



Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF REMOVAL OF PROVISIONAL CONDITIONAL LICENSE

Electronic Delivery

April 13, 2026

Licensee
Richangel Care Inc
425 Laurie Road East
Maplewood, MN 55117

RE: Initial License Number 417692
Health Facility Identification Number (HFID) 41005
Project Number(s) SL41005015

Dear Licensee:

On March 24, 2026, The Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed October 30, 2025. The follow-up survey found the facility to be in substantial compliance. Based on these findings, the condition(s) on the license were removed effective April 13, 2026.

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.

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.

Furthermore, the follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the October 30, 2025 initial survey.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a), state correction orders issued pursuant to the last survey completed on October 30, 2025, found not corrected at the time of the follow-up survey follow-up survey and/or subject to a penalty assessment are as follows:

0660-Tuberculosis Prevention And Control-144g.42 Subd. 9

The details of the violations noted at the time of this follow-up survey completed on March 24, 2026

(listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, no immediate fines are assessed.

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 resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

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

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

Sincerely,



Rick Michals, J.D.
Executive Regional Operations Manager

**Minnesota Department of Health
Health Regulation Division**

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 03/24/2026
NAME OF PROVIDER OR SUPPLIER RICHANGEL CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 425 LAURIE ROAD E MAPLEWOOD, MN 55117		
(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 In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction order is 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: SL#41005015-2 On March 23, 2026, through March 24, 2026, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a follow-up survey completed on December 31, 2025. At the time of the survey, there were 4 active residents; 4 receiving services under the Provisional Assisted Living license. As a result of the revisit, the following order was reissued.	{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 License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
{0 480} SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	{0 480}			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 03/24/2026
NAME OF PROVIDER OR SUPPLIER RICHANGEL CARE INC		STREET ADDRESS, CITY, STATE, ZIP CODE 425 LAURIE ROAD E MAPLEWOOD, MN 55117			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
{0 480}	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are	{0 480}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 03/24/2026
NAME OF PROVIDER OR SUPPLIER RICHANGEL CARE INC		STREET ADDRESS, CITY, STATE, ZIP CODE 425 LAURIE ROAD E MAPLEWOOD, MN 55117			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
{0 480}	Continued From page 2 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:	{0 480}	Not reviewed during this survey.		
{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 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	{0 660}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 03/24/2026
NAME OF PROVIDER OR SUPPLIER RICHANGEL CARE INC		STREET ADDRESS, CITY, STATE, ZIP CODE 425 LAURIE ROAD E MAPLEWOOD, MN 55117			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
{0 660}	Continued From page 3 by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included a TB history and symptom screening, TB baseline testing and TB transmission training for one of one employee (unlicensed personnel/employee supervisor (ULP/ES)-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 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 March 23, 2026, the surveyor conducted a revisit to follow-up on orders issued pursuant to a follow up survey completed on December 31, 2025, on the licensee's provisional assisted living facility license with health facility identification (HFID) 41005. The licensee completed a facility TB risk assessment on November 2, 2025, indicating the licensee was at low risk for TB transmission. ULP/ES-D's employee record included a TB history and symptom screen dated August 1, 2022, which was a record from another facility (HFID 34993) under the same ownership umbrella as the licensee but lacked documentation of a completed TB testing at time	{0 660}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 03/24/2026
NAME OF PROVIDER OR SUPPLIER RICHANGEL CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 425 LAURIE ROAD E MAPLEWOOD, MN 55117		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
{0 660}	Continued From page 4 of ULP/ES-D's hire. On March 23, 2026, at approximately 11:00 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A provided a one-page document, titled Staff Information, undated, that indicated the licensee's current employee list and ULP/ES-D had a hire date of June 1, 2025. On March 23, 2026, at approximately 11:05 a.m., LALD/CNS-A stated ULP/ES-D had not completed TB testing since the last follow up survey because ULP/ES-D had been away outside the country since January 3, 2026, and was returning the first week in April 2026. LALD/CNS-A also stated the licensee's plan was for ULP/ES-D to complete TB testing upon return. On March 23, 2026, at approximately 11:10 a.m., LALD/CNS-A provided a one-page document, dated June 2, 2018, that indicated ULP/ES-D completed Tuberculin skin testing (TST) on May 14, 2018, and June 2, 2018, which was a record from another facility (HFID 34993) under the same ownership umbrella as the licensee. On March 23, 2026, at approximately 11:15 a.m., LALD/CNS-A stated ULP/ES-D worked as an employee at the licensee's HFID 34993 and HFID 41005. ULP/ES-D had a break in employment between May 1, 2025, and June 1, 2025, when the licensee's HFID 34993 closed on May 1, 2025, and ULP/ES-D was hired at the licensee's HFID 41005 on June 1, 2025. On March 24, 2026, at approximately 9:45 a.m., by phone interview, LALD/CNS-A confirmed ULP/ES-A had a break in employment between	{0 660}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 03/24/2026
NAME OF PROVIDER OR SUPPLIER RICHANGEL CARE INC		STREET ADDRESS, CITY, STATE, ZIP CODE 425 LAURIE ROAD E MAPLEWOOD, MN 55117			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
{0 660}	Continued From page 5 May 1, 2025, and June 1, 2025, and acknowledged ULP/ES-D would need to complete a new TB history and symptom screen and TB testing. The licensee's Tuberculosis Screening/Prevention policy dated August 5, 2024, indicated all staff are required as a part of their employment to be screened and tested for TB. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and the CDC guidelines, indicated an employee may begin working with residents after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employees' record. No further information was provided.	{0 660}			
{0 775} SS=E	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:	{0 775}	Not reviewed during this survey.		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 03/24/2026
NAME OF PROVIDER OR SUPPLIER RICHANGEL CARE INC		STREET ADDRESS, CITY, STATE, ZIP CODE 425 LAURIE ROAD E MAPLEWOOD, MN 55117			
(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
{0 780}	Continued From page 6	{0 780}			
{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 by:	{0 780}			
{0 790} SS=E	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment	{0 790}	Not reviewed during this survey.		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 03/24/2026
NAME OF PROVIDER OR SUPPLIER RICHANGEL CARE INC		STREET ADDRESS, CITY, STATE, ZIP CODE 425 LAURIE ROAD E MAPLEWOOD, MN 55117			
(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	
{0 790}	Continued From page 7 (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by:	{0 790}	Not reviewed during this survey.		
{0 800} SS=E	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by:	{0 800}			
{0 810} SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and	{0 810}	Not reviewed during this survey.		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 03/24/2026
NAME OF PROVIDER OR SUPPLIER RICHANGEL CARE INC		STREET ADDRESS, CITY, STATE, ZIP CODE 425 LAURIE ROAD E MAPLEWOOD, MN 55117			
(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 8 maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by:	{0 810}	Not reviewed during this survey.		



Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF PROVISIONAL EXTENSION AND CONDITIONAL LICENSE

Electronically Delivered

February 26, 2026

Licensee

Richangel Care Inc
425 Laurie Road East
Maplewood, MN 55117

RE: Conditional License Number 417692
Health Facility Identification Number (HFID) 41005
Project Number(s) SL41005015

Dear Licensee:

On December 31, 2025, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on October 30, 2025. Based on the follow-up survey results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, pursuant to Minn. Stat. § 144G.20, MDH is extending the conditional assisted living facility license for an additional 30-days, due to expire on **March 28, 2026**.

