Electronically Delivered

July 1, 2026

Licensee
Delightful Home Healthcare LLC
7124 France Avenue North
Brooklyn Center, MN 55429

RE: Project Number(s) SL41669015

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 May 12, 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
St - 0 - 0810 - 144g.45 Subd. 2 (b-F) - Fire Protection And Physical Environment - $500.00

The total amount you are assessed is $1,000.00. 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.

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,

Casey DeVries, Supervisor
State Evaluation Team
Email: Casey.DeVries@state.mn.us
Telephone: 651-201-5917 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41669	A. BUILDING: _____ B. WING _____	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELIGHTFUL HOME HEALTHCARE LLC	7124 FRANCE 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: SL41669015-0 On May 11, 2026, through May 12, 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 residents; two receiving services under the Provisional Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level pursuant to 144G.31 Subd. 1, 2 and 3.	
0 110 SS=C	144G.10 Subdivision 1a Assisted living director license required Each assisted living facility must employ an assisted living director who is licensed or permitted by the Board of Executives for Long	0 110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41669	A. BUILDING: _____ B. WING _____	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELIGHTFUL HOME HEALTHCARE LLC	7124 FRANCE 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
0 110	Continued From page 1 Term Services and Supports and affiliated as the director of record with the board. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the licensed assisted living director (LALD) was listed as the director of record for the licensee. This had the potential to affect all the licensee's residents, staff, and visitors. This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident 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). These findings include: The licensee's Employee List indicated LALD-D worked at the facility. On May 11-12, 2026, the surveyor observed LALD-D performing their duties throughout the survey. On May 11, 2026, at 6:45 a.m., the surveyor observed the Board of Executives for Long-Term Services and Supports (BELTSS) website which indicated the licensee lacked an affiliated LALD. On May 11, 2026, at 9:32 a.m., LALD-D stated they were the LALD for the licensee. On May 11, 2026, at 11:31 a.m., LALD-D stated	0 110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41669	A. BUILDING: _____ B. WING _____	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELIGHTFUL HOME HEALTHCARE LLC	7124 FRANCE 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
0 110	Continued From page 2 they were having difficulty affiliating themselves with the licensee on BELTSS and would try again. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
0 180 SS=F	144G.16 Subd. 2 Initial survey (a) During the provisional license period, the commissioner shall survey the provisional licensee after the commissioner is notified or has evidence that the provisional licensee is providing assisted living services to at least one resident. (b) Within two days of beginning to provide assisted living services, the provisional licensee must provide notice to the commissioner that it is providing assisted living services by sending an e-mail to the e-mail address provided by the commissioner. (c) If the provisional licensee does not provide services during the provisional license period, the provisional license shall expire at the end of the period and the applicant must reapply. (d) If the provisional licensee notifies the commissioner that the licensee is providing assisted living services within 45 calendar days prior to expiration of the provisional license, the commissioner may extend the provisional license for up to 60 calendar days in order to allow the commissioner to complete the on-site survey required under this section and follow-up survey visits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to notify the Minnesota	0 180		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41669	A. BUILDING: _____ B. WING _____	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELIGHTFUL HOME HEALTHCARE LLC	7124 FRANCE 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
0 180	Continued From page 3 Department of Health (MDH) within two days of first providing 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 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: The licensee was issued their Provisional Assisted Living license effective April 9, 2025. R1 was admitted and began receiving assisted living services on December 29, 2025. The licensee submitted a Notice of Providing Assisted Living Services form to MDH. The form indicated they began providing services for R1 on December 29, 2025. Owner/unlicensed personnel (O/ULP)-B signed the form on January 13, 2026, 15 days after R1 was admitted. The licensee failed to provide notice to MDH within two (2) days of the licensee first providing assisted living services. On May 12, 2026, at 10:07 a.m., licensed assisted living director (LALD)-D stated they did submit the above-mentioned notice to MDH on time. LALD-D began looking through their email account to find the email they sent to MDH. LALD-D stated they found the email and the form was emailed to MDH on January 14, 2026. LALD-D then stated the form was submitted late.	0 180		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41669	A. BUILDING: _____ B. WING _____	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELIGHTFUL HOME HEALTHCARE LLC	7124 FRANCE 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
0 180	Continued From page 4 On May 12, 2026, at 10:17 a.m., O/ULP-B provided an email which indicated the licensee submitted the Notice of Providing Assisted Living Services form to MDH on January 14, 2026, 16 days after R1 was admitted. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 180		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for 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;	0 470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41669	A. BUILDING: _____ B. WING _____	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELIGHTFUL HOME HEALTHCARE LLC	7124 FRANCE 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
