Electronically Delivered

March 13, 2026

Licensee
Triple B Home Care LLC
7025 Quail Ave North
Brooklyn Center, MN 55429

RE: Project Number(s) SL41393015

Dear Licensee:

This is your **official notice** that you have been **granted your assisted living facility license.** Your license effective and expiration dates remain the same as on your provisional license. Your updated status will be listed on the license certificate at renewal and **this letter serves as proof** in the meantime. If you have not received a letter from us with information regarding renewing your license within 60 days prior to your expiration date, please contact us at (651) 201-5273 or by email at Health.assistedliving@state.mn.us.

The Minnesota Department of Health completed an initial survey on February 5, 2026, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

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

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

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

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

The total amount you are assessed is $500.00. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
Per 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 residents/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 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 the Department of Health 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 MDH within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

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

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

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

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

If you have any questions, please contact me.

Sincerely,

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

CLN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41393	A. BUILDING: _____ B. WING _____	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRIPLE B HOME CARE LLC	7025 QUAIL AVE N 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: SL41393015-0 On February 3, 2026, through February 5, 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 two (2) residents; 2 receiving services under the Provisional 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.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470		

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0 470	Continued From page 1 determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a written staffing plan that included an evaluation completed by the clinical nurse supervisor (CNS) at least twice a year. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 470		

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0 470	Continued From page 2 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 February 3, 2026, at 10:14 a.m., owner/CNS (O/CNS)-A provided a staffing plan that was in the emergency preparedness manual. O/CNS-A stated this was the staffing plan for the facility. The Facility Staffing Plan, undated, indicated it was reviewed by O/CNS-A on July 1, 2025. The staffing plan lacked evidence that it had been reviewed twice per year. On February 3, 2026, at 10:15 a.m., O/CNS-A stated they were unaware the staffing plan was to be evaluated at least twice per year. O/CNS stated they did not have a policy for staffing. The Facility Staffing Plan, undated, indicated a biannual evaluation of the plan would occur in March and September each year. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter	0 480		

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0 480	Continued From page 3 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part	0 480		

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0 480	Continued From page 4 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated February 3, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		

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0 630	Continued From page 5	0 630		
0 630 SS=D	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 two residents (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 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: R2 was admitted to the licensee on October 22, 2025. R2's Service Plan - Modification indicated R2's	0 630		

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0 630	Continued From page 6 services included assistance with dressing, grooming, mobility, medication administration, and blood glucose monitoring. R2's Individual Abuse Prevention Plan dated February 2, 2026, lacked an assessment of R2's risk of abusing other vulnerable adults. On February 3, 2026, at 12:30 p.m., owner/clinical nurse supervisor (O/CNS)-A stated the assessment of R2's risk of abusing other vulnerable adults was not assessed and would be amended through R-Task (electronic documentation system). The licensee's Abuse Prevention Plan policy, undated, indicated that all residents admitted to the facility would be assessed for their susceptibility to abuse by other individuals, including other vulnerable adults and their risk of abusing other vulnerable adults. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 660 SS=D	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	0 660		

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0 660	Continued From page 7 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 baseline TB testing 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 was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The licensee's Facility TB Risk Assessment form was completed June 9, 2025, and identified the facility TB risk level as low. ULP-D was hired July 1, 2025, and began providing assisted living services. ULP-D's record included a TB history and symptom screen completed on July 21, 2025. ULP-D's record also included a negative chest	0 660		

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0 660	Continued From page 8 x-ray dated July 21, 2025. ULP-D's record lacked evidence that a two-step tuberculin skin test (TST) or a TB blood test was performed prior to the chest x-ray. On February 4, 2026, at 11:03 a.m., owner/clinical nurse supervisor (O/CNS)-A stated they thought a chest x-ray was an acceptable form of TB testing. O/CNS-A stated they understood that they were required to screen and test all employees annually. The MDH guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and the CDC guidelines, indicated the three steps for baseline TB testing included the following: -assessing current symptoms of active TB disease; -assessing TB history; and -testing for the presence of TB infection by administering either a two-step TST or a TB blood test. The licensee's Tuberculosis Screening policy, undated, indicated each employee would have documentation of a baseline health symptom screening and testing for TB via a TB skin test or a TB blood test. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness	0 680		

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0 680	Continued From page 9 (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 disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to have a written emergency preparedness (EP) plan with all the required content. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when	0 680		