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.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on October 30, 2025, found not corrected at the time of the December 31, 2025, follow-up survey and/or subject to penalty assessment are as follows:

0640-Posting Information For Reporting Suspected C-144g.42 Subd. 7 - \$500.00

0680-Disaster Planning And Emergency Preparedness-144g.42 Subd. 10 - \$500.00

1290-Background Studies Required-144g.60 Subdivision 1 - \$1,000.00

1880-Storage Of Medications-144g.71 Subd. 19 - \$500.00

The details of the violations noted at the time of this follow-up survey completed on December 31, 2025 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Also, at the time of this follow-up survey completed on December 31, 2025, we identified the following violation(s):

0250-Conditions-144g.20 Subdivision 1 - \$500.00

The details of the violation(s) noted at the time of this follow-up survey are delineated on the attached State Form. Only the ID Prefix Tag in the left hand column without brackets will identify these state correction orders. It is not necessary to develop a plan of correction.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$3,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

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

REQUESTING A HEARING

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

To submit a hearing request, please visit:

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

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

CONDITIONAL LICENSE ISSUED:

MDH will extend the conditional assisted living facility license for Richangel Care Inc, for an additional 30 calendar days from the date of this notice. At an unannounced point in time, within the 30 calendar days, MDH will conduct a follow-up survey, as defined in Minn. Stat. § 144G.30, Subd. 6. Based on the results of the follow-up survey, MDH will determine if Richangel Care Inc is in substantial compliance.

The following conditions will continue to be in effect on the conditional assisted living facility license:

- a. **No new substantiated maltreatment allegations:** If any new investigations begin in the conditional license period, and the allegations are substantiated, MDH may pursue additional enforcement actions up to and including immediate temporary suspension and revocation of the license.
- b. **No new admissions:** Richangel Care Inc will continue to not admit any new residents under its conditional assisted living facility license until MDH removes the “no new admissions” condition. Richangel Care Inc must provide the Department:
 - i. A list of the names and birthdates of any individuals Richangel Care Inc is currently in the process of admitting. These individuals will be able to continue the admittance process.
 - ii. A list of all current residents including:
 - 1. Name and birthdate of each resident
 - 2. Current payment source for services
 - 3. If Elderly Waiver, the name and contact information of the care coordinator/case manager
 - 4. If the resident is not able to make informed decisions, the name of their representative and how to contact the representative
- c. **Monitoring visits:** MDH may make unannounced monitoring visits to assess the progress of Richangel Care Inc to correct the violations cited during the follow-up survey as well as to determine the overall practice of Richangel Care Inc in meeting the needs of the people it serves. In addition, the Office of Ombudsman for Long-Term Care (OOLTC) may also make unannounced monitoring visits to determine the level of satisfaction of those people who receive licensed assisted living services. The OOLTC will share their findings with MDH.
- d. **Follow-up survey:** At the time of the follow-up survey, MDH may pursue additional enforcement actions, up to and including immediate temporary suspension or revocation of the license if MDH identifies any level 3 or 4 violations or widespread care related violations.
- e. **Corrective Action Plan:** Richangel Care Inc will continue to develop and work

within a corrective action plan (CAP). The CAP is a working document that includes at least the following information:

- i. A statement of the concern
- ii. A description of what will happen to correct the concern
- iii. A target date for when each correction will be complete
- iv. Who is responsible to make sure it happens
- v. Current status of correction work
- vi. Description of a plan to monitor and ensure ongoing substantial compliance for each corrected order

RESULTS OF FOLLOW-UP EVALUATION DURING THE CONDITIONAL LICENSE PERIOD:

MDH will determine if Richangel Care Inc is in substantial compliance based on the results of the follow up survey. MDH will make this determination within the 30-day conditional license period. If MDH determines Richangel Care Inc is in substantial compliance on the follow up survey, MDH will remove the conditions from Richangel Care Inc's assisted living facility license, and Richangel Care Inc will correct any outstanding violations identified during the survey. If Richangel Care Inc is not in substantial compliance on the follow-up survey, MDH may take additional enforcement action, up to and including immediate temporary suspension and revocation, as authorized by Minn. Stat. § 144G.20.

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 Jess Schoenecker directly at: 651-201-3789 or email at: Jess.Schoenecker@state.mn.us.

Sincerely,



Rick Michals, J.D.

