



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

July 1, 2026

Licensee

ANGEL'S HEALTH & HOME CARE SERVICES INC

4213 63rd Avenue North

Brooklyn Center, MN 55429

RE: Project Number(s) SL35639016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on May 13, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement;

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;

Level 3: a fine of \$1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

Level 4: a fine of \$3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

Level 5: a fine of \$5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

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

assessed pursuant to this survey:

St - 0 - 0330 - 144g.30 Subd. 4 - Information Provided By Facility - \$500.00

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - \$500.00

St - 0 - 0810 - 144g.45 Subd. 2 (b-F) - Fire Protection And Physical Environment - \$1,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$2,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

REQUESTING A HEARING

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

To submit a hearing request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

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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.

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

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35639	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/13/2026
NAME OF PROVIDER OR SUPPLIER ANGEL'S HEALTH & HC SRV INC			STREET ADDRESS, CITY, STATE, ZIP CODE 4213 63RD AVENUE NORTH BROOKLYN CENTER, MN 55429		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 000	Initial Comments *****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: SL35639016-0 On May 11, 2026, through May 13, 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 four residents; three (3) 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.		
0 330 SS=F	144G.30 Subd. 4 Information provided by facility (a) The assisted living facility shall provide	0 330			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 330	Continued From page 1 accurate and truthful information to the department during a survey, investigation, or other licensing activities. (b) Upon request of a surveyor, assisted living facilities shall within a reasonable period of time provide a list of current and past residents and their legal representatives and designated representatives that includes addresses and telephone numbers and any other information requested about the services to residents. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide the Minnesota Department of Health (MDH) with accurate and truthful information during a survey. 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: NON-RESIDENT RESIDING IN FACILITY On May 11, 2026, during a facility tour, the surveyor observed resident room #4 on the lower level. The room contained clothing and belongings, and the bed appeared as if it had been slept in. On May 11, 2026, at 11:05 a.m., clinical nurse supervisor (CNS)-A stated the room was reserved for R4, who had not yet been admitted	0 330			

Minnesota Department of Health

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0 330	Continued From page 2 as they were waiting for a service authorization. CNS-A stated R4 was currently unhoused, and they had allowed him to move his belongings into the room. On May 11, 2026, at 11:05 a.m., house manager (HM)-B stated "[R4] doesn't live here". HM-B also stated they allowed R4 to sleep on the couch in the common area of the lower level. On May 12, 2026, at 10:28 a.m., the surveyor observed an unidentified male come from the lower level of the residence and exit through the front door. When the surveyor asked about the identity of the person, R1 stated "that is [R4], he lives downstairs." On May 12, 2026, at 10:28 a.m., HM-B stated "R4 doesn't live here". HM-B stated R4 usually used the back door to enter and exit the facility, and he may have been picking up something from his room downstairs. On May 13, 2026, at 10:30 a.m., the surveyor observed bedroom #4 on the lower level was locked and requested the door to be opened for the environmental engineer. When the door was opened, the surveyor, environmental engineer, and licensed assisted living director (LALD)-D observed R4 sleeping in the bed. On May 13, 2026, at 10:30 a.m., LALD-D stated "R4 is not supposed to be living here". On May 13, 2026, at 10:30 a.m., HM-B stated R4 didn't like sleeping at the shelter, so they allowed him to sleep at the facility. On May 13, 2026, at 11:06 a.m., LALD-D stated R4 had not moved in as his intake and	0 330			

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0 330	Continued From page 3 assessment were not complete.; LALD-D stated they authorized R4 to have meals at the facility. LALD-D stated they did not have a service agreement from R4's case manager and conversations related to R4's pending admission were not documented. FALSIFIED DOCUMENTATION R2 was admitted to the licensee on February 1, 2026. On May 12, 2026, at 9:12 a.m., surveyor requested R2's service plan from R2's re-admission to the licensee on February 1, 2026. On May 12, 2026, at 9:12 a.m., CNS-A provided the surveyor with a Service Plan (waiver) for R2 that was effective May 12, 2026 (during the survey) and signed by R2 on February 4, 2026. On May 12, 2026, at 9:15 a.m., the surveyor reviewed the discrepancy between the creation and signature dates on R2's Service Plan (waiver) with CNS-A. On May 12, 2026, at 9:15 a.m., CNS-A stated the Service Plan had been created that morning and that R2 had not signed the service plan that morning. CNS-A stated they must have misunderstood what the surveyor was requesting. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 330			
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 4 (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 5 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 May 12, 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 6	0 480			
0 630 SS=D	TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates. 144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop an individual abuse prevention plan (IAPP) with the required content for one of four residents (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R4's record lacked an individualized abuse	0 630			

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0 630	Continued From page 7 prevention plan to include the following content: -an assessment of R4's susceptibility to abuse by another individual, including other vulnerable adults; -R4's risk of abusing other vulnerable adults; and -statements of specific measures to be taken to minimize the risk of abuse to R4 and other vulnerable adults. On May 11, 2026, during a facility tour, the surveyor observed resident room #4 on the lower level. The room contained clothing and belongings, and the bed appeared as if it had been slept in. On May 11, 2026, at 11:05 a.m., clinical nurse supervisor (CNS)-A stated the room was reserved for R4, who had not yet been admitted as they were waiting for a service authorization. CNS-A stated R4 was currently unhoused, and they had allowed him to move his belongings into the room. On May 11, 2026, at 11:05 a.m., house manager (HM)-B stated "[R4] doesn't live here". HM-B also stated they allowed R4 to sleep on the couch in the common area of the lower level. On May 12, 2026, at 10:28 a.m., the surveyor observed an unidentified male come from the lower level of the residence and exit through the front door. When the surveyor asked about the identity of the person, R1 stated "that is [R4], he lives downstairs." On May 12, 2026, at 10:28 a.m., HM-B stated "R4 doesn't live here". HM-B stated R4 usually used the back door to enter and exit the facility, and he may have been picking up something from his room downstairs.	0 630			