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0 680	Continued From page 10 problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On February 4, 2026, at 12:20 p.m., the surveyor was provided with a binder labeled Emergency Preparedness Plan. Owner/clinical nurse supervisor (O/CNS)-A stated it was the EP plan for the facility. The licensee's EP Plan reviewed on January 1, 2026, included a Missing Resident Plan. The EP plan lacked documentation that the plan was reviewed quarterly. On February 4, 2026, at 12:30 p.m., O/CNS-A stated they had not reviewed the missing resident plan quarterly and thought it needed to be evaluated annually. The licensee's Missing Resident policy, undated, did not indicate the frequency of review of the missing resident plan. No further 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	0 730		

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

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	41393	A. BUILDING: _____ B. WING _____	02/05/2026

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0 730	Continued From page 12 status. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the resident's record included documentation of a risk vs. benefits discussion related to bed rails for two of two residents (R2, 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 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: R2 R2 was admitted to the licensee on October 22, 2025. R2's Service Plan signed on February 2, 2026, indicted R2's services included assistance with dressing, bathing, transfers, and positioning/repositioning. On February 3, 2026, at 11:10 a.m., during a facility tour, the surveyor observed that R2 used a hospital bed with bilateral quarter bedrails near the headboard of the bed. R2's nursing assessment completed on February 2, 2026, indicated bed rails were in use and included zone measurements and assessment of bedrail need.	0 730		

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0 730	Continued From page 13 R3 R3 was admitted to the licensee on June 26, 2025. R3's Service Plan - Modification signed on November 23, 2025, indicated R3's services included assistance with dressing, bed mobility and repositioning, medication administration, and transfers. On February 3, 2026, at 11:10 a.m., during a facility tour, the surveyor observed that R3 used a hospital bed with bilateral quarter bedrails near the headboard of the bed. R3's nursing assessment completed on November 21, 2025, indicated bed rails were in use and included zone measurements and assessment of bedrail need. R2 and R3's records lacked documentation of a risk vs. benefit discussion of bed rail use with the resident or resident's representative. On February 3, 2026, at 12:27 p.m., owner/clinical nurse supervisor (O/CNS)-A stated R2 and R3's records did not include a risk vs benefit discussion. O/CNS-A stated they had discussed bedrail risk vs benefits with both R2 and R3 but had not documented the discussion. On February 4, 2026, at 12:37 p.m., R2 stated he didn't remember if the nurse discussed bed rail risk vs benefits with him. The licensee's undated Use of Side Rails policy indicated the registered nurse would document the teaching provided regarding the risks of using side rails. The policy also indicated the	0 730		

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0 730	Continued From page 14 documentation would include family members or resident representatives who received the education on the safe use of side rails. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (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 February 5, 2026, for the specific violations	0 775		

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0 775	Continued From page 15 related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 775		
0 780 SS=D	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced	0 780		

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0 780	Continued From page 16 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 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: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated February 5, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for	0 810		

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0 810	Continued From page 17 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 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	0 810		

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0 810	Continued From page 18 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 February 5, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Tweny-one (21) days.	0 810		
01060 SS=F	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	01060		

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01060	Continued From page 19 provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 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 (4) days for two of three residents (R1, 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 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 of the residents).	01060		

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01060	Continued From page 20 The findings include: R1 R1 was admitted on March 27, 2025, and began receiving assisted living services. R1 was discharged from the licensee on December 21, 2025. R1's record included a progress note dated November 15, 2025, at 12:01 a.m., indicating R1 was transferred to the hospital. R1's progress note dated December 4, 2025, at 6:43 p.m., indicated R1 had returned from the hospital. R3 R3 was admitted to the licensee on June 26, 2025, and began receiving assisted living services. R3's Service Plan Modification dated November 23, 2025, indicated R3's services included assistance with dressing, grooming, bathing, mobility, medication administration, and behavior management. R3's record included progress notes indicating R3 was transferred to the hospital on November 18, 2025. The progress notes indicated R3 returned from the hospital stay on November 21, 2025. R1and R3's records lacked evidence of a written notice provided to the residents, the residents' legal representative, designated representative, and OOLTC (for relocations where the resident did not return within four days) that contained, at a minimum: - the reason for the relocation;	01060		