0 470	Continued From page 5 (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 observation, interview, and record review, the licensee failed to post their 24-hour staffing schedule in a central location. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: May 11, 2026, at 9:39 a.m., during the facility tour with owner/unlicensed personnel (O/ULP)-B, the surveyor observed the licensee lacked a 24-hour staffing schedule posting. O/ULP-B stated they had a schedule downstairs in their office and would show it to the surveyor later in the tour. May 11, 2026, at 9:50 a.m., the surveyor observed the facility office in the basement where there was a yellow sticky note on the wall with a handwritten schedule. O/ULP-B stated residents and visitors did not have access to the office. O/ULP-B stated they were aware the schedule needed to be posted in a central location and would get it posted right away. The sticky note identified the morning, evening, and overnight shift hours.	0 470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41669	A. BUILDING: _____ B. WING _____	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELIGHTFUL HOME HEALTHCARE LLC	7124 FRANCE 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
0 470	Continued From page 6 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 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	0 480		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41669	A. BUILDING: _____ B. WING _____	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELIGHTFUL HOME HEALTHCARE LLC	7124 FRANCE 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
0 480	Continued From page 7 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 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 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:	0 480		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41669	A. BUILDING: _____ B. WING _____	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELIGHTFUL HOME HEALTHCARE LLC	7124 FRANCE 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
0 480	Continued From page 8 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 on May 12, 2026. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post information directing individuals to the Office of Health Facility Complaints (OHFC) at the Minnesota Department of Health (MDH) if they had complaints about the	0 550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41669	A. BUILDING: _____ B. WING _____	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELIGHTFUL HOME HEALTHCARE LLC	7124 FRANCE 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
0 550	Continued From page 9 facility or person providing 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 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 9:39 a.m., during the facility tour with owner/unlicensed personnel (O/ULP)-B, the surveyor observed the licensee Grievance/Complaint Procedure policy, undated, posted on a bulletin board in the kitchen. The posting lacked information directing individuals to OHFC at MDH if they had a complaint about the facility or person providing services. O/ULP-B searched the bulletin board and was also unable to locate information directing individuals to OHFC. On May 12, 2026, at 10:07 a.m., licensed assisted living director (LALD)-D stated information directing individuals to OHFC was not posted. LALD-D asked the surveyor to explain what OHFC was. The surveyor explained what OHFC was, and LALD-D stated they now understood. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41669	A. BUILDING: _____ B. WING _____	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELIGHTFUL HOME HEALTHCARE LLC	7124 FRANCE 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
0 680	Continued From page 10	0 680		
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 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 post an emergency preparedness plan (EPP) prominently. Further, the licensee failed to develop an EPP with all of the required content tailored to the licensee. 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	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41669	A. BUILDING: _____ B. WING _____	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELIGHTFUL HOME HEALTHCARE LLC	7124 FRANCE 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
0 680	Continued From page 11 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: On May 12, 2025, at 9:12 a.m., the surveyor completed a review of the undated facility Emergency Preparedness Manual (EPP), which was only partially tailored to the facility's needs and lacked evidence of the following required information: - documentation of a risk assessment; - take an all-hazards approach, including EIDs, as applicable; - categorize the various probable risks/hazards by likelihood of occurrence; - develop strategies for addressing facility & community-based risks (i.e.: evacuation plans, staffing surges/shortages, back-up plans) - arrangements/contracts to re-establish utility services; - missing resident plan updated quarterly; - develop/implement EPP P/P to address the following whether evacuated or shelter in place for staff/residents: - food, water, medical supplies, pharmaceutical supplies; - alternate sources of energy to maintain: - temperatures to protect residents' health/safety; - safe/sanitary storage of provisions; - emergency lighting; - fire detection, extinguishing, alarm systems; - sewage and waste disposal; - if on-duty staff and sheltered residents are relocated, facility must document the specific	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41669	A. BUILDING: _____ B. WING _____	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELIGHTFUL HOME HEALTHCARE LLC	7124 FRANCE 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