Executive Regional Operations Manager

**Minnesota Department of Health
Health Regulation Division**

CLN

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 12/31/2025
NAME OF PROVIDER OR SUPPLIER RICHANGEL CARE INC		STREET ADDRESS, CITY, STATE, ZIP CODE 425 LAURIE ROAD E MAPLEWOOD, MN 55117			
(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 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: SL#41005015-1 On December 29, 2025, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on October 27, 2025. At the time of the survey, there were 4 residents; 4 receiving services under the Provisional Assisted Living license. As a result of the revisit, the following orders were reissued and/or issued. On December 30, 2025, an immediate correction order was issued for tag identification 1290. During the course of the survey, the licensee took action to mitigate the imminent risk. Noncompliance remained and the scope and level remain unchanged.	{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 License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
0 250 SS=F	144G.20 Subdivision 1 Conditions	0 250			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 12/31/2025
NAME OF PROVIDER OR SUPPLIER RICHANGEL CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 425 LAURIE ROAD E MAPLEWOOD, MN 55117		
(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
0 250	Continued From page 1 (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or staff of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or staff; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter;	0 250			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 12/31/2025
NAME OF PROVIDER OR SUPPLIER RICHANGEL CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 425 LAURIE ROAD E MAPLEWOOD, MN 55117		
(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
0 250	Continued From page 2 (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to fully cooperate with an inspection, survey, or investigation as evidenced by failure to comply with providing the requested records. 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 December 29, 2025, the surveyor conducted a revisit to follow-up on orders issued pursuant to a survey completed on October 27, 2025.	0 250			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 12/31/2025
NAME OF PROVIDER OR SUPPLIER RICHANGEL CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 425 LAURIE ROAD E MAPLEWOOD, MN 55117		
(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
0 250	Continued From page 3 On December 29, 2025, at 10:04 a.m., by phone conversation, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated there were four new employees hired, and one new resident admitted since the first survey on October 27, 2025. LALD/CNS-A also stated to use the resident roster and employee list from the first survey. The surveyor requested the licensee to have the licensee's current resident roster and employee list ready for the surveyor upon arrival at the facility. On December 29, 2025, at 10:08 a.m., by survey entrance email, the surveyor requested the licensee to have the licensee's current resident roster and employee list ready for the surveyor upon arrival at the facility. On December 29, 2025, at approximately 11:05 a.m., during the entrance conference with unlicensed personnel/employee supervisor (ULP/ES)-D, the surveyor requested the licensee's current resident roster and employee list. On December 30, 2025, at approximately 2:00 p.m., the surveyor reminded ULP/ES-D about the surveyor's request for the licensee's current resident roster and employee list. On December 30, 2025, at approximately 3:45 p.m., the surveyor reminded LALD/CNS-A and ULP/ES-D about the surveyor's request for the licensee's current resident roster and employee list. On January 2, 2026, at 8:26 a.m., the surveyor emailed the licensee and requested the licensee's current resident roster and employee	0 250			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 12/31/2025
NAME OF PROVIDER OR SUPPLIER RICHANGEL CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 425 LAURIE ROAD E MAPLEWOOD, MN 55117		
(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
0 250	Continued From page 4 list be emailed to the surveyor. The follow up survey was entered on December 29, 2025, and exited on January 2, 2026. The licensee did not provide the surveyor with the licensee's resident roster and employee list as requested by the surveyor multiple times throughout the survey. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250			
0 450 SS=C	144G.41 Subdivision 1 Minimum requirements All assisted living facilities shall: (1) distribute to residents the assisted living bill of rights; (2) provide services in a manner that complies with the Nurse Practice Act in sections 148.171 to 148.285; (3) utilize a person-centered planning and service delivery process; (4) have and maintain a system for delegation of health care activities to unlicensed personnel by a registered nurse, including supervision and evaluation of the delegated activities as required by the Nurse Practice Act in sections 148.171 to 148.285; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide the current assisted living bill of rights (ALBOR) to one of one resident (R4). This practice resulted in a level one violation (a	0 450			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 12/31/2025
NAME OF PROVIDER OR SUPPLIER RICHANGEL CARE INC		STREET ADDRESS, CITY, STATE, ZIP CODE 425 LAURIE ROAD E MAPLEWOOD, MN 55117			
(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
0 450	Continued From page 5 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). The findings include: R4 admitted on December 4, 2025. R4's record lacked evidence R4 was provided the ALBOR. On December 30, 2025, at approximately 2:40 p.m., per phone interview, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated if the ALBOR was not in R4's file then it was not provided to R4 by the licensee. LALD/CNS-A also stated the licensee would need to provide and document receipt of the current ALBOR to R4. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 450			
{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	{0 480}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 12/31/2025
NAME OF PROVIDER OR SUPPLIER RICHANGEL CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 425 LAURIE ROAD E MAPLEWOOD, MN 55117		
(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 6 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 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	{0 480}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 12/31/2025
NAME OF PROVIDER OR SUPPLIER RICHANGEL CARE INC		STREET ADDRESS, CITY, STATE, ZIP CODE 425 LAURIE ROAD E MAPLEWOOD, MN 55117			
(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 (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:	{0 480}	Not reviewed during this survey.		
{0 640} SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post required content to include the 911 emergency number in common areas. 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	{0 640}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 12/31/2025
NAME OF PROVIDER OR SUPPLIER RICHANGEL CARE INC		STREET ADDRESS, CITY, STATE, ZIP CODE 425 LAURIE ROAD E MAPLEWOOD, MN 55117			
(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
{0 640}	Continued From page 8 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: On December 29, 2025, the surveyor conducted a revisit to follow-up on orders issued pursuant to a survey completed on October 27, 2025. On December 29, 2025, at 11:45 a.m., during the facility tour, the surveyor observed the main areas of the facility with unlicensed personnel/employee supervisor (ULP/ES)-D. The surveyor did not observe a 911 emergency number posted near a cordless telephone that was located on a desk in an open office area next to the living room on the main level. On December 29, 2025, at 11:50 a.m., ULP/ES-D stated the cordless telephone could be used by staff, residents, or visitors. On December 29, 2025, at 11:55 a.m., per phone interview, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee was aware of the requirement for the 911 emergency number to be posted near the cordless telephones in the common areas. On December 29, 2025, at 11:57 a.m., ULP/ES-D verified there was no 911 emergency number posted near the phone in the main level office area and was an oversight by the licensee. No further information was provided.	{0 640}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 12/31/2025
NAME OF PROVIDER OR SUPPLIER RICHANGEL CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 425 LAURIE ROAD E MAPLEWOOD, MN 55117		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 660	Continued From page 9	0 660			
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 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 observation, interview, and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention and control program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) when the licensee failed to complete a TB baseline screening for one of one employee (unlicensed personnel/employee supervisor (ULP/ES)-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	0 660			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 12/31/2025
NAME OF PROVIDER OR SUPPLIER RICHANGEL CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 425 LAURIE ROAD E MAPLEWOOD, MN 55117		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 660	Continued From page 10 situation has occurred only occasionally). The findings include: ULP/ES-D had a hire date of June 5, 2025. ULP/ES-D's employee record included a TB history and symptom screen dated August 1, 2022, which was a record from another facility under the same ownership umbrella as the licensee but lacked documentation of a completed TB testing at time of ULP/ES-D's hire. On December 30, 2025, at approximately 2:50 p.m., ULP/ES-D verified ULP/ES-D's employee record lacked TB testing upon hire. ULP/ES-D stated he was unsure if he completed TB testing upon hire and if there was a record of the TB testing. On December 30, 2025, at approximately 2:55 p.m., per phone interview, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated ULP/ES-D should have completed TB testing when ULP/ES-D worked at another facility under the same ownership umbrella as the licensee and ULP/ES-D's TB testing record had to be somewhere. The licensee's Tuberculosis Screening/Prevention policy dated August 5, 2024, indicated all staff are required as a part of their employment to be screened and tested for TB. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and the CDC guidelines, indicated an employee may begin working with residents after	0 660			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 12/31/2025
NAME OF PROVIDER OR SUPPLIER RICHANGEL CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 425 LAURIE ROAD E MAPLEWOOD, MN 55117		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
0 660	Continued From page 11 a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660			
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and 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	{0 680}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 12/31/2025
NAME OF PROVIDER OR SUPPLIER RICHANGEL CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 425 LAURIE ROAD E MAPLEWOOD, MN 55117		
(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 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 plan (EPP) with all the required content. This had the potential to affect all visitors, employees, and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 December 29, 2025, the surveyor conducted a revisit to follow-up on orders issued pursuant to a survey completed on October 27, 2025. On December 29, 2025, at approximately 12:00 p.m., unlicensed personnel/employee supervisor (ULP/ES)-D provided a binder and stated the contents were the licensee's EPP. The licensee's EPP dated October 25, 2025, lacked an individualized plan to include all the required content below: -missing resident quarterly review; -missing hazard and vulnerability assessment (HVA); -process for EP collaboration;	{0 680}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 12/31/2025
NAME OF PROVIDER OR SUPPLIER RICHANGEL CARE INC		STREET ADDRESS, CITY, STATE, ZIP CODE 425 LAURIE ROAD E MAPLEWOOD, MN 55117			
(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 -development of all policies/procedures (P/P) based on HVA; -development of communication plan; and -EP training and testing program. On December 29, 2025, at approximately 12:05 p.m., ULP/ES-D acknowledged the licensee's EPP lacked the above listed required content. ULP/ES-D stated the licensee was not aware of the HVA and all the requirements of Appendix Z. The licensee's Emergency Preparedness policy dated August 5, 2024, indicated the licensee would have an identified EPP in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services. No further information was provided.	{0 680}			
{0 775} SS=E	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:	{0 775}	Not reviewed during this survey.		
{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:	{0 780}			

Minnesota Department of Health
STATE FORM 6899 G4RR12 If continuation sheet 15 of 30

Minnesota Department of Health
STATE FORM 6899 G4RR12 If continuation sheet 16 of 30