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01060	Continued From page 21 - the name and contact information for the location to which the resident had been relocated and any new service provider; - contact information for the OOLTC; - if known and applicable, the approximate date or range of dates within which the resident was expected to return to the facility, or a statement that a return date was not currently known; and - a statement that, if the facility refused to provide housing or services after a relocation, the resident had the right to appeal and the contact information for the agency to which the resident may submit an appeal. On February 3, 2026, at 11:34 a.m., owner/clinical nurse supervisor (O/CNS)-A stated they had just learned about the requirement for an emergency relocation notice and had not yet had the chance to implement the document. O/CNS-A stated they had not been completing an emergency relocation notice for any residents transferred to the hospital. The licensee's undated Assisted Living Contract Terminations policy indicated that in the event of an emergency relocation, the facility would provide a written notice containing the following information: -the reason for relocation; -the name and contact information for the location to which the resident had been relocated and any new service provider; -contact information for the OOLTC; -the approximate date or range of dates within which the resident is expected to return to the facility or a statement that a return date is not currently known; and -a statement that if the facility refused to provide housing or services after a relocation, the resident had the right to appeal and the contact	01060		

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01060	Continued From page 22 information for the agency to which the resident may submit an appeal. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
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 23 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 include all required content for two of two employees (assisted living director/unlicensed personnel (ALD/ULP)-B, ULP-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01470		

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01470	Continued From page 24 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: ALD/ULP-B ALD/ULP-B was hired on February 11, 2025, and began providing assisted living services. ALD/ULP-B's employee record lacked documentation of the following required orientation topics: -overview of assisted living statutes; -compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); -the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; -the handling of resident complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints (OHFC); -consumer advocacy services including information on the Office of the Ombudsman for Long-Term Care, Office of the Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and -a review of the types of assisted living services the employee will be providing and the facility's category of licensure.	01470		

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01470	Continued From page 25 ULP-D ULP-D was hired on July 1, 2025, and began providing assisted living services. ULP-D's employee record lacked documentation of the following required orientation topics: -an overview of assisted living statues; -consumer advocacy services including information on the Office of the Ombudsman for Long-Term Care, Office of the Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; -the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; and -a review of the types of assisted living services the employee will be providing and the facility's category of licensure. On February 4, 2026, at 11:24 a.m., owner/clinical nurse supervisor (O/CNS)-A stated she did not know that orientation content had not been completed by O/ULP-B and ULP-D. O/CNS-A stated the content had not been assigned and they would have the content added to the online education program. The licensee's undated Facility Employee Orientation policy indicated orientation topics would include: -An overview of Minnesota's home care law (MN statutes 144A.43 to 144.4798); -reporting the maltreatment of vulnerable minors or adults under the Minnesota statutes 626.556 and 626.557; -the home care bill of rights (Minnesota Statutes 144A.44);	01470		

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01470	Continued From page 26 -handling of resident complaints and reporting of complaints to the OHFC; -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 other relevant advocacy services; and -a review of the types of services the employee will be providing and the scope of the facility's services under the specific license. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an	01650		

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01650	Continued From page 27 emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure residents' service plans included all required content for two of two residents (R2, 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 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: R2 R2 was admitted on October 22, 2025, and began receiving assisted living services. R2's Service Plan - Modification dated February 2, 2026, indicated R2's services included assistance with dressing, grooming, medication administration, mobility, and behavior management.	01650		

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01650	Continued From page 28 R3 R3 was admitted on June 26, 2025, and began receiving assisted living services. R3's Service Plan - Modification dated November 23, 2025, indicated R3's services included assistance with dressing, grooming, medication administration, mobility, and behavior management. R2 and R3's service plans lacked the following required content: -fees for services provided; -the schedule and methods of monitoring assessments of the resident; -the schedule and methods of monitoring staff providing the services; and -a contingency plan that includes the action to be taken if the service cannot be completed. On February 3, 2026, at 12:27 p.m., owner/clinical nurse supervisor (O/CNS)-A stated the service plans for R2 and R3 did not include all required content. O/CNS-A stated the content had not yet been added to the R-Task (electronic record) template and they would get the content added. The licensee's undated Service Plan policy indicated service plans would include the following content: -the fees for services; -the schedule and methods of monitoring assessments of the resident; -the schedule and methods of monitoring staff providing services; and -a contingency plan for circumstances when services cannot be provided. No further information was provided.	01650		

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01650	Continued From page 29 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		
01700 SS=D	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse	01700		