0 680	Continued From page 12 name/location of the receiving facility or other location; - identify a qualified person who is authorized in writing to act in the absence of the administrator; - a process for cooperation and collaboration with local, tribal, regional, State and Federal EP to maintain integrated response; - developed policies and procedures (P/P) to address safe evacuation from the facility, including consideration of care/tx needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); primary/alternate communication means with external sources of assistance; - P/P must address: use of volunteers, including the process/role for integration; - communication plan must include all the following names/contact information: staff, entities providing services under agreement, residents' physicians, other facilities, volunteers; - communication plan must include: primary and alternate means of communicating with: facility staff and Federal, State, tribal, regional & local emergency management agencies; - a process for cooperation and collaboration with local, tribal, regional, State and Federal EP to maintain integrated response - must develop P/P to address: system of medical documentation that preserves resident information, protects confidentiality, and secures/maintains availability of records; - emergency Prep Training Program. Training program must include all of the following: - initial training in EP P/P to all new and existing staff, individuals providing services under arrangement, and volunteers consistent with their expected role; - provide EP training at least annually; - maintain documentation of all EP training; - demonstrate staff knowledge of EP;	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41669	A. BUILDING: _____ B. WING _____	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELIGHTFUL HOME HEALTHCARE LLC	7124 FRANCE 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
0 680	Continued From page 13 - must conduct exercises to test the EP at least twice per year, including unannounced staff drills using the EP. Must include the following: - participate in an annual full-scale exercise that is community based OR conduct an annual, individual, facility-based functional exercise OR if the facility experiences an actual emergency requiring activation of plan, facility is exempt from engaging in its next required full-scale exercise; - conduct an additional annual exercise that may include: a second full-scale exercise that is community-based or an individual, facility based functional exercise OR mock disaster drill OR table-top exercise; - analyze the facility's response to and maintain documentation of all drills, tabletop exercises and emergency events & revise plan as needed; - communication plan must include: - methods for sharing information and medical documentation for residents under the facility's care, as necessary, with other HCPs to maintain continuity of care; - means, in event of evacuation, to release resident information as permitted under 45 CFR 164.510(b)(1)(ii); - means of providing information about general condition/ location of residents under the facility's care as permitted under 45 CFR 164.510(b)(4); - communication plan must include all of the following: means to providing information about the facility's occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee; - communication plan must include all of the following: methods for sharing information from the emergency plan, that the facility has determined appropriate, with residents and their	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41669	A. BUILDING: _____ B. WING _____	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELIGHTFUL HOME HEALTHCARE LLC	7124 FRANCE 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
0 680	Continued From page 14 families/representatives; and On May 12, 2026, at 9:31 a.m., licensed assisted living director (LALD)-D, clinical nurse supervisor (CNS)-A, and owner/unlicensed personnel (O/ULP)-B stated they were unaware their EPP was missing the above-mentioned information and would work on getting it updated. Minnesota Administrative Rule 4659.0100 Emergency Disaster and Preparedness Plan 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 483.73, or successor requirements. The code references documents, specifications, methods, and standards in the State Operations Manual Appendix Z - Emergency Preparedness for All Provider and Certified Supplier Types. The licensee's EPP, undated, indicated, "Effective August 1, 2021, licensed assisted living establishments must comply with the federal emergency preparedness regulations for long-term care facilities under the Code of Federal Regulations, title 42, section 483. 73, or successor requirements." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
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	0 775		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41669	A. BUILDING: _____ B. WING _____	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELIGHTFUL HOME HEALTHCARE LLC	7124 FRANCE 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
0 775	Continued From page 15 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 12, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Two (2) days	0 775		
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;	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41669	A. BUILDING: _____ B. WING _____	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELIGHTFUL HOME HEALTHCARE LLC	7124 FRANCE 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
0 810	Continued From page 16 (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 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	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41669	A. BUILDING: _____ B. WING _____	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELIGHTFUL HOME HEALTHCARE LLC	7124 FRANCE 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
0 810	Continued From page 17 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 12, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery.	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41669	A. BUILDING: _____ B. WING _____	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELIGHTFUL HOME HEALTHCARE LLC	7124 FRANCE 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