Minnesota Department of Health
STATE FORM 6899 G4RR12 If continuation sheet 17 of 30

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 12/31/2025
NAME OF PROVIDER OR SUPPLIER RICHANGEL CARE INC		STREET ADDRESS, CITY, STATE, ZIP CODE 425 LAURIE ROAD E MAPLEWOOD, MN 55117			
(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
0 900	Continued From page 17 directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for one of one resident (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).	0 900			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 12/31/2025
NAME OF PROVIDER OR SUPPLIER RICHANGEL CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 425 LAURIE ROAD E MAPLEWOOD, MN 55117		
(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
0 900	Continued From page 18 The findings include: R4 admitted on December 4, 2025. R4's record lacked evidence the licensee and R4 or R4's designated representative had authenticated a written contract prior to R4 being provided assisted living services and housing from the licensee. On December 30, 2025, at 2:30 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A and unlicensed personnel/employee supervisor (ULP/ES)-D verified R4 started to receive services and housing from the licensee when R4 was admitted on December 4, 2025. On December 30, 2025, at 2:35 p.m., per phone interview, LALD/CNS-A stated the licensee had provided a contract to R4 and R4's designated representative and thought authentication was obtained to execute the contract. On December 30, 2025, at 2:40 p.m., ULP/ES-D stated the licensee was waiting for R4's case manager to review services before signing R4's contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 900			
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility.	0 910			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 12/31/2025
NAME OF PROVIDER OR SUPPLIER RICHANGEL CARE INC		STREET ADDRESS, CITY, STATE, ZIP CODE 425 LAURIE ROAD E MAPLEWOOD, MN 55117			
(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
0 910	Continued From page 19 (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for one of one resident (R4). 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 the potential to affect a large portion or all the residents). The findings include: R4 was admitted on December 4, 2025. On December 30, 2025, at approximately 1:50 p.m., unlicensed personnel/employee supervisor (ULP/ES)-D provided R4's unsigned Residency Agreement for Assisted Living Services and stated the contract was used by the licensee for all residents who would live in the facility. R4's Residency Agreement for Assisted Living Services undated, lacked inclusion of the licensee's Health Facility Identification (HFID)	0 910			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 12/31/2025
NAME OF PROVIDER OR SUPPLIER RICHANGEL CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 425 LAURIE ROAD E MAPLEWOOD, MN 55117		
(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	
0 910	Continued From page 20 number. On December 30, 2025, at approximately 2:00 p.m., per phone interview, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee was not aware of the requirement to have the HFID number on the contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 910			
{01290} SS=G	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study (BGS) was submitted and a clearance received in	{01290}			
			During the course of the survey, the licensee took action to mitigate the imminent risk. Noncompliance remained		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 12/31/2025
NAME OF PROVIDER OR SUPPLIER RICHANGEL CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 425 LAURIE ROAD E MAPLEWOOD, MN 55117		
(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
{01290}	Continued From page 21 affiliation with the assisted living licensee's current health facility identification (HFID) for one of one employee (unlicensed personnel/employee supervisor (ULP/ES)-D). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On December 29, 2025, the surveyor conducted a revisit to follow-up on orders issued pursuant to a survey completed on October 27, 2025. On December 29, 2025, at approximately 10:00 a.m., per phone conversation, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated LALD/CNS-A and program director (PD)-B were unable to be on site for the follow up survey due to a family emergency, but were accessible by phone. LALD/CNS-A also stated ULP/ES-D was next in charge, had access to records, and would be on site to help with the follow up survey. ULP/ES-D's employee record lacked evidence of current, cleared BGS affiliated with the licensee's assisted living HFID license 41005. On December 30, 2025, at approximately 10:47 a.m., the Minnesota Department of Human Services NETStudy2 website indicated ULP/ES-D was not affiliated with HFID 41005. The NETStudy2 website also indicated ULP/ES-D was	{01290}	and the scope and level remain unchanged.		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 12/31/2025
NAME OF PROVIDER OR SUPPLIER RICHANGEL CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 425 LAURIE ROAD E MAPLEWOOD, MN 55117		
(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	
{01290}	Continued From page 22 separated from two facilities under the same ownership umbrella as the licensee: one on November 30, 2022, for HFID 34993 and one on March 9, 2024, for HFID 29149. On December 29, 2025, from approximately 11:00 a.m. to 1:00 p.m., and on December 30, 2025, from approximately 2:00 p.m. to 4:00 p.m., ULP/ES-D was on site to help the surveyor with the follow up survey. On December 30, 2025, at approximately 2:30 p.m., per phone conference, LALD/CNS-A stated ULP/ES-D was hired on June 5, 2025, worked three days a week at the facility, was the employee supervisor and helped train ULPs for the licensee. ULP/ES-D verified LALD/CNS-A's statements. On December 30, 2025, at approximately 2:40 p.m., per phone conference, LALD/CNS-A stated ULP/ES-D had a BGS completed for the other two facilities owned by the licensee that were now closed. LALD/CNS-A also stated ULP/ES-D's BGS for HFID 41005 must have been missed during transition and was an oversight by the licensee. The licensee's Recruitment and Hiring policy dated August 5, 2024, indicated the licensee complied with all state regulations for pre-employment background checks/studies required for all employees. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	{01290}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 12/31/2025
NAME OF PROVIDER OR SUPPLIER RICHANGEL CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 425 LAURIE ROAD E MAPLEWOOD, MN 55117		
(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=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the current service plan included a signature or other authentication by the licensee and the resident or resident's designated representative to document agreement on the services to be provided for one of one resident (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	01640			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 12/31/2025
NAME OF PROVIDER OR SUPPLIER RICHANGEL CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 425 LAURIE ROAD E MAPLEWOOD, MN 55117		
(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 cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R4 was admitted on December 4, 2025. R4's record lacked a service plan with authentication by the resident or resident's designated representative and a representative from the licensee. On December 30, 2025, at 2:30 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A and unlicensed personnel/employee supervisor (ULP/ES)-D verified R4 started to receive assisted living services and housing from the licensee when R4 was admitted on December 4, 2025. On December 30, 2025, at 2:40 p.m., ULP/ES-D stated the licensee was waiting for R4's case manager to review services before signing R4's service plan. The licensee's Service Plan policy dated August 5, 2024, indicated a service plan would be developed, implemented, and authenticated for each resident beginning when assisted living services were provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 12/31/2025
NAME OF PROVIDER OR SUPPLIER RICHANGEL CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 425 LAURIE ROAD E MAPLEWOOD, MN 55117		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
{01880}	Continued From page 25	{01880}			
{01880} SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure refrigerated medications were maintained at manufacturer recommended temperatures by failing to monitor and document medication refrigerator temperatures 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 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 December 30, 2025, at approximately 1:10 p.m., during a review of the medication storage area located on the main level with unlicensed personnel (ULP)-F, the surveyor observed a portable mini refrigerator on a counter in a closet with lockable bifold doors. The refrigerator contained a thermometer that indicated a reading of 60°F [degrees Fahrenheit] observed by the surveyor and verified by ULP-F. Taped to the front door of the medication	{01880}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 12/31/2025
NAME OF PROVIDER OR SUPPLIER RICHANGEL CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 425 LAURIE ROAD E MAPLEWOOD, MN 55117		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
{01880}	Continued From page 26 refrigerator was a Refrigerator Temperature Tracking log for December 2025. There was only one temperature of 46 degrees recorded on the first line of the tracking form dated December 28, 2025. There was no temperature tracking recorded for December 29, 2025, or December 30, 2025. There were no other records of temperature tracking for previous months. Five (5) prefilled pens of the medication Lantus Solostar (insulin glargine) 100 unit/ml for R2 and six (6) prefilled pens of the medication Lantus Solostar (insulin glargine) 100 unit/ml for R3 was observed stored in the refrigerator. On December 30, 2025, at approximately 1:30 p.m., ULP-F stated the temperature gauge in the small refrigerator was used by the licensee for temperature tracking and was unsure how often it gets checked. ULP-F also stated licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A removed the previous temperature tracking form and was unsure where it was located. R2 R2 was admitted on February 4, 2025. R2's Service Plan dated February 4, 2025, indicated services R2 was receiving that included medication administration. R2's Assessment dated September 6, 2025, indicated R2 needed medication management that included help with injectable medications and secured storage of medications. R2's medication orders dated September 4, 2025, indicated medication Lantus Solostar (insulin glargine) 100 unit/ml (inject 18 Units subcutaneously every morning for type 2 diabetes	{01880}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 12/31/2025
NAME OF PROVIDER OR SUPPLIER RICHANGEL CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 425 LAURIE ROAD E MAPLEWOOD, MN 55117		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
{01880}	Continued From page 27 mellitus). R3 R3 was admitted on October 8, 2025. R3's Service Plan dated October 8, 2025, indicated services R3 was receiving that included medication administration. R3's Assessment dated October 24, 2025, indicated R3 needed medication management that included help with injectable medications and secured storage of medications. R3's record contained a Medication Review Report dated August 25, 2025, that indicated medication Lantus Solostar (insulin glargine) 100 unit/ml (inject 10 Units subcutaneously at bedtime for type 2 diabetes mellitus). Manufacturer storage directions for Lantus (insulin glargine) U-100 Insulin 100 units/ml dated August 2022, indicated protect from light, store in the refrigerator at 36°F [degrees Fahrenheit] to 46°F, and do not freeze. On December 30, 2025, at approximately 2:15 p.m., per phone interview, LALD/CNS-A stated the licensee disposed of the temperature tracking forms from previous months and was unaware of keeping the forms to show evidence of temperature tracking. The licensee's Storage/Control of Medications policy dated August 5, 2024, indicated medication stored would be secured and consistent with manufacturer's recommendations. No further information was provided.	{01880}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 12/31/2025
NAME OF PROVIDER OR SUPPLIER RICHANGEL CARE INC		STREET ADDRESS, CITY, STATE, ZIP CODE 425 LAURIE ROAD E MAPLEWOOD, MN 55117			
(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 28	{03090}			
{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, interview, and record review, the licensee failed to ensure the required notice was posted at the main entryway of the establishment to display statutory language to disclose electronic monitoring activity, potentially affecting all current residents in the assisted living facility, staff, and any visitors to the facility. This practice resulted in a level one violation (a violation that has not 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 the residents). The findings include: On December 29, 2025, the surveyor conducted a revisit to follow-up on orders issued pursuant to a survey completed on October 27, 2025. On December 30, 2025, at 11:00 a.m., the surveyor observed a doorbell with a camera system installed and a posted sign that indicated	{03090}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 12/31/2025
NAME OF PROVIDER OR SUPPLIER RICHANGEL CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 425 LAURIE ROAD E MAPLEWOOD, MN 55117		
(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 29 "Property Monitored by Video Security" at the main entrance accessible by visitors to the facility. On December 30, 2025, at approximately 2:00 p.m., unlicensed personnel/employee supervisor (ULP/ES)-D stated the licensee was not aware of the required verbatim notice to be posted at the entrance accessible by visitors. ULP/ES-D also stated the required electronic monitoring posting would need to be updated at the entrance. The licensee's Electronic Monitoring policy dated August 5, 2024, indicated the licensee would post a sign at each facility entrance accessible by visitors that indicated "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." No further information was provided.	{03090}			



Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF PROVISIONAL EXTENSION AND CONDITIONAL LICENSE

Electronically Delivered

November 17, 2025

Licensee
Richangel Care Inc
66 Kipling Street
Saint Paul, MN 55119

RE: Provisional Conditional License Number 417692
Health Facility Identification Number (HFID) 41005
Project Number SL41005015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on October 30, 2025, for the purpose of assessing compliance with state licensing statutes. Based on the survey results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, pursuant to Minn. Stat. § 144G.16, Subd. 3(b)(2), MDH is extending the provisional license for 60-days and applying conditions necessary to bring the facility into substantial compliance. The provisional license extension and conditions are due to expire **January 16, 2026**.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement;

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

Level 3: a fine of \$1,000 per incident, in addition to any enforcement mechanism

authorized in § 144G.20;

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

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

MDH may assess fines based on the level and scope of the orders outlined below. The total amount of **potential** fines that may be assessed related to these correction orders is \$1,000.00. **MDH is not imposing these fines against your provisional license at this time.**

St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - \$1,000.00

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

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the provisional licensee must document actions taken to comply with the correction orders and immediately correct any reissued orders outlined on the state form; however, plans of correction are not required to be submitted for approval. **If corrections are not made, MDH may impose fines as described above and in accordance with Minnesota Statutes 144G.**

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

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

CONDITIONAL LICENSE ISSUED:

MDH will issue Richangel Care Inc a conditional provisional assisted living facility license for 60 calendar days from the date of this notice. At an unannounced point in time, within the 60 calendar days, MDH will conduct a follow-up survey, as defined in Minn. Stat. § 144G.30, Subd. 6. Based on the results of the follow-up survey, MDH will determine if Richangel Care Inc is in substantial compliance.

The following conditions apply on the conditional provisional assisted living facility license:

- a. **No new substantiated maltreatment allegations:** If any new investigations begin in the conditional provisional license period, and the allegations are substantiated, MDH may pursue additional enforcement actions up to and including immediate temporary suspension and revocation of the provisional license.
- b. **No new admissions:** Richangel Care Inc will not admit any new residents under its conditional provisional assisted living facility license until MDH removes the “no new admissions” condition. Richangel Care Inc must provide the Department:
 - i. A list of the names and birthdates of any individuals Richangel Care Inc is currently in the process of admitting. These individuals will be able to continue the admittance process.
 - ii. A list of all current residents including:
 - 1. Name and birthdate of each resident
 - 2. Current payment source for services
 - 3. If Elderly Waiver, the name and contact information of the care coordinator/case manager
 - 4. If the resident is not able to make informed decisions, the name of their representative and how to contact the representative
- c. **Monitoring visits:** MDH may make unannounced monitoring visits to assess the progress of Richangel Care Inc to correct the violations cited during the survey as well as to determine the overall practice of Richangel Care Inc in meeting the needs of the people it serves. In addition, the Office of Ombudsman for Long-Term Care (OOLTC) may also make unannounced monitoring visits to determine the level of satisfaction of those people who receive provisional licensed assisted living services. The OOLTC will share their findings with MDH.
- d. **Follow-up survey:** At the time of the follow-up survey, MDH may pursue additional enforcement actions, up to and including immediate temporary suspension or revocation of the provisional license if MDH identifies any level 3 or 4 violations or widespread care related violations.
- e. **Submit a plan of correction to Jess.schoenecker@state.mn.us by December 4, 2025:** The plan of correction should include the following:
 - a. Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
 - b. Identify how the area(s) of noncompliance was corrected for all of the provider’s resident(s)/employees that may be affected by the noncompliance.