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0 630	Continued From page 8 On May 13, 2026, at 10:30 a.m., the surveyor observed bedroom #4 on the lower level was locked and requested the door to be opened for the environmental engineer. When the door was opened, the surveyor, environmental engineer, and licensed assisted living director (LALD)-D observed R4 sleeping in the bed. On May 13, 2026, at 10:30 a.m., LALD-D stated "R4 is not supposed to be living here". On May 13, 2026, at 10:30 a.m., HM-B stated R4 didn't like sleeping at the shelter, so they allowed him to sleep at the facility. On May 13, 2026, at 11:06 a.m., LALD-D stated R4 had not moved in as his intake and assessment were not complete.; LALD-D stated they authorized R4 to have meals at the facility. LALD-D stated they did not have a service agreement from R4's case manager and conversations related to R4's pending admission were not documented. The licensee's undated Abuse Prevention Plan policy indicted all residents would be assessed for their susceptibility to abuse by other individuals and their risk of abusing other vulnerable adults. The policy also indicated the facility would develop a statement of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630			

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0 650	Continued From page 9	0 650			
0 650 SS=F	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 information: (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 interview and record review, the licensee failed to ensure employee records included all required content for two of two employees (house manager (HM)-B, unlicensed personnel (ULP)-C). 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	0 650			

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0 650	Continued From page 10 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 number or all the residents). The findings include: ULP-C ULP-C was hired on September 6, 2024, and began providing assisted living services. ULP-C's employee record lacked evidence that annual performance reviews had been completed. HM-B HM-B was hired on September 11, 2025, and began providing assisted living services. R1's Service Recap Summary dated April 26, 2026, indicated HM-B had provided urinary catheterization and catheter care to R1 on April 1, 2, 3, 7, 8, 14, and 14, 2026. R1's Service Recap Summary dated April 2026, indicted HM-B had provided blood glucose monitoring for R2 on April 1, 2, 3, 8, 9, 24. HM-B's employee record lacked evidence of training or competency evaluation by a registered nurse for catheterization, catheter care, or blood glucose monitoring. On May 13, 2026, at 11:36 a.m., HM-B stated she was trained by the nurse and had been observed by the nurse for the tasks listed above. On May 13, 2026, at 11:36 a.m., clinical nurse supervisor (CNS)-A stated she had trained and verified competencies for HM-B and did not know	0 650			

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NAME OF PROVIDER OR SUPPLIER ANGEL'S HEALTH & HC SRV INC			STREET ADDRESS, CITY, STATE, ZIP CODE 4213 63RD AVENUE NORTH BROOKLYN CENTER, MN 55429		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 650	Continued From page 11 why the documentation was missing from the file. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650			
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 establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included a current Facility TB Risk Assessment and baseline testing for one of two employees (house manager (HM)-B). This practice resulted in a level two violation (a	0 660			

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0 660	Continued From page 12 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 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: The licensee's facility TB risk assessment dated June 28, 2024, indicated the facility was a low risk setting for TB transmission. The Facility TB Risk Assessment had not been completed for 682 days. HM-B HM-B was hired on September 11, 2025, and began providing assisted living services. HM-B's record included a TB symptoms and history screen dated September 11, 2025, and a chest x-ray dated December 18, 2025. HM-B's record lacked evidence of a two-step tuberculin skin test (TST) or a TB blood test predating the chest x-ray. On May 12, 2026, at 2:13 p.m., HM-B stated she did not have a skin test as she had received a BCG vaccine when she was younger. HM-B stated she would arrange to get a TB blood test. The Minnesota Department of Health (MDH) guidelines Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, and based on CDC guidelines, indicated "an employee may begin working with patients	0 660			

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0 660	Continued From page 13 (residents) after a negative TB history and symptom screen 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 (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record." The licensee's undated Tuberculosis Screening policy indicated each employee having direct contact with residents would have documentation of baseline TB screening and testing prior to caring for residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and	0 680			

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0 680	Continued From page 14 disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have a written emergency preparedness plan with all the required content and failed to post an emergency preparedness plan prominently. This had the potential to impact all visitors, employees, and 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 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On May 12, 2026, at 2:48 p.m., clinical nurse supervisor (CNS)-A provided the surveyor with a white binder titled Emergency Plan and stated it was the Emergency Preparedness Plan for the facility. The binder review page indicated the plan was last reviewed on August 1, 2024. The Emergency Plan binder included a Missing	0 680			