01620	Continued From page 18 (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted a comprehensive reassessment no more than 14 days after initiation of services for one of two residents (R1).	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41669	A. BUILDING: _____ B. WING _____	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELIGHTFUL HOME HEALTHCARE LLC	7124 FRANCE 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
01620	Continued From page 19 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 to the licensee on December 29, 2025. R1's Service Plan dated May 11, 2026, indicated R1 received services for dressing, grooming, behavior management, medication management, and skin care. R1's record included an Admission Assessment dated December 29, 2025. It indicated a 14-day assessment would be due on January 12, 2026, and a 90 day would be due on March 26, 2026. R1's record included a 14 Day Reassessment dated January 15, 2026, completed 17 days after the admission assessment. On May 12, 2026, at 8:00 a.m., the surveyor observed owner/unlicensed personnel (O/ULP)-B administer medications and a blood glucose (BG) check for R1. On May 12, 2026, at 9:26 a.m., clinical nurse supervisor (CNS)-A stated R1's 14-day assessment was completed late. CNS-A stated they were not sure why it had been completed late but they were aware of the requirement.	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41669	A. BUILDING: _____ B. WING _____	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELIGHTFUL HOME HEALTHCARE LLC	7124 FRANCE 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
01620	Continued From page 20 The licensee's Nursing Assessment and Reassessment of Residents policy, undated, indicated, "Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiating services." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01630 SS=F	144G.70 Subd. 3 Temporary service plan When a facility initiates services and the individualized assessment required in subdivision 2 has not been completed, the facility must complete a temporary plan and agreement with the resident for services. A temporary service plan shall not be effective for more than 72 hours. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to execute a temporary service plan with a signature from the resident for services to be provided at the time of admission 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 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:	01630		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41669	A. BUILDING: _____ B. WING _____	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELIGHTFUL HOME HEALTHCARE LLC	7124 FRANCE 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
01630	Continued From page 21 R1 R1 was admitted to the licensee on December 29, 2025. R1's Service Plan dated May 11, 2026, signed during the survey on May 11, 2026, indicated R1 received services for dressing, grooming, behavior management, medication management, and skin care. R1's admission Service Plan, included with contract paperwork but seperate from the contract, undated and unsigned, indicated R1 received services for housekeeping, laundry, medication management, meals, and dressing assistance. On May 12, 2026, at 8:00 a.m., the surveyor observed owner/unlicensed personnel (O/ULP)-B administer medications and a blood glucose (BG) check for R1. R2 R2 was admitted to the licensee on January 2, 2026. R2's Service Plan dated January 16, 2026, unsigned, indicated R2 received services for medication management. On May 12, 2026, at 7:43 a.m., the surveyor observed O/ULP-B administer medications for R2. On May 11, 2026, at 9:34 a.m., the surveyor observed licensed assisted living director (LALD)-D request R1 to sign a service plan. The surveyor inquired if they were having R1 sign a service plan. LALD-D stated, "yes," because they	01630		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41669	A. BUILDING: _____ B. WING _____	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELIGHTFUL HOME HEALTHCARE LLC	7124 FRANCE 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
01630	Continued From page 22 wanted to make sure they had an updated service plan for R1. On May 11, 2026, at 11:56 a.m., LALD-D stated they had a temporary service plan for R1, but it was not signed. LALD-D stated they had R1 sign a new service plan today. On May 12, 2026, at 8:26 a.m., LALD-D stated R2 had an admission service plan and an updated service plan from January 16, 2026, but neither had been signed. On May 12, 2026, at 9:02 a.m., clinical nurse supervisor (CNS)-A stated R1 and R2 did not have a signed service plan. CNS-A stated they did not know service plans required a signature or how frequently they were required to be updated. CNS-A stated they did not know a service plan must be agreed on at the time of admission. The licensee's Service Plan policy, undated, indicated, "Assisted living services will be provided according to a suitable and current written service plan. The service plan is developed with the resident/representative and is based on resident needs and preferences. When services are initiated for a new resident prior to completion of the individualized resident assessment, a temporary service plan will be developed. A temporary service plan will not be effective for more than 72 hours. A Service Plan shall be finalized with each resident no later than 14 calendar days after the start of service." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01630		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41669	A. BUILDING: _____ B. WING _____	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELIGHTFUL HOME HEALTHCARE LLC	7124 FRANCE 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
01640	Continued From page 23	01640		
01640 SS=F	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. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to obtain signatures on service plans when changes were made to the services 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 was issued at a widespread scope (when	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41669	A. BUILDING: _____ B. WING _____	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELIGHTFUL HOME HEALTHCARE LLC	7124 FRANCE 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