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01700	Continued From page 30 (RN) conducted a face-to-face medication management assessment to include all required content for one of two residents (R2) who received medication management services. 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: During the entrance conference on February 3, 2026, at 10:14 a.m., owner/clinical nurse supervisor (O/CNS)-A stated the licensee provided medication management services to all the licensee's residents. R2 was admitted on October 22, 2025, and began receiving assisted living services. R2's Service Plan - Modification dated February 2, 2026, indicated R2's services included assistance with medication administration. R2's record included a Medication Administration Summary dated January 2026, indicating the following medications had been administered to R2: -acetaminophen 650 milligrams (mg); take one tablet by mouth (po) every day; -amlodipine 10mg, take one tablet daily at bedtime; -aspirin 81mg, take one table daily; -baclofen 10mg, take one tablet daily;	01700		

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01700	Continued From page 31 -bisacodyl tab 5 mg, take one tablet daily; -Fiber Lax 625 mg, take one tablet daily; -hydrochlorothiazide 50mg, take ne tablet daily; -Januvia 50mg, take one tablet daily; -lisinopril 20 mg, take one tablet daily; -senna 8.6 mg, take 2 tablets by mouth twice daily; -atorvastatin 40mg, take one tablet at bedtime; -Lantus insulin; inject 21 unites subcutaneously at bedtime; and -tizanidine 2mg, take one tablet at bedtime. R2's record included an initial assessment dated October 22, 2025. Under the Medications section, the assessment lacked identification of all medications ordered for R2 and lacked a review of the side effects, contraindications, allergic or adverse reactions. The assessment also lacked interventions needed in management of medications to prevent diversion. On February 3, 2026, at 12:40 p.m., owner/clinical nurse supervisor (O/CNS)-A stated R2's medication assessment did not include all required content. O/CNS-A stated content had not been built into the R-Task (electronic documentation system) template. The licensee's undated Medication Management Services policy indicated the RN would develop a medication management plan for each resident based on the resident assessment and preferences. The policy also indicated the RN would develop procedures to assess resident medication management services, including signs and symptoms of side effects, allergic reactions, or dose intolerance. No further information was provided.	01700		

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01700	Continued From page 32 TIME PERIOD FOR CORRECTION: Seven (7) days	01700		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, a registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use	01730		

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01730	Continued From page 33 to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop an individualized medication management plan with all required content for one of two residents (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 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: R2 was admitted on October 22, 2025, and began receiving assisted living services. R2's Service Plan - Modification signed on February 2, 2026, indicated R2's services included assistance with medication administration. R2's Individualized Medication Management Plan printed February 3, 2026, indicated it had been	01730		

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01730	Continued From page 34 completed by owner/clinical nurse supervisor (O/CNS)-A on February 3, 2026 (during the survey). R2's Individualized Medication Management Plan lacked the following required content: -a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with manufacturer's directions; -identification of medication management tasks that may be delegated to unlicensed personnel; -procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and -any resident-specific requirements related to documenting medication administration, verifications that all medications are administered as prescribed and monitoring of medications to prevent possible complications or adverse reactions. On February 3, 2026, at 12:40 p.m., O/CNS-A stated required content was missing from R2's medication management plan. O/CNS stated the content was not addressed in R2's assessment. The licensee's undated Individualized Medication Management Plan and Record policy indicated medication management plans would include the following content: -a description of how medications will be stored, based on resident needs, risk of diversion and consistent with manufacturer's directions; -identification of medication management tasks that may be delegated to unlicensed personnel; -procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and	01730		

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01730	Continued From page 35 -any resident-specific requirements relating to documentation of medication administration, verifications that all medications are administered as prescribed and monitoring of medication use to prevent possible complications or adverse reactions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01770 SS=F	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure documentation of medication setup included all the required content for two of two residents (R2, 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 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).	01770		

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01770	Continued From page 36 The findings include: R2 R2 was admitted on October 22, 2025, and began receiving assisted living services. R2's Service Plan - Modification dated February 2, 2026, indicated R2's services included assistance with medication administration. R3 R3 was admitted on June 26, 2025, and began receiving assisted living services. R3's Service Plan - Modification dated November 23, 2025, indicated R3's services included assistance with medication administration. R2 and R3's records lacked documentation of medication set up to include: -dates of medication setup, -name of medication, -quantity of dose, -times to be administered, -route of administration, and -name of person completing medication setup. On February 3, 2026, at 12:09 p.m., the surveyor observed assisted living director/unlicensed personnel (ALD/ULP)-B administering medications to R3 that had previously been set up in a pillbox. On February 4, 2026, at 9:40 a.m., owner/clinical nurse supervisor (O/CNS)-A stated they set up resident medications weekly into pill boxes for ULPs to administer. O/CNS-A stated they did not document medication set up for any of their residents. O/CNS-A stated they would leave the medications in the pill packs provided by the	01770		