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0 680	Continued From page 15 Resident Plan review page, indicating the missing resident plan was last reviewed on August 1, 2024. The licensee's Emergency Plan dated August 1, 2024, lacked the following required content: -a hazard vulnerability assessment (HVA) describing facility and community-based risks; -a process for cooperation and collaboration with local, tribal, regional, state, and federal EP to maintain an integrated response; -policies and procedures to address the provision of food, water, medical, and pharmaceutical supplies; -a system for tracking the location of on-duty staff and sheltered residents; -policies and procedures addressing safe evacuation from the facility including consideration of care and treatment needs of evacuees, staff responsibilities, transportation, and communication means with external sources of assistance; -policies and procedures to address a system of medical documentation that preserves resident information, protects confidentiality, and secures/maintains availability of records; -policy and procedure for use of volunteers, including the process/role for integration; and -evidence of exercises conducted twice yearly to test the EP to include an analysis of the facility's response and documentation of all drill, tabletop exercises, and emergency events. On May 12, 2026, at 3:20 p.m., CNS-A stated they kept the Emergency Plan locked in a downstairs office so "the residents don't destroy it". CNS-A stated they were not responsible for the contents of the Emergency Plan. On May 13, 2026, at 11:48 a.m., registered nurse	0 680			

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0 680	Continued From page 16 consultant (RNC)-E stated they would review and revise the contents of the Emergency Plan manual. The licensee's 9.01 Emergency Preparedness Plan - Appendix Z Compliance policy dated January 1, 2024, indicated the licensee would have an effective and compliant emergency preparedness plan in place that aligned with the Centers for Medicare and Medicaid Services State Operation Manual Appendix Z. Minnesota Administrative Rule 4659.0100 dated August 11, 2021, indicated assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.72, or successor requirements. This part referenced documents, specifications, methods, and standards in "State Operations Manual Appendix Z - Emergency Preparedness for All Provider and Certified Supplier Types: Interpretive Guidance." No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 730 SS=F	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;	0 730			

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0 730	Continued From page 17 (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 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.	0 730			

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0 730	Continued From page 18 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure resident records included documentation of services provided for two of two residents (R1, R2). 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: R1 R1 was admitted on May 31, 2024, and began receiving assisted living services. R1's Service Plan (Waiver) signed on January 20, 2026, indicated R1's services included assistance with dressing, grooming, bathing, behavior management, medication administration, transfers, and catheter care. R1's service log for April 2026, lacked documentation of services provided for the following services and dates: -safety checks on April 6, 7, 10, 12, 14, 15, 18, 19, 20, 21, 28, 29, and 30; -behavior management on April 6, 7, 10, 18, 19, 20, and 21; -dressing assistance on April 2, 6, 7, 9, 10, 14, 15, 18, 19, 20, 21, 22, 23, 28, 29, and 30; -grooming assistance on April 2, 6, 7, 9, 10, 14, 15, 18, 19, 20, 21, 22, 23, 28, 29, and 30; and	0 730			

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0 730	Continued From page 19 -catheter care on April 6, 7, 9, 10, 12, 14, 15, 18, 19, 20, 21, 22, 23, 28, and 29. R2 R2 was admitted on February 1, 2026, and began receiving assisted living services. R2's Service Plan (Waiver) signed on April 28, 2026, indicated R2's services included assistance with dressing, grooming, behavior management, medication administration, and blood sugar monitoring. R2's service log dated April 2026, lacked documentation of services provided for the following services and dates: -dressing assistance on April 2, 7, 9, 10, 11, 12, 13, 14, 15, 19, 21, 22, 23, 28, 29, and 30; -grooming assistance on April 2, 7, 9, 10, 11, 12, 13, 14, 15, 19, 21, 22, 23, 28, 29, and 30; -behavior management on April 2, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 19, 21, 22, 23, 28, 29, and 30; and -blood glucose monitoring on April 2, 3, 6, 7, 9, 10, 11, 12, 14, 15, 19, 21, 22, 23, 28, 29, and 30. On May 12, 2026, at 2:46 p.m., clinical nurse supervisor (CNS)-A and house manager (HM)-B stated they did not know that services were not documented. HM-B stated they would start auditing documentation. The licensee's undated Resident Records policy indicated the resident record would include documentation that services had been provided as identified in the resident's service plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 730			

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0 730	Continued From page 20 (21) days	0 730			
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated May 13, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) Days	0 775			

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0 810	Continued From page 21	0 810			
0 810 SS=I	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	0 810			

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0 810	Continued From page 22 review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated May 13, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty One (21) Days	0 810			
0 900 SS=F	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must:	0 900			

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0 900	Continued From page 23 (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to execute an assisted living (AL) contract before offering housing and assisted living services for one of four residents (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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:	0 900			

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0 900	Continued From page 24 R4's record lacked a written and signed contract prior to the provision of housing or services. On May 11, 2026, during a facility tour, the surveyor observed resident room #4 on the lower level. The room contained clothing and belongings, and the bed appeared as if it had been slept in. On May 11, 2026, at 11:05 a.m., clinical nurse supervisor (CNS)-A stated the room was reserved for R4, who had not yet been admitted as they were waiting for a service authorization. CNS-A stated R4 was currently unhoused, and they had allowed him to move his belongings into the room. On May 11, 2026, at 11:05 a.m., house manager (HM)-B stated "[R4] doesn't live here". HM-B also stated they allowed R4 to sleep on the couch in the common area of the lower level. On May 12, 2026, at 10:28 a.m., the surveyor observed an unidentified male come from the lower level of the residence and exit through the front door. When the surveyor asked about the identity of the person, R1 stated "that is [R4], he lives downstairs." On May 12, 2026, at 10:28 a.m., HM-B stated "R4 doesn't live here". HM-B stated R4 usually used the back door to enter and exit the facility, and he may have been picking up something from his room downstairs. On May 13, 2026, at 10:30 a.m., the surveyor observed bedroom #4 on the lower level was locked and requested the door to be opened for the environmental engineer. When the door was opened, the surveyor, environmental engineer,	0 900			