01640	Continued From page 24 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 to the licensee on December 29, 2025. R1's Service Plan dated May 11, 2026, signed during the survey on May 11, 2026, indicated R1 received services for dressing, grooming, behavior management, medication management, and skin care. R1's admission Service Plan, included with contract paperwork but seperate from the contract, undated and unsigned, indicated R1 received the following services: - arranging non-medical transportation; - assistance making appointments; - bathing assistance; - delegated clinical monitoring; - dressing assistance; - grooming assistance; - housekeeping; - laundry; - manage behaviors including: anxiety, physical aggression and property destruction repetitive behavior,agitation, self-injurious behavior, verbal aggression; - medication administration; - meals; - money management; - shopping; - socialization; - TED stockings application and removal; - transfer assistance; - vital sign monitoring;	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41669	A. BUILDING: _____ B. WING _____	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELIGHTFUL HOME HEALTHCARE LLC	7124 FRANCE 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
01640	Continued From page 25 - walking assistance; and - wandering. R1's Service Plan - Modification dated May 11, 2026, and signed during survey on May 11, 2026, indicated R1 received the following services: - arranging non-medical transportation; - assistance making appointments; - bathing assistance; - dressing assistance; - glasses care; - grooming assistance; - home management; - housekeeping; - incontinence care; - manage behaviors including agitation, anxiety, disrobing, self-injurious behavior, verbal aggression and wandering. - medication administration; - meals preparation and serving; - money management; - remove garbage; - shopping assistance; - skin care; - socialization. On May 12, 2026, at 8:00 a.m., the surveyor observed owner/unlicensed personnel (O/ULP)-B administer medications and check blood glucose (BG) levels for R1. R2 R2 was admitted to the licensee on January 2, 2026. R2's Service Plan dated January 16, 2026, unsigned, indicated R2 received the following services: - arranging non-medical transportation; - assistance making appointments;	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41669	A. BUILDING: _____ B. WING _____	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELIGHTFUL HOME HEALTHCARE LLC	7124 FRANCE 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
01640	Continued From page 26 - bathing assistance; - delegated clinical monitoring; - dressing assistance; - grooming assistance; - housekeeping; - laundry; - manage behaviors including: anxiety, physical aggression and property destruction repetitive behavior,agitation, self-injurious behavior, verbal aggression; - medication administration; - meals; - money management; - shopping; - socialization; - TED stockings application and removal; - transfer assistance; - vital sign monitoring; - walking assistance; and - wandering. R2's record lacked a signed service plan developed after the temporary admission service plan expired 72 hours after admission. On May 12, 2026, at 7:43 a.m., the surveyor observed O/ULP-B administer medications for R2. On May 11, 2026, at 9:34 a.m., the surveyor observed licensed assisted living director (LALD)-D request R1 to sign a service plan. The surveyor inquired if they were having R1 sign a service plan. LALD-D stated, "yes," because they wanted to make sure they had an updated service plan for R1. On May 11, 2026, at 11:56 a.m., LALD-D stated they had R1 sign a new service plan today. LALD-D stated R1 did not have a signed service	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41669	A. BUILDING: _____ B. WING _____	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELIGHTFUL HOME HEALTHCARE LLC	7124 FRANCE 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
01640	Continued From page 27 plan until today. On May 12, 2026, at 8:26 a.m., LALD-D stated R2 had an admission service plan and an updated service plan dated January 16, 2026, but neither had been signed. On May 12, 2026, at 9:02 a.m., clinical nurse supervisor (CNS)-A stated neither R1 or R2 had a signed service plan. CNS-A stated they did not know service plans required a signature or how frequently, how often they needed to be updated and when a new one was required to be signed. The licensee's Service Plan policy, undated, indicated, "The Service Plan shall be signed by the resident or financially responsible party." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01700 SS=F	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	01700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41669	A. BUILDING: _____ B. WING _____	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELIGHTFUL HOME HEALTHCARE LLC	7124 FRANCE 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
01700	Continued From page 28 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 observation, interview, and record review, the licensee failed to document a face-to-face medication management assessment completed by a registered nurse (RN) to include all required content prior to providing medication management services 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 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: R1 R1 was admitted to the licensee on December 29, 2025.	01700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41669	A. BUILDING: _____ B. WING _____	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELIGHTFUL HOME HEALTHCARE LLC	7124 FRANCE 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