- c. Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

RESULTS OF FOLLOW-UP EVALUATION DURING THE CONDITIONAL PROVISIONAL LICENSE PERIOD:

MDH will determine if Richangel Care Inc is in substantial compliance based on the results of the follow up survey. MDH will make this determination within the 60-day conditional provisional license period. If MDH determines Richangel Care Inc is in substantial compliance on the follow up survey, MDH will remove the conditions and grant the assisted living facility license to Richangel Care Inc. If MDH determines Richangel Care Inc is not in substantial compliance, MDH may deny the license pursuant to Minn. Stat. § 144G.16, Subd. 3 (b) (2).

REQUEST FOR RECONSIDERATION:

Pursuant to Minn. Stat. §144G.16, Subd. 4, if a provisional licensee whose assisted living facility license has been denied, or extended with conditions, disagrees with the action taken against the provisional license under this section, the provisional licensee may request a reconsideration no later than 15 calendar days after provisional licensee receives notice of the action. **This is your only ability to request a reconsideration under this enforcement action.**

To submit a reconsideration request, please visit:

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

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 Jess Schoenecker directly at: 651-201-3789 or email at: Jess.Schoenecker@state.mn.us.

Sincerely,



Rick Michals, J.D.
Executive Regional Operations Manager

**Minnesota Department of Health
Health Regulation Division**

CLN

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/30/2025
NAME OF PROVIDER OR SUPPLIER RICHANGEL CARE INC		STREET ADDRESS, CITY, STATE, ZIP CODE 66 KIPLING STREET SAINT PAUL, MN 55119			
(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 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: SL#41005015 On October 27, 2025, through October 30, 2025, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 3 residents; 3 receiving services under the Provisional Assisted Living license. On October 28, 2025, an immediate correction order was issued for tag identification 2310. During the course of the survey, the licensee took action to mitigate the imminent risk. Noncompliance remained and the scope and level remain unchanged.	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 License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
0 460 SS=F	144G.41 Subdivision 1 Minimum requirements	0 460			