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0 900	Continued From page 25 and licensed assisted living director (LALD)-D observed R4 sleeping in the bed. On May 13, 2026, at 10:30 a.m., LALD-D stated "R4 is not supposed to be living here". On May 13, 2026, at 10:30 a.m., HM-B stated R4 didn't like sleeping at the shelter, so they allowed him to sleep at the facility. On May 13, 2026, at 11:06 a.m., LALD-D stated R4 had not moved in as his intake and assessment were not complete.; LALD-D stated they authorized R4 to have meals at the facility. LALD-D stated they did not have a service agreement from R4's case manager and conversations related to R4's pending admission were not documented. The licensee's undated Assisted Living Contracts policy indicated the facility would establish a contract with each client at the time of admission to the program. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 900			
0 950 SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES.	0 950			

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0 950	Continued From page 26 You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to include the required verbiage notifying the residents of their right to designate a representative for two of two residents (R1, R2). This practice resulted in a level one violation (a violation that that will cause only minimal impact on the residents and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R1	0 950			

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0 950	Continued From page 27 R1's contract was signed on May 31, 2024, and lacked identification of a designated representative. The contract also lacked a box the resident must initial if the resident declines to name a representative. R1's record included a Designated Support Person Acknowledgement form dated January 29, 2026, indicating R1's sister was designated as a support person. The form lacked the verbatim language required by Minnesota Statute 144G.50 Subd. 3. R2 R2's contract was signed on February 1, 2026, and lacked identification of a designated representative. The contract also lacked a box the resident must initial if the resident declines to name a representative. R2's record included a Designated Support Person Acknowledgement form dated February 3, 2026, indicating R2's mother was designated as a support person. The form lacked the verbatim language required by Minnesota Statute 144G.50 Subd. 3. During an interview on May 12, 2026, at 2:24 p.m., clinical nurse supervisor (CNS)-A stated they were using the form that was provided to them by their nurse consultant. CNS-A stated they were unaware of the verbatim language requirements for the designated representative notice. The licensee's undated Assisted Living Contracts policy indicated the licensee would offer the resident the opportunity to identify a representative in writing on the contract and would provide the required notice on a document	0 950			

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0 950	Continued From page 28 separate from the contract. The policy also indicated the contract would include a box for the residents to initial in the event they declined to identify a designated representative. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 950			
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property of a resident for two of two residents (R1, R2). This practice resulted in a level one violation (a violation that that will cause only minimal impact on the residents and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).	0 970			

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0 970	Continued From page 29 The findings include: R1 R1 was admitted on May 31, 2024, and began receiving assisted living services. R1's record included a Resident Contract/Agreement signed on May 31, 2024. R2 R2 was admitted on February 1, 2026, and began receiving assisted living services. R2's record included a Resident Contract/Agreement signed on February 1, 2026. R1 and R2's contracts included the following clause that indicated the resident would waive the facility's liability for health, safety, or personal property of a resident: "Indemnification (page 16): Resident will indemnify and hold harmless Provider, it's employees and agents from and against any and all claims, actions damages, and liability and expense in connection with loss of life, personal injury, or damage to property, arising from or out of the use by Resident of the rented premises or any other part of Provider's property, or caused wholly or in part by an act or omission of Resident..." On May 13, 2026, at 9:16 a.m., licensed assisted living director (LALD)-D stated they were unaware that the contracts included language waiving liability. LALD-D stated the contracts would be re-evaluated. The licensee's undated Assisted Living Contracts policy indicated the contract would not include a	0 970			

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0 970	Continued From page 30 waiver of facility liability for the health, safety, and personal property of a resident. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970			
01060 SS=D	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to:	01060			

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01060	Continued From page 31 (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation and failed to notify the Office of Ombudsman for Long-Term Care (OOLTC) of the emergency relocation lasting more than four days for one of four residents (R3). 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: R3 was admitted on August 7, 2025, and began receiving assisted living services. R3 was discharged from the licensee on January	01060			

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01060	Continued From page 32 10, 2026. R3's Resident Notes included a nursing note dated December 30, 2025, at 2:30 p.m., indicating R3 was transferred to the hospital. R3's Resident Notes included an Emergency Relocation Notification dated December 30, 2025, at 9:45 p.m., the emergency relocation note included the new location, the reason for relocation and the estimated length of stay. R3's Emergency Relocation Notification dated December 30, 2026, lacked the following required information: -contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; and -a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54, including contact information for the agency to which the resident may submit an appeal. R3's record lacked documentation that the Emergency Relocation notice dated December 30, 2026, had been delivered to the resident, legal representative, and designated representative, and the Ombudsman when the resident had not returned to the licensee after four (4) days. On May 13, 2026, at 11:59 a.m., clinical nurse supervisor (CNS)-A stated they had notified R3's case manager by phone of the emergency relocation and did not document that the case manager had been notified. CNS-A stated they did not forward the emergency relocation notice	01060			

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01060	Continued From page 33 to the Ombudsman as required. The licensee's undated Assisted Living Contract Terminations policy indicated that in the event of an emergency relocation, the licensee would provide a written notice to the residents and other required parties. The relocation notice would include the following content: -the reason for relocation; -the name and contact information of the new location and service provider; -contact information for the OOLTC; -the estimated return date or a statement that the return date is unknown; and -a statement of the residents' right to appeal if housing or services are refused post-relocation, including agency contact information. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060			
01410 SS=F	144G.62 Subd. 2 Delegation of assisted living services (a) A registered nurse or licensed health professional may delegate tasks only to staff who are competent and possess the knowledge and skills consistent with the complexity of the tasks and according to the appropriate Minnesota practice act. The assisted living facility must establish and implement a system to communicate up-to-date information to the registered nurse or licensed health professional regarding the current available staff and their competency, so the registered nurse or licensed health professional has sufficient information to determine the appropriateness of delegating	01410			

