.2]

   Comments: The fire evacuation diagrams labeled the door to the deck and door by the office as an emergency exit. Both doors did not meet egress standards. House manager (HM-C) stated that they would be updating egress maps and would be removing the two doors from the map since they are not required exits. Exit plan diagrams must be correctly labeled to reduce confusion and potential obstructions to egress in a fire or similar emergency.

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

   Comments: The Fire Safety and Evacuation Plans (FSEP) included standard employee procedures but must provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks.

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

   Comments: The FSEP did not identify specific fire protection actions for residents. The section in the policy failed to include the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency

4. Each assisted living facility shall develop and maintain fire safety and evacuation plans that include 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. [Minn. Stat. 144G.45 subd.2]

Comments: The FSEP failed to identified the individual resident needs for movement or evacuation in the event of an emergency or fire.