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/30/2025
NAME OF PROVIDER OR SUPPLIER RICHANGEL CARE INC		STREET ADDRESS, CITY, STATE, ZIP CODE 66 KIPLING STREET SAINT PAUL, MN 55119			
(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
0 460	Continued From page 1 (5) provide a means for residents to request assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide a means for residents to request assistance for health and safety needs 24 hours a day, seven days a week. This had the potential to affect all current residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a 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).	0 460			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/30/2025
NAME OF PROVIDER OR SUPPLIER RICHANGEL CARE INC		STREET ADDRESS, CITY, STATE, ZIP CODE 66 KIPLING STREET SAINT PAUL, MN 55119			
(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
0 460	Continued From page 2 The findings include: On October 27, 2025, at approximately 10:15 a.m., during facility tour, the surveyor observed the facility was a rambler style home with a main floor and lower level. The surveyor also observed no pendants, call light system, or means to request assistance were available in the residents' rooms. On October 27, 2025, at approximately 11:05 a.m., during the entrance conference, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee did not have a call light or pendant system residents could use to summon staff. LALD/CNS-A also stated residents would verbally call out to the licensee's staff if needed assistance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 460			
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	0 480			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/30/2025
NAME OF PROVIDER OR SUPPLIER RICHANGEL CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 66 KIPLING STREET SAINT PAUL, MN 55119		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 480	Continued From page 3 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 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.	0 480			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/30/2025
NAME OF PROVIDER OR SUPPLIER RICHANGEL CARE INC		STREET ADDRESS, CITY, STATE, ZIP CODE 66 KIPLING STREET SAINT PAUL, MN 55119			
(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 4 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 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 October 28, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			
0 630 SS=F	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	0 630			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/30/2025
NAME OF PROVIDER OR SUPPLIER RICHANGEL CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 66 KIPLING STREET SAINT PAUL, MN 55119		
(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
0 630	Continued From page 5 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 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 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 October 27, 2025, at approximately 1:30 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated R2's and R3's IAPPs were included in the assessments. R2 R2 was admitted on February 4, 2025. R2's Assessment dated September 6, 2025, indicated R2 was at risk to be abused and did not include: - the resident's susceptibility to abuse by another	0 630			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/30/2025
NAME OF PROVIDER OR SUPPLIER RICHANGEL CARE INC		STREET ADDRESS, CITY, STATE, ZIP CODE 66 KIPLING STREET SAINT PAUL, MN 55119			
(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
0 630	Continued From page 6 individual, including other vulnerable adults; and - statements of specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. R3 R3 was admitted on October 8, 2025. R3's Assessment dated October 24, 2025, indicated R3 was at risk to be abused and did not include: - the resident's susceptibility to abuse by another individual, including other vulnerable adults; and - statements of specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. On October 27, 2025, at 3:00 p.m., LALD/CNS-A confirmed R2 and R3's IAPPs did not address the above noted areas of risk or include statements of specific measures to be taken to minimize risks. LALD/CNS-A stated the licensee was not aware of the required contents of the IAPP and the IAPP was completed based on the questions shown in the electronic health record. The licensee's Vulnerable Adult policy, dated August 5, 2024, indicated the licensee developed individualized vulnerable adult abuse prevention plans that include the resident's susceptibility to be abused by another individual, including other vulnerable adults, the resident's risk of abusing other vulnerable adults, and specific measures to minimize the risk of abuse to that person and other vulnerable adults. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	0 630			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/30/2025
NAME OF PROVIDER OR SUPPLIER RICHANGEL CARE INC		STREET ADDRESS, CITY, STATE, ZIP CODE 66 KIPLING STREET SAINT PAUL, MN 55119			
(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
0 630	Continued From page 7 days	0 630			
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, and record review, the licensee failed to post required content to include the 911 emergency number in common areas. 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 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:	0 640			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/30/2025
NAME OF PROVIDER OR SUPPLIER RICHANGEL CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 66 KIPLING STREET SAINT PAUL, MN 55119		
(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
0 640	Continued From page 8 On October 27, 2025, at 10:20 a.m., during the facility tour, the surveyor observed the main areas of the facility with program director (PD)-B. The surveyor did not observe a 911 emergency number posted near a cordless telephone that was located on a desk in an open office area next to the living room. On October 27, 2025, at 10:25 a.m., PD-B stated the cordless telephone could be used by staff, residents, or visitors. On October 27, 2025, at 10:55 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee was aware of the requirement for the 911 emergency number to be posted near the cordless telephones in the common areas and was an oversight by the licensee. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 640			
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;	0 680			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/30/2025
NAME OF PROVIDER OR SUPPLIER RICHANGEL CARE INC		STREET ADDRESS, CITY, STATE, ZIP CODE 66 KIPLING STREET SAINT PAUL, MN 55119			
(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 9 (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 plan (EPP) with all the required content. This had the potential to affect all visitors, employees, and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 October 27, 2025, at approximately 1:00 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A provided a binder and stated the contents were the licensee's EPP.	0 680			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/30/2025
NAME OF PROVIDER OR SUPPLIER RICHANGEL CARE INC		STREET ADDRESS, CITY, STATE, ZIP CODE 66 KIPLING STREET SAINT PAUL, MN 55119			
(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 The licensee's EPP undated, lacked an individualized plan to include all the required content below: -missing resident quarterly review; -missing hazard and vulnerability assessment (HVA); -process for EP collaboration; -development of all policies/procedures (P/P) based on HVA; -development of communication plan; and -EP training and testing program. On October 27, 2025, at approximately 3:30 p.m., LALD/CNS-A acknowledged the licensee's EPP lacked the above listed required content. LALD/CNS-A stated was not aware of the HVA and all the requirements of Appendix Z. The licensee's Emergency Preparedness policy, dated August 5, 2024, indicated the licensee would have an identified EPP in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680			
0 775 SS=E	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	0 775			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/30/2025
NAME OF PROVIDER OR SUPPLIER RICHANGEL CARE INC		STREET ADDRESS, CITY, STATE, ZIP CODE 66 KIPLING STREET SAINT PAUL, MN 55119			
(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 11 by: Based on observation, record review, and interview, the licensee failed to comply with the requirements of Minnesota State Fire Code Rules, Chapter 7511. This had the potential to directly affect all building occupants. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On October 27, 2025, at 12:50 p.m., the surveyor toured the facility with program director (PD)-B. During the facility tour, the surveyor observed the following: - At 1:35 p.m., on the exterior wood deck on the side of the building, resident (R)-3 was smoking a cigarette. A container for smoking materials was not provided. During the facility tour interview, PD-B verified the above listed observations and stated the deck was designated for smoking. PD-B stated there had been a disposal container and they were not sure why it was missing. Improper disposal of smoking materials creates a fire hazard. A container of an approved style and sufficient size shall be provided for smoking materials. - In the living/dining room, an exit sign was	0 775			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/30/2025
NAME OF PROVIDER OR SUPPLIER RICHANGEL CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 66 KIPLING STREET SAINT PAUL, MN 55119		
(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 12 posted at the door leading out to deck on the side of the building. The posted evacuation floor plan labeled this door as an exit. A table with chairs was positioned in front of this exit door obstructing the egress path. The improper placement of furniture could delay exiting in the event of an emergency. During the facility tour interview, PD-B verified the exit door obstruction. - In the basement, covers were not installed on three electrical wall outlets and one wall switch. During the facility tour interview, PD-B verified the electrical observations. Covers shall be installed to prevent contact with live electrical parts. - A discolored smoke alarm was installed in the basement on the wall in the room labeled as a flex area on the posted floor plan. PD-B removed the smoke alarm from the wall and during the facility tour interview, verified the smoke alarm was outdated, battery operated, and not part of the interconnected wireless system. Installed smoke alarms must be maintained with a manufacture date of ten years or less. TIME PERIOD FOR CORRECTION: Two (2) 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;	0 780			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/30/2025
NAME OF PROVIDER OR SUPPLIER RICHANGEL CARE INC		STREET ADDRESS, CITY, STATE, ZIP CODE 66 KIPLING STREET SAINT PAUL, MN 55119			
(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
0 780	Continued From page 13 (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 by: Based on observation and interview, the licensee failed to provide a smoke alarms that complied with fire protection requirements. This had the potential to directly affect all building occupants. 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).	0 780			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/30/2025
NAME OF PROVIDER OR SUPPLIER RICHANGEL CARE INC		STREET ADDRESS, CITY, STATE, ZIP CODE 66 KIPLING STREET SAINT PAUL, MN 55119			
(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
0 780	Continued From page 14 The findings include: On October 27, 2025, at 12:50 p.m., the surveyor toured the facility with program director (PD)-B. During the facility tour, the surveyor observed when PD-B tested the smoke alarms, the smoke alarm installed outside occupied resident room 4 was not actuated. All smoke alarms installed in the dwelling unit must be interconnected so actuation of one alarm causes all alarms in the dwelling unit to operate. During the facility tour interview, PD-B verified this smoke alarm was not interconnected. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780			
0 790 SS=E	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to maintain the portable fire extinguishers as required by statute. This had the potential to directly affect all building	0 790			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/30/2025
NAME OF PROVIDER OR SUPPLIER RICHANGEL CARE INC		STREET ADDRESS, CITY, STATE, ZIP CODE 66 KIPLING STREET SAINT PAUL, MN 55119			
(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