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01410	Continued From page 34 tasks to meet individual resident needs and preferences. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) determined the appropriateness of delegating tasks to unlicensed personnel (ULP) when the ULPs performed the invasive procedure of catheterization for one of one resident (R1) with a suprapubic stoma. This practice resulted in a level two violation (a violation that did not harm a client'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 number or all the residents). The findings include: R1 was admitted on May 31, 2024, and began receiving assisted living services. R1's Service Plan Waiver signed on January 20, 2026, indicated R1's services included catheter care. R1's Individualized Treatment and Therapy plan dated May 11, 2026, indicated R1 received catheter care three times daily. The treatment plan instructed the ULPs to "assist resident with suprapubic straight cath [catheter] every 4-6 hrs [hours] as needed". R1's Service Recap Summary dated April 2026	01410			

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01410	Continued From page 35 indicated catheter care was performed three times daily. The Service Recap Summary indicated that the service had been provided by house manager (HM)-B on April 1, 2, 3, 7, 8, 14, and 24, 2026. The Service Recap Summary indicated that the service had been provided by ULP-C on April 6, 12, 13,16, 23, 25, 26, 27, and 30, 2026. On May 12, 2026, at 1:51 p.m., clinical nurse supervisor (CNS)-A stated R1 had a suprapubic stoma. CNS-A stated the ULPs inserted a catheter into the stoma every four to six hours as needed to drain the urine from R1's bladder. CNS-A stated the catheterization procedure was included in the service plan and the treatment plan under catheter care. CNS-A stated they trained the ULPs to perform the catheterization procedure. Ostendorf, Patricia A. Potter, Anne G. Perry, Patricia A. Stockert, Amy Hall, Wendy R. Fundamentals of Nursing. Available from: VitalSource Bookshelf, (12th Edition). Elsevier Health Sciences (US), 2025, page 288, indicated nursing delegation included assigning noninvasive and repetitive interventions to ULPs, while retaining responsibility and accountability for nursing practice. Based on the National Guidelines for Nursing Delegation, developed by the American Nurses Association (ANA) effective April 29, 2019, the licensed nurse cannot delegate any activity which requires clinical reasoning, nursing judgment, or critical decision making. The licensee's undated Treatment and Therapy Management Plan policy indicated treatments and therapies prescribed for residents would be	01410			

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01410	Continued From page 36 administered by a nurse or other health professional authorized to provide the treatment or therapy. No further information was provided. TIME PERIOD FOR CORRECTION: 7 days	01410			
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or	01470			

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01470	Continued From page 37 other relevant advocacy services; and (9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received orientation to assisted living facility licensing requirements and regulations with all required content for one of two employees (house manager (HM)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01470			

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(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
01470	Continued From page 38 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: HM-B was hired on September 11, 2025, and began providing assisted living services. HM-B's record lacked evidence of the following required orientation topics: -handling of resident complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; and -an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person. On May 13, 2026, at 3:08 p.m., clinical nurse supervisor (CNS)-A stated they were unaware that HM-B was missing orientation content. CNS-A stated the Educare (online training) assignments were not being done correctly. CNS-A stated "the office" was responsible for assigning Educare courses for completion. The licensee's undated Facility Employee Orientation policy indicated all employees of the licensee would complete an orientation on topics required by Minnesota statutes and rules for assisted living. No further information was provided.	01470			

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01470	Continued From page 39	01470			
	TIME PERIOD FOR CORRECTION: Twenty-one (21) days				
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person.	01500			

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01500	Continued From page 40 (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure annual training included all required content for one of two employees (unlicensed personnel (ULP)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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:	01500			

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01500	Continued From page 41 ULP-C was hired on September 6, 2024, and began providing assisted living services. ULP-C's My Transcript (online education) dated May 12, 2026, indicated annual training had been completed in January 2026. ULP-C's My Transcript lacked documentation of required annual training in the following topics: -training on the reporting of maltreatment of vulnerable adults under section 626.557; -review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment; disinfecting environmental surfaces; and reporting communicable diseases; - effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; -review of the facility's policy and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. On May 12, 2026, at 3:08 p.m., clinical nurse supervisor (CNS)-A stated the online training courses for annual training were being incorrectly assigned. CNS-A stated "the office" was responsible for assigned the online training courses. The licensee's undated Annual Training	01500			

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01500	Continued From page 42 Requirements policy indicated annual training would include: -training on the reporting of maltreatment of vulnerable adults under section 626.557; -review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment; disinfecting environmental surfaces; and reporting communicable diseases; - effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; -review of the facility's policy and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500			
01530 SS=F	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1)	01530			

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01530	Continued From page 43 to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide supervising employees with the initial eight (8) hours of	01530			