01700	Continued From page 29 R1's Service Plan dated May 11, 2026, indicated R1 received services for medication management. R1's May 2026 Med Admin Summary (medication administration record (MAR)) indicated R1 took the following medications: - aspirin 81 milligrams (mg), give one tablet by mouth (PO) daily; - atorvastatin calcium 80 mg, give one tablet PO daily; - carvedilol 6.25mg, give one tablet PO twice daily; - divalproex sodium 500mg, give three tablets PO daily; - lisinopril 10mg, give one tablet PO daily; - melatonin 3mg, give one tablet PO at bedtime; - metformin hydrochloride (HCL) extended release (ER) 500mg, give two tablets (1000mg) PO daily; - nystatin cream, apply thin layer daily to affected abdominal areas; - petrolatum 42% ointment, apply topically to incision line three times daily; - polyethylene glycol 3350, once daily dose 17 grams (g), give one tablespoonful mixed with eight ounces (oz) of water daily; - prednisolone acetate 1% drops, place one drop into right ear twice daily; - olanzapine 20mg, give one tablet PO daily; - risperidone 1mg, give one tablet PO at bedtime; and - Tiotropium bromide 18 microgram (mcg); inhale the contents of one capsule daily using the handheld device. R1's Admission Assessment dated December 29, 2025, included a space on page 21 to complete a medication management assessment but was left	01700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41669	A. BUILDING: _____ B. WING _____	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELIGHTFUL HOME HEALTHCARE LLC	7124 FRANCE 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
01700	Continued From page 30 blank. On May 12, 2026, at 8:00 a.m., the surveyor observed owner/unlicensed personnel (O/ULP)-B administer medications and perform a blood glucose (BG) check for R1. R2 R2 was admitted to the licensee on January 2, 2026. R2's Service Plan, unsigned and undated, indicated R2 received services for medication management. R2's May 2026 MAR indicated R2 took the following medications: - acetaminophen give 1-2 tablets (500mg-1000mg) every six hours PRN; - bupropion HCL ER 150mg, give one tablet PO daily; - duloxetine HCL 60mg, give one tablet PO daily; - folic acid 1mg, give one tablet PO daily; - gabapentin 300mg, give one tablet PO three times daily; - melatonin, give one tablet at bedtime PRN; - quetiapine fumarate 50mg, give one tablet PO two times daily; - nystatin 100,000 units/1g, apply topically two times daily under breasts; - senna concentrate/docusate sodium, give one tablet PO as needed PRN up to two times daily; and - trazodone 150mg, give two tablets PO daily. R2's Admission Assessment dated January 2, 2026, included a space on page 21 to complete a medication management assessment but was left blank.	01700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41669	A. BUILDING: _____ B. WING _____	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELIGHTFUL HOME HEALTHCARE LLC	7124 FRANCE 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
01700	Continued From page 31 On May 12, 2026, at 7:43 a.m., the surveyor observed O/ULP-B administer medications for R2. R1 and R2's records lacked a face-to-face medication management assessment to include: - identification and review of all medications the resident is known to be taking; - indications for medications; - side effects; - contraindications; - allergic or adverse reactions; and - actions to address these issues. On May 12, 2026, at 9:10 a.m., clinical nurse supervisor (CNS)-A stated they completed a face-to-face medication reconciliation for both R1 and R2 but did not document it. CNS-A stated they did not know the medication reconciliation/assessment needed to be documented. The licensee's Individualized Medication Management Plan and Record, undated, indicated, "Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700		
01820 SS=F	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41669	A. BUILDING: _____ B. WING _____	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELIGHTFUL HOME HEALTHCARE LLC	7124 FRANCE 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
01820	Continued From page 32 medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure written or electronically recorded prescriptions were obtained 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 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: R1 R1 was admitted to the licensee on December 29, 2025. R1's Service Plan dated May 11, 2026, signed during survey on May 11, 2026, indicated R1 received medication management. On May 12, 2026, at 8:00 a.m., the surveyor observed owner/unlicensed personnel (O/ULP)-B administer medications and a blood glucose (BG) check for R1. R1's May 2026 Med Admin Summary (medication administration record (MAR)) indicated R1 took the following medications: - aspirin 81 milligrams (mg), give one tablet by mouth (PO) daily;	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41669	A. BUILDING: _____ B. WING _____	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELIGHTFUL HOME HEALTHCARE LLC	7124 FRANCE 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
01820	Continued From page 33 - atorvastatin calcium 80 mg, give one tablet PO daily; - carvedilol 6.25mg, give one tablet PO twice daily; - divalproex sodium 500mg, give three tablets PO daily; - lisinopril 10mg, give one tablet PO daily; - melatonin 3mg, give one tablet PO at bedtime; - metformin hydrochloride (HCL) extended release (ER) 500mg, give two tablets (1000mg) PO daily; - nystatin cream, apply thin layer daily to affected abdominal areas; - petrolatum 42% ointment, apply topically to incision line three times daily; - polyethylene glycol 3350, once daily dose 17 grams (g), give one tablespoonful mixed with eight ounces (oz) of water daily; - prednisolone acetate 1% drops, place one drop into right ear twice daily; - olanzapine 20mg, give one tablet PO daily; - risperidone 1mg, give one tablet PO at bedtime; and - Tiotropium bromide 18 microgram (mcg); inhale the contents of one capsule daily using the handheld device. R1's record lacked medication prescriptions. R2 R2 was admitted to the licensee on January 2, 2026. R2's Service Plan dated January 16, 2026, unsigned, indicated R2 received services for medication management. R2's May 2026 MAR indicated R2 took the following medications: - acetaminophen give 1-2 tablets	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41669	A. BUILDING: _____ B. WING _____	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELIGHTFUL HOME HEALTHCARE LLC	7124 FRANCE 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