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01770	Continued From page 37 pharmacy and would not continue setting up medications. The licensee's undated Medication Set Up policy did not address documentation at the time of medication setup. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and	01940		

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01940	Continued From page 38 therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a current individualized treatment management record was developed to include the required content for one of two residents (R2). 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 client'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: R2 R2 was admitted to the licensee on October 22, 2025. R2's Service Plan signed on February 2, 2026, indicated R2's services included assistance with an orthotic device, therapeutic exercises, compression stockings, and blood glucose monitoring. R2's record included a prescriber order for blood glucose monitoring once daily and as needed dated October 23, 2025.	01940		

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01940	Continued From page 39 R2's record lacked an Individualized Treatment or Therapy Management Plan including the following required content: -documentation of specific resident instructions relating to the treatments or therapy administration; - procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and -any resident specific requirements related to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. On February 3, 2026, at 12:27 p.m., owner/clinical nurse supervisor (O/CNS)-A stated R2 did not have a treatment plan as they did not know how to generate one in their electronic record. O/CNS-A stated they did not provide written instruction to staff on how to perform treatment and therapy tasks. O/CNS-A stated the instruction was verbally provided and demonstrated to staff during their training. The licensee's undated Treatment and Therapy Management Plan policy indicated an individualized plan would be developed for each resident receiving treatment or therapy services consistent with current practice standards and guidelines. The policy also indicated treatment and therapy plans would include the following content: -documentation of specific instructions that relate	01940		

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TRIPLE B HOME CARE LLC	7025 QUAIL AVE N BROOKLYN CENTER, MN 55429

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01940	Continued From page 40 to providing the treatment or therapy administration; -procedures for notifying a registered nurse if problems arose with the treatment or therapy services; -any resident specific requirements that relate to documentation of treatments and therapy, and direction on where tasks are to be documented; -frequency of supervision of personnel providing delegated treatment or therapy services; and -verification by the registered nurse that services are administered as prescribed and monitoring of treatment or therapy to prevent complications or adverse reactions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure up-to-date written or electronic treatment orders were maintained for one of two residents (R2).	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41393	A. BUILDING: _____ B. WING _____	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRIPLE B HOME CARE LLC	7025 QUAIL AVE N 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
01970	Continued From page 41 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: R2 was admitted to the licensee on October 22, 2025. R2's Service Plan signed on February 2, 2026, indicated R2's services included assistance with an orthotic device, therapeutic exercises, compression stockings, and blood glucose monitoring. R2's record included a prescriber order for blood glucose monitoring once daily and as needed dated October 23, 2025. R2's record lacked prescriber orders for an orthotic device, therapeutic exercises, and compression stockings. On February 3, 2026, at 12:27 p.m., owner/clinical nurse supervisor (O/CNS)-A stated R2 did not have orders for his orthotic brace, compression stockings, or therapeutic exercises on admission. O-CNS-A stated R2 insisted on receiving those services. O/CNS-A stated they had not contacted the physician for orders and were looking for a physical therapy company to provide the services. The licensee's undated Treatment and Therapy	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41393	A. BUILDING: _____ B. WING _____	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRIPLE B HOME CARE LLC	7025 QUAIL AVE N 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
01970	Continued From page 42 Management Plan policy indicated orders would be obtained for treatments and therapies that would require orders from an authorized provider before the services were provided. The policy also indicated orders would be written or electronically recorded from an authorized prescriber for all treatments and therapies. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		

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

Food & Beverage Inspection Report

Establishment Info

Triple B Care LLC
7025 Quail Ave N
Brooklyn Center, MN 55429
Hennepin County
Parcel:

Phone:

License Info

License: HFID 41393

Risk:
License:
Expires on:
CFPM: Olabimpe T. Aladedunye
CFPM #: 108341; Exp: 11/7/2027

Inspection Info

Report Number: F8041261021
Inspection Type: Full - Single
Date: 2/3/2026 Time: 10:00 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 1
Delivery: Emailed