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01530	Continued From page 44 dementia training and two (2) hours of training on topics related to mental illness and de-escalation within 120 hours of providing direct care to residents for one of one supervising employees (house manager (HM)-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, 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: HM-B was hired on September 11, 2025, and began providing assisted living services and supervision of unlicensed staff. HM-B's record included an undated Educare transcript (online training) indicating HM-B had completed a total of 2.5 hours of dementia training on October 25, 2025, and one hour of mental illness training on October 26, 2025. The licensee's Monthly Schedule dated October 3, 2025, indicated HM-B had worked a total of 176 hours during the month of October 2025. HM-B's record lacked evidence that HM-B had completed 8 hours of dementia care training and two hours of training on topics related to mental illness and de-escalation within 120 working hours. On May 12, 2026, at 3:08 p.m., clinical nurse supervisor (CNS)-A stated HM-B had not	01530			

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01530	Continued From page 45 completed the required number of dementia and mental illness training hours within 120 hours of employment. CNS-A stated the training was assigned incorrectly. The licensee's undated Dementia Care Training policy indicated supervisors of direct-care staff would have at least 8 hours of initial training within 120 working hours of their employment start date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530			
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable.	01640			

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01640	Continued From page 46 (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plan was revised to reflect the current services provided 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 on May 31, 2024, and began receiving assisted living services. R1's Service Plan (Waiver) signed on January 20, 2026, indicated R1's services included assistance with dressing, grooming, medication administration, catheter care, and blood glucose monitoring. R1's service log dated April 2026, indicated R1 received RN supervision for blood glucose monitoring and lacked documentation that blood glucose monitoring had been provided twice daily as indicated on R1's service Plan. R1's unsigned Service Plan (waiver) dated May 12, 2026, indicated blood glucose monitoring and supervision had been removed from R1's service	01640			

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01640	Continued From page 47 plan. On May 12, 2026, at 8:40 a.m., clinical nurse supervisor (CNS)-A stated they had discontinued R1's blood glucose monitoring because R1 refused it. CNS-A stated they had updated the service plan but were unaware they needed to have the plan authenticated by the facility and the resident to document agreement on the services to be provided. A physician order discontinuing the blood glucose monitoring was requested and not provided during the survey. The licensee's undated Service Plan policy indicated the service plan, and any revisions, would include a signature or other authentication by the assisted living provider and by the resident or resident's representative documenting agreement on the services to be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640			
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	01760			

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01760	Continued From page 48 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 document medication administration in resident records for two of two residents (R1, R2). 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: R1 R1 was admitted on May 31, 2024, and began receiving assisted living services. R1's record included a Service Plan Waiver dated April 28, 2026, indicating R1 received medication administration services. R1's record included a Medication Administration Summary dated April 2026. The Medication Administration Summary indicated the licensee failed to document administration of the following medications on February 10 and 28, at 8:00 a.m.: -baclofen 10 milligrams (mg); -clonazepam 0.5 mg;	01760			

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01760	Continued From page 49 -divalproex 500 mg, take three (3) tablets; -ferrous sulfate 325 mg; -levetiracetam 1000 mg; -metformin 500 mg, take two (2) tablets; -oxybutynin 10 mg, take 2 tablets; -risperidone 0.5 mg; -rosuvastatin 20 mg; -tamsulosin 0.4 mg; -Venlafaxine 75 mg, take 2 tablets; and -vitamin D3 tablet. R2 R2 was admitted on February 1, 2026, and began receiving assisted living services. R2's record included a service plan signed February 3, 2026, indicating R2's services included medication administration. R2's record included a Medication Administration Summary dated April 2026. The Medication Administration Summary indicated the licensee failed to document administration of the following medications: -amlodipine 5 mg at 8:00 a.m. on April 10, 28, and 30; -bupropion 300 mg at 8:00 a.m., on April 10, 28, and 30; -calcium antacid chewable 500 mg at 8:00 a.m., on April 10, 28, and 30; -calcium antacid chewable 500 mg at 2:00 p.m., on April 12; -duloxetine 60 mg at 8:00 a.m., pm April 10, 28, and 30; -gabapentin 300 mg, take 3 capsules at 8:00 a.m., on April 10, 28, 30; -gabapentin 300 mg, take 3 capsules at 2:00 p.m., on April 12; -meloxicam 15 mg at 8:00 a.m., on April 10, 28, and 30;	01760			

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01760	Continued From page 50 -polyethylene glycol powder 17 gram (gm) at 8:00 a.m., on April 10, 28, and 30; -topiramate 100 mg at 8:00 a.m., on April 1-10, 13-18, 20-26, 28, and 30; -topiramate 100 mg at 8:00 p.m., on April 27 and 30: and -Ozempic 2 mg injection at 8:00 a.m., on April 10 and 17; On May 11, 2026, at 11:37 a.m., the surveyor observed house manager (HM)-B administer medications to R2. On May 13, 2026, at 3:13 p.m., clinical nurse supervisor (CNS)-A and HM-B stated they were unaware that medication documentation had not been completed for R1 and R2. HM-B stated they would begin auditing the medication administration records. The licensee's undated Documentation on Medication Administration policy indicated each medication administered by the licensee would be documented in the resident's record. The policy also indicated that staff would 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. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all	01880			