01820	Continued From page 34 (500mg-1000mg) every six hours PRN; - bupropion HCL ER 150mg, give one tablet PO daily; - duloxetine HCL 60mg, give one tablet PO daily; - folic acid 1mg, give one tablet PO daily; - gabapentin 300mg, give one tablet PO three times daily; - melatonin, give one tablet at bedtime PRN; - quetiapine fumarate 50mg, give one tablet PO two times daily; - nystatin 100,000 units/1g, apply topically two times daily under breasts; - senna concentrate/docusate sodium, give one tablet PO as needed PRN up to two times daily; and - trazodone 150mg, give two tablets PO daily. On May 12, 2026, at 7:43 a.m., the surveyor observed O/ULP-B administer medications for R2. On May 12, 2026, at 8:06 a.m., licensed assisted living director (LALD)-D stated they did not have medication orders to provide for R1 or R2. On May 12, 2026, at 9:10 a.m., clinical nurse supervisor (CNS)-A stated they did not know they needed medication orders. They said when medications changed on an after visit summary report (AVS) they would update the MAR and wait for the medications to arrive from the pharmacy. CNS-A stated they did not know they needed to have medication orders themselves. The licensee's Medication Prescriptions and Refills policy, undated, indicated: "1. The RN is responsible for assuring that current, authorized prescriber prescriptions for medications, including over-the-counter medications and dietary supplements, are	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41669	A. BUILDING: _____ B. WING _____	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELIGHTFUL HOME HEALTHCARE LLC	7124 FRANCE 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
01820	Continued From page 35 addressed in the resident's care plan, service plan and Medication Administration Record, and are communicated to all appropriate staff. 2. When new medication prescriptions are sent directly to the pharmacy by the prescriber or resident, the RN or LPN will request a copy of the prescription from the prescriber or from the pharmacy. 3. When medication prescriptions are initiated by another health care provider (hospice/home care, etc.), the RN or LPN will request a copy of the prescription signed by a prescriber. 4. Upon receiving verbal orders, the RN or LPN will record and sign the verbal order and forward the order to the prescriber for a signature. The RN or LPN will continue to follow up with the prescriber's office or the pharmacy until a signed prescription/verbal order is received and will document all efforts to obtain a signature. 5. The RN or LPN will assure that the prescriber renews a medication order at least every 12 months, or more frequently if determined necessary based on the nursing assessment." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
02400 SS=C	144G.91 Subd. 12 Visitors and social participation (a) Residents have the right to meet with or receive visits at any time by the resident's family, guardian, conservator, health care agent, attorney, advocate, or religious or social work counselor, or any person of the resident's choosing. This right may be restricted in certain	02400		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41669	A. BUILDING: _____ B. WING _____	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELIGHTFUL HOME HEALTHCARE LLC	7124 FRANCE 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
02400	Continued From page 36 circumstances if necessary for the resident's health and safety and if documented in the resident's service plan. (b) Residents have the right to engage in community life and in activities of their choice. This includes the right to participate in commercial, religious, social, community, and political activities without interference and at their discretion if the activities do not infringe on the rights of other residents. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to respect the resident's right to receive visits at any time. This had the potential to affect all residents at the facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident 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 potential to affect a large portion or all of the residents). The findings include: On May 11, 2026, at 9:32 a.m., the surveyor observed the front entrance of the facility had a sign posted which indicated visiting hours were from 8:00 a.m., to 8:00 p.m. On May 11, 2026, at 12:50 p.m., owner/unlicensed personnel (O/ULP)-B stated the visiting hours posting was there to alert visitors and residents that visitors were welcome between the hours of 8:00 a.m., and 8:00 p.m. O/ULP-B stated the residents were normally sleeping	02400		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41669	A. BUILDING: _____ B. WING _____	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELIGHTFUL HOME HEALTHCARE LLC	7124 FRANCE 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
02400	Continued From page 37 outside of those hours so no visitors were allowed. On May 12, 2026, at 9:31 a.m., licensed assisted living director (LALD)-D stated they did not know residents had the right to have visitors at any time. LALD-D stated they would remove the visiting hours sign from the front door. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02400		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the required verbatim notice was posted at the facility main entrance to disclose electronic monitoring activity. This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident 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).	03090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41669	A. BUILDING: _____ B. WING _____	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELIGHTFUL HOME HEALTHCARE LLC	7124 FRANCE 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
03090	Continued From page 38 The findings include: On May 11, 2026, at 9:32 a.m., the surveyor approached the facility. The front door had a posting which indicated, "Security Cameras In Use." On May 11, 2026, at 11:31 a.m., the surveyor explained the, "Security Camera In Use," signage lacked the required verbatim language required for video monitoring postings. Licensed assisted living director (LALD)-D stated they were unaware of the video monitoring posting requirement. The licensee's Electronic Monitoring policy, undated, did not address the required verbatim language for video monitoring posting. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090		