New Order: 4-600 Cleaning Equipment and Utensils
4-602.12 *Priority Level: Priority 3 CFP#: 16*
MN Rule 4626.0850 Clean the food contact surfaces of cooking and baking equipment and interior cavities of microwave ovens at least every 24 hours.
COMMENT: BUILD-UP OF FOOD DEBRIS INSIDE THE MICROWAVE. DISCUSSED CLEANING THE MICROWAVE DAILY WITH THE PERSON IN CHARGE.
Comply By: 2/4/2026 Originally Issued On: 2/3/2026

Food & Beverage General Comment

Inspection was completed with the food service manager, Olabimpe Alademunye and Laura Yang (MDH). Michelle Winters was the lead Health Regulation Division Nurse Evaluator.

This establishment has a residential kitchen. Food must be prepared for same say service only. The kitchen has wood cabinets with a hollow base, solid surface countertop, smooth ceiling and vinyl flooring.

LG dish machine was tested and achieved a utensil surface temperature of at least 160F for sanitizing.

Discussed the following:
- Employee illness policy and logging requirements
- Reporting foodborne illness complaints to the health dept.
- Handwashing
- Date marking
-Glove-use and bare hand contact
- Proper food storage
-Vomit clean-up procedures
- Restrictions concerning serving a highly susceptible population

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

I acknowledge receipt of the Metro District Office inspection report number F8041261021 from 2/3/2026

Olabimpe Aladedunye

Sarah Conboy,
Public Health Sanitarian Supervisor
651-201-3984
sarah.conboy@state.mn.us

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

Temperature Observations/Recordings

Establishment Info

Triple B Care LLC
Brooklyn Center
County/Group: Hennepin County

Inspection Info

Report Number: F8041261021
Inspection Type: Full
Date: 2/3/2026
Time: 10:00 AM

Food Temperature: Product/Item/Unit: milk**; Temperature Process:** Cold-Holding
Location: kitchen cooler at 41 Degrees F.
Comment:
Violation Issued?: No

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ASSISTED LIVING | ASSISTED LIVING WITH DEMENTIA CARE

Project No: SL41393015-0	**Date:** 2/5/2026
Facility Name: Triple B Care	
Facility Address: 7025 Quail Ave. N, Brooklyn Center, MN 55429	

☒ **TAG IDENTIFICATION: 0775**

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

1. Each assisted living facility must comply with the provisions of the Minnesota State Fire Code (MSFC) in Minnesota Rules chapter 7511. [Minn. Stat. 144G.45 subd. 2]

2. Where smoking is permitted, suitable noncombustible ash trays or match receivers shall be provided on each table and at other appropriate locations. [Minn. Stat. 144G.45 subd. 2; MSFC 310.6]

   Comments: There was a plastic container on the front ramp being used as an ashtray.

3. Lighted matches, cigarettes, cigars or other burning objects 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: Several cigarette butts were discarded on the front ramp and on the ground next to the facility by the side door.

☒ **TAG IDENTIFICATION: 0780**

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

1. Smoke alarms must be interconnected so that actuation of one alarm causes all alarms in the individual dwelling or sleeping unit to operate where more than one smoke alarm is required within an individual dwelling or sleeping unit. [Minn. Stat. 144G.45 subd.2]

   Comments: There was a hard-wired smoke alarm in the main floor hallway that was not connected to any other alarm. O/CNS-A tested the alarm, and it functioned, but no other alarms sounded during test.

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Twenty One (21) days

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

   Comments: There was no evacuation map included in the Fire and Evacuation Policy dated 1/31/2025.

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

   Comments: The Fire and Evacuation Policy dated 1/31/2025 had not been updated to include employee actions to take at this licensed facility. Areas of the policy had not been filled in for this facility such as company/organization name, communication system and designated assembly point. The policy stated to follow illuminated exit signs, but the facility was not equipped with illuminated exit signs.

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

   Comments: There was no section in the Fire and Evacuation Policy dated 1/31/2025 that included the fire protection procedures for residents to follow.

4. Each assisted living facility shall develop and maintain fire safety and evacuation plans that include procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. [Minn. Stat. 144G.45 subd.2]

   Comments: The Fire and Evacuation Policy dated 1/31/2025 included instructions to assist individuals with disabilities but did not include current resident assessments that identified which residents would need assistance in evacuation.

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: O/CNS-A stated residents were offered training when they move in and during drills. O/CNS-A stated there was no documentation of when any residents were offered or participated in training.