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01880	Continued From page 51 prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to store all prescription medications in securely locked and substantially constructed compartments. The deficient practice had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On May 11, 2026, at 10:10 a.m., during the entrance conference, the surveyor observed house manager (HM)-B remove medications from the locked medication closet and take them downstairs. On May 11, 2026, at 10:10 a.m., the surveyor requested that any medication set up or administration be made available for observation. On May 11, 2026, at 10:25 a.m., the survey observed the door to the medication closet was unlocked and was open. HM-B had failed to lock the medication closet when removing medications.	01880			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35639	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/13/2026
NAME OF PROVIDER OR SUPPLIER ANGEL'S HEALTH & HC SRV INC			STREET ADDRESS, CITY, STATE, ZIP CODE 4213 63RD AVENUE NORTH BROOKLYN CENTER, MN 55429		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01880	Continued From page 52 On May 11, 2026, at 10:25 a.m., clinical nurse supervisor (CNS)-A stated HM-B had taken the medications downstairs to "prepare them". CNS-A stated they would call HM-B to return upstairs with the medications so the surveyor could observe the medication preparation and administration process. The licensee's 7.11 Medication Storage policy dated August 1, 2022, indicated medications would be kept securely locked and stored per manufacturer's instructions and only authorized staff would have access to stored medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880			
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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical or nursing standards for one of one resident (R1) who utilized bed rails. This practice resulted in a level two violation (a violation that did not harm a resident's health or	02310			

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02310	Continued From page 53 safety but had the potential to have harmed a resident's health or safety by 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 the residents). The findings include: R1 was admitted May 31, 2024, and began receiving assisted living services. R1's Service Plan (Waiver) signed January 20, 2026, indicated R1's services included assistance with dressing, grooming, medication administration, transfers, catheter care, and behavior management. R1's nursing assessment completed April 6, 2026, indicated R1 used a hospital bed with bilateral half rails. The assessment lacked measurements of bedrails zones identified as potential areas of entrapment. R1's record included a Side-rail Assessment Form signed by clinical nurse supervisor (CNS)-A on January 20, 2026, The Side-rail Assessment Form lacked actual measurements of bed rail zones identified as potential areas of entrapment. On May 11, 2026, at 11:00 a.m., during a facility tour, the surveyor observed R1's hospital bed with a trapeze to assist mobility. The surveyor noted there was a lack of bed rails on R1's bed. On May 11, 2026, at 11:00 a.m., R1 stated they preferred to have one bed rail on the side of the bed against the wall to assist with bed mobility.	02310			

Minnesota Department of Health

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02310	Continued From page 54 On May 11, 2026, at 11:00 a.m., clinical nurse supervisor (CNS)-A stated the bed rail had "fallen off the bed" over the previous weekend and they were calling someone to have it replaced. On May 12, 2026, at 10:28 a.m., the surveyor observed R1's hospital bed with a bed rail leaning up against the side of the bed. A second bed rail was observed lying on the floor under the bed. On May 12, 2026, at 10:30 a.m., house manager (HM)-B stated they had removed the bed rail per request of R1. On May 12, 2025, at 1:05 p.m., CNS-A stated the Side-rail Assessment form was the only bed rail assessment she has completed. CNS-A stated she was unaware that side rail assessments needed to be completed and include measurements. The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs), updated April 17, 2026, 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	02310			

Minnesota Department of Health

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02310	Continued From page 55 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 residents' preferences; - Installation and use according to manufacturer's 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 undated Use of Siderails policy indicated bedrails would not be used except in situations where assessment determined they are necessary for the safety of the resident. The policy also indicated the assessment would determine whether the bedrail meets the Food and Drug Administration (FDA) standards for bedrails. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	02310			



Rochester District Office
Minnesota Department of Health
3425 40th Ave NW, Suite 115
Rochester, MN 55901
Phone: 651-201-4500

Food & Beverage Inspection Report

Page: 1

Establishment Info

Angel's Health & Home Care Services
4213 63RD AVENUE NORTH
Brooklyn Center, MN 55429
Hennepin County
Parcel:

Phone:

License Info

License: HFID 35639

Risk:
License:
Expires on:
CFPM: Estella G. GarderFallah
CFPM #: 90192; Exp: 03/14/2027

Inspection Info

Report Number: F8044261144
Inspection Type: Full - Single
Date: 5/12/2026 Time: 10:30:02 AM
Duration: minutes
Announced Inspection: Yes
Total Priority 1 Orders: 2
Total Priority 2 Orders: 1
Total Priority 3 Orders: 2
Delivery: Emailed

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 chlorine or quaternary ammonium test kit.

Comply By: 5/13/2026 Originally Issued On: 5/12/2026

! New Order: 4-500 Equipment Maintenance and Operation

4-501.114B *Priority Level: Priority 1 CFP#: 16*

MN Rule 4626.0805B Discontinue using a sanitizer concentration that exceeds the EPA approved manufacturer's label amount.

COMMENT: Chlorine in spray bottle measured above 200 ppm.

50 ppm obtained while on site.

Comply By: 5/12/2026 Originally Issued On: 5/12/2026

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: Sign missing from restroom.

Comply By: 5/12/2026 Originally Issued On: 5/12/2026

New Order: 6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.12A *Priority Level: Priority 3 CFP#: 55*

MN Rule 4626.1520A Clean and maintain all physical facilities clean.

COMMENT: Soiled floors in hard to reach areas in kitchen.

Comply By: 5/18/2026 Originally Issued On: 5/12/2026

! New Order: 7-200 Toxic Supplies and Applications

7-204.11 *Priority Level: Priority 1 CFP#: 28*

MN Rule 4626.1620 Discontinue using chemical sanitizers, including chemical sanitizing solutions generated on site and other chemical antimicrobials on food-contact surfaces that do not meet the requirements specified in 40 CFR part 180, section 180.940, or part 180, subpart E, section 180.2020.

COMMENT: Lysol wipes used to sanitize food contact surfaces are not approved.

Disinfecting bleach will be used.