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

Food & Beverage Inspection Report

Establishment Info

Delightful Home Healthcare LLC
7124 FRANCE AVE N
Brooklyn Center, MN 55429
Hennepin County
Parcel:

Phone:

License Info

License: HFID 41669

Risk:
License:
Expires on:
CFPM: Rena Sebge
CFPM #: 55686; Exp: 01/20/2028

Inspection Info

Report Number: F8044261142
Inspection Type: Full - Single
Date: 5/12/2026 Time: 9:21:04 AM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 1
Total Priority 2 Orders: 0
Total Priority 3 Orders: 1
Delivery: Emailed

New Order: 4-200 Equipment Design and Construction
4-201.11GMN *Priority Level: Priority 3 CFP#: 47*
MN Rule 4626.0506G Discontinue serving TCS foods that are held for more than same-day service in an adult or child care center or boarding establishment or provide equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.
COMMENT: Leftover foods in domestic refrigerator.
Comply By: 5/12/2026 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 cleaner and wipes used to sanitize food contact surfaces.

Disinfecting bleach will be purchased.
Comply By: 5/12/2026 Originally Issued On: 5/12/2026

Food & Beverage General Comment

HRD inspection conducted with nurse evaluator Joey Keen. Inspection report reviewed on site with Rena.

Domestic kitchen consists of tile flooring, painted gypsum walls and ceilings, wooden hollow-base cabinets, solid surface counters, and domestic equipment.

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 F8044261142 from 5/12/2026

Rena Sebge
Owner

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

Establishment Info

Delightful Home Healthcare LLC
Brooklyn Center
County/Group: Hennepin County

Inspection Info

Report Number: F8044261142
Inspection Type: Full
Date: 5/12/2026
Time: 9:21:04 AM

Food Temperature: Product/Item/Unit: Deli roast beef**; Temperature Process:** Cold-Holding
Location: Refrigerator at 36.5 Degrees F.
Comment:
Violation Issued?: No

Equipment Temperature: Product/Item/Unit: ; Temperature Process: Cold-Holding
Location: Refrigerator at 36.0 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

Establishment Info

Delightful Home Healthcare LLC
Brooklyn Center
County/Group: Hennepin County

Inspection Info

Report Number: F8044261142
Inspection Type: Full
Date: 5/12/2026
Time: 9:21:04 AM

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dishwasher
Location: Kitchen **Equal To** 160.0 Degrees F.
Comment:
Violation Issued?: No

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ASSISTED LIVING | ASSISTED LIVING WITH DEMENTIA CARE

Project No: SL41669015-0	**Date:** 5/12/2026
Facility Name: DELIGHTFUL HOME HEALTHCARE LLC	
Facility Address: 7124 FRANCE AVE N BROOKLYN CENTER, MN 55429	

☒ **TAG IDENTIFICATION: 0775**

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

1. 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: Cigarette butts were observed in the mulch and landscaping in the front yard.

☒ **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 (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.