Comply By: 5/12/2026 Originally Issued On: 5/12/2026

Food & Beverage General Comment

HRD inspection conducted with nurse evaluator Michelle Winters. Inspection report reviewed on site with Estella.

FLOOR IS VINYL, CABINETS ARE WOOD WITH HALLOWED ENCLOSED BASES, SOLID SURFACE COUNTER TOPS AND POPCORN TEXTURED CEILING. ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT ANY TIME THERE IS FOUND TO BE A RISK OF CONTAMINATION OR CONCERN THE PHYSICAL FACILITIES WILL BE REQUIRED TO BE BROUGHT UP TO CODE.

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Rochester District Office inspection report number F8044261144 from 5/12/2026

Estella



Michael DeMars, RS
Public Health Sanitarian 3
michael.demars@state.mn.us



Rochester District Office
Minnesota Department of Health
3425 40th Ave NW, Suite 115
Rochester, MN 55901

Temperature Observations/Recordings

Page: 1

Establishment Info

Angel's Health & Home Care Services
Brooklyn Center
County/Group: Hennepin County

Inspection Info

Report Number: F8044261144
Inspection Type: Full
Date: 5/12/2026
Time: 10:30:02 AM

Food Temperature: Product/Item/Unit: Lasagna; Temperature Process: Cold-Holding

Location: Refrigerator at 38.6 Degrees F.

Comment:

Violation Issued?: No

Equipment Temperature: Product/Item/Unit: ; Temperature Process: Cold-Holding

Location: Refrigerator at 38.0 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: Product/Item/Unit: Mac N Cheese; Temperature Process: Hot-Holding

Location: Stove at 136.5 Degrees F.

Comment:

Violation Issued?: No



Rochester District Office
Minnesota Department of Health
3425 40th Ave NW, Suite 115
Rochester, MN 55901

Sanitizer Observations/Recordings

Page: 1

Establishment Info

Angel's Health & Home Care Services
Brooklyn Center
County/Group: Hennepin County

Inspection Info

Report Number: F8044261144
Inspection Type: Full
Date: 5/12/2026
Time: 10:30:02 AM

Sanitizing Chemical: Product: Chlorine; **Sanitizing Process:** Spray Bottle

Location: Kitchen **Greater Than** 200 PPM

Comment:

Violation Issued?: Yes

Sanitizing Equipment: Product: Hot Water; **Sanitizing Process:** Dishwasher

Location: Kitchen **Equal To** 160.0 Degrees F.

Comment:

Violation Issued?: No

Physical Environment Inspection Report

ASSISTED LIVING | ASSISTED LIVING WITH DEMENTIA CARE

Project No: SL35639016-0	Date: 5-13-26
Facility Name: ANGEL'S HEALTH & HOME CARE SER	
Facility Address: 4213 63RD AVENUE NORTH BROOKLYN CENTER MN	

☒ **TAG IDENTIFICATION: 0775**

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Seven (7) days

1. Each assisted living facility must comply with the provisions of the Minnesota State Fire Code (MSFC) in Minnesota Rules chapter 7511. [Minn. Stat. 144G.45 subd. 2]
2. Clothes dryers and their exhaust systems shall be cleaned as necessary to keep lint traps, exhaust ducts, and mechanical and heating components free from excessive lint accumulation. [Minn. Stat. 144G.45 subd. 2; MSFC 304.4]

Comments: The dryer vent was disconnected at the dryer allowing a build up of lint and potential carbon monoxide exposure.

3. Lighted matches, cigarettes, cigars or other burning object shall not be discarded in such a manner that could cause ignition of other combustible material. [Minn. Stat. 144G.45 subd. 2; MSFC 310.7]

Comments: Cigarettes were observed on the wood ramp at the front entrance.

4. Relocatable power taps (power strips) shall be directly connected to a permanently installed receptacle. [Minn. Stat. 144G.45 subd. 2; MSFC 604.4.2]

Comments: The office had power strips plugged into power strips.

5. Extension cords and flexible cords shall not be a substitute for permanent wiring and shall be listed and labeled in accordance with UL 817. Extension cords and flexible cords shall not be affixed to structures, extended through walls, ceilings or floors, or under doors or floor coverings, nor shall such cords be subject to environmental damage or physical impact. Extension cords shall be used only with portable appliances. Extension cords marked for indoor use shall not be used outdoors. [Minn. Stat. 144G.45 subd. 2; MSFC 604.5]

Comments: Resident room 4 had extension cords that are not approved by UL.

The office freezer was plugged into an extension cord.

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 3; Widespread

TIME PERIOD OF CORRECTION: Twenty One (21) days

1. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that are readily available at all times within the facility. [Minn. Stat. 144G.45 subd.2]

Comments: When the surveyor requested the FSEP the licensed assisting living director (LALD)-D stated the FSEP was in the locked office located in the lower level, and we needed to wait for the house manager to get to access the FSEP.

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

Comments: The FSEP failed to 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. The provided FSEP was from a third-party provider and had not been updated to the specific facility.

3. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) 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: LALD-D stated a policy was not in place at the time of the survey.

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

Comments: LALD-D stated that staff training was done in tandem with fire drills. No documentation was provided, indicating training was completed.

5. Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. [Minn. Stat. 144G.45 subd.2]

Comments: LALD-D stated that resident training was done in tandem with fire drills. No documentation was provided indicating training was completed.

6. Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. [Minn. Stat. 144G.45 subd.2]

Comments: Review of the evacuation drill log indicated fire drills were conducted with the day shift only.