0 790	Continued From page 15 occupants. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On October 27, 2025, at 12:50 p.m., the surveyor toured the facility with program director (PD)-B. During the facility tour, the surveyor observed the following: - The maintenance tags attached to the portable fire extinguishers were dated April 2024. During the facility tour interview, PD-B verified annual maintenance had not been completed in the last 12 months. Annual maintenance shall be performed by certified service personnel to ensure the extinguisher is operable in the event of an emergency. - A portable fire extinguisher without a tag was stored on a countertop in unoccupied resident room 5. During the facility tour interview, PD-B verified the fire extinguisher was not properly installed and maintained. PD-B stated this was not a required fire extinguisher and the licensee would remove it. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/30/2025
NAME OF PROVIDER OR SUPPLIER RICHANGEL CARE INC		STREET ADDRESS, CITY, STATE, ZIP CODE 66 KIPLING STREET SAINT PAUL, MN 55119			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 800 SS=E	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all building occupants. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On October 27, 2025, at 12:50 p.m., the surveyor toured the facility with program director (PD)-B. During the facility tour, the surveyor observed the following:	0 800			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/30/2025
NAME OF PROVIDER OR SUPPLIER RICHANGEL CARE INC		STREET ADDRESS, CITY, STATE, ZIP CODE 66 KIPLING STREET SAINT PAUL, MN 55119			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 800	Continued From page 17 - There was unfinished drywall around the egress windows in resident rooms 2 and 3. - On the exterior of the building, there was unfinished siding around the egress windows. During the facility tour interview, PD-B verified the egress window observations. PD-B stated the egress windows had been recently installed and the licensee was still in the process of finishing these surfaces - There was a wood deck on the exterior of the building. The deck steps were loose creating a safety risk to the building occupants. Additionally, the surfaces of the wood deck were rough, and the surface finishes worn. During the facility tour interview, PD-B verified the wood deck observations. - There was a hole in the wall between the laundry room and basement stairway. The opening was covered by a plastic flap in the laundry room and the interior of the wall was exposed on the stairway side of the wall. During the facility tour interview, PD-B verified the hole and stated they were not sure why it was there. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800			
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms;	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/30/2025
NAME OF PROVIDER OR SUPPLIER RICHANGEL CARE INC		STREET ADDRESS, CITY, STATE, ZIP CODE 66 KIPLING STREET SAINT PAUL, MN 55119			
(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 18 (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 develop the fire safety and evacuation plan with required content and provide required drills. This had the potential to directly affect all building occupants. This practice resulted in a level two violation (a	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/30/2025
NAME OF PROVIDER OR SUPPLIER RICHANGEL CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 66 KIPLING STREET SAINT PAUL, MN 55119		
(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 19 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 October 27, 2025, program director (PD)-B provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee failed to develop and maintain the FSEP with site specific procedures for the facility and building occupants evident by the following: - On October 27, 2025, at 12:50 p.m., the surveyor toured the facility with PD-B. During the facility tour, the surveyor observed a portable fire extinguisher was not installed above the basement stairway. The posted safety information indicated a portable fire extinguisher was installed above the door entry to the basement stairway. During the facility tour interview, PD-B verified a portable fire extinguisher was not provided in this location. Fire extinguisher locations must be accurately identified as part of the FSEP. - Record review of the available documentation indicated the FSEP had been created using a template from a third party provider. The FSEP included a fire safety policy dated August 5, 2024	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/30/2025
NAME OF PROVIDER OR SUPPLIER RICHANGEL CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 66 KIPLING STREET SAINT PAUL, MN 55119		
(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 20 and pull fire alarms were inaccurately referenced. - Record review of the available documentation indicated the FSEP included standard employee procedures, but 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 employee actions were limited to the RACE (Remove, Alarm, Confine, Extinguish/Evacuate) and PASS (Pull, Aim, Squeeze, Sweep) acronyms. - Record review of the available documentation indicated the FSEP failed to include specific fire safety and evacuation instructions for residents evident by limited instructions for residents to stoop or crawl to avoid smoke. - Record review of the available documentation indicated the FSEP failed to include resident evacuation procedures with site specific actions for resident movement and evacuation or relocation during a fire or similar emergency evident by a lack of these procedures in the plan. - Record review of the available documentation indicated the FSEP failed to include evacuation procedures for the individualized unique needs of residents evident by a lack of these procedures in the plan. During an interview on October 27, 2025, at 2:15 p.m., PD-B verified the FSEP required revision. DRILLS Record review of the available documentation indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/30/2025
NAME OF PROVIDER OR SUPPLIER RICHANGEL CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 66 KIPLING STREET SAINT PAUL, MN 55119		
(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 21 other month evident by a review of fire drill reports lacking the required frequency. The surveyor requested records for evacuation drills completed between January 2025 and October 2025. One fire drill was recorded, dated September 13, 2025, at 2:30 p.m., and the report indicated this drill combined all three employee shifts. During an interview on October 27, 2025, at 2:15 p.m., PD-B verified the evacuation fire drill frequency was not met and all employees had participated in the same drill conducted on September 13, 2025. Fire drills must be conducted during each shift to ensure employees are familiar with the procedures under their specific working conditions. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
0 950 SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney	0 950			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/30/2025
NAME OF PROVIDER OR SUPPLIER RICHANGEL CARE INC		STREET ADDRESS, CITY, STATE, ZIP CODE 66 KIPLING STREET SAINT PAUL, MN 55119			
(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
0 950	Continued From page 22 ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract included the designation of representative statutory language for two of two residents (R2, R3). 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). The findings include: On October 27, 2025, at 1:30 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A provided R3's Assisted Living Contract dated October 16, 2025, and stated the same contract was used for all residents who resided at the facility. The Assisted Living Contract lacked the verbatim	0 950			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/30/2025
NAME OF PROVIDER OR SUPPLIER RICHANGEL CARE INC		STREET ADDRESS, CITY, STATE, ZIP CODE 66 KIPLING STREET SAINT PAUL, MN 55119			
(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
0 950	Continued From page 23 notice and a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declined to name a designated representative. On October 27, 2025, at 2:00 p.m., LALD/CNS-A stated residents were allowed to designate a representative and verbatim language should be included in each assisted living contract and was unsure why that was missing. LALD/CNS-A also stated the licensee would need to update their assisted living contract to include the required verbatim notice. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 950			
01290 SS=D	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits.	01290			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/30/2025
NAME OF PROVIDER OR SUPPLIER RICHANGEL CARE INC		STREET ADDRESS, CITY, STATE, ZIP CODE 66 KIPLING STREET SAINT PAUL, MN 55119			
(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
01290	Continued From page 24 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a background study (BGS) was submitted and a clearance received in affiliation with the assisted living licensee's current health facility identification (HFID) for one of one employee (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and 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: ULP-C was hired on September 15, 2022. On October 27, 2025, at approximately 11:15 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated ULP-C worked the day shift today for the licensee at this facility and provided cares for the residents. On October 27, 2025, at approximately 11:30 a.m., the surveyor observed ULP-C perform a medication administration on a resident (R3). ULP-C's employee record included a BGS clearance dated September 15, 2022, affiliated with HFID 34993, another license owned by the same owner. ULP-C's employee record lacked	01290			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/30/2025
NAME OF PROVIDER OR SUPPLIER RICHANGEL CARE INC		STREET ADDRESS, CITY, STATE, ZIP CODE 66 KIPLING STREET SAINT PAUL, MN 55119			
(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
01290	Continued From page 25 evidence of current, cleared BGS affiliated with the licensee's assisted living HFID 41005. On October 27, 2025, at approximately 12:20 p.m., the Minnesota Department of Human Services NETStudy2 website indicated ULP-C's BGS was affiliated with HFID 34993, a facility under the same ownership umbrella as the licensee and was not affiliated with HFID 41005. On October 27, 2025, at approximately 12:45 p.m., LALD/CNS-A stated the BGS for ULP-C was under a license of a different facility the licensee used to own, and ULP-C was not affiliated with HFID 41005 and was not sure why. The licensee's Recruitment and Hiring policy, dated August 5, 2024, indicated the licensee complied with all state regulations for pre-employment background checks/studies required for all employees. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290			
01470 SS=D	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	01470			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/30/2025
NAME OF PROVIDER OR SUPPLIER RICHANGEL CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 66 KIPLING STREET SAINT PAUL, MN 55119		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01470	Continued From page 26 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 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	01470			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/30/2025
NAME OF PROVIDER OR SUPPLIER RICHANGEL CARE INC		STREET ADDRESS, CITY, STATE, ZIP CODE 66 KIPLING STREET SAINT PAUL, MN 55119			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01470	Continued From page 27 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 orientation with all the required content was completed for one of one employee (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and 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: ULP-C was hired on September 15, 2022. On October 27, 2025, at approximately 11:15 a.m., during the entrance conference, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she was responsible for all orientation requirements for the licensee. ULP-C's employee record lacked documentation of a completed orientation to assisted living regulations with the required content related to:	01470			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/30/2025
NAME OF PROVIDER OR SUPPLIER RICHANGEL CARE INC		STREET ADDRESS, CITY, STATE, ZIP CODE 66 KIPLING STREET SAINT PAUL, MN 55119			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01470	Continued From page 28 -Overview of Assisted Living statutes; -Review of provider's policies and procedures; and -Consumer advocacy services. On October 27, 2025, at 1:15 p.m., LALD/CNS-A stated she was unsure if ULP-C completed the required orientation because ULP-C started at another location of the licensee. LALD/CNS-A also stated the licensee would ensure all the required training would be assigned to all employees during orientation. The licensee's Staff Orientation and Education policy dated August 5, 2024, indicated the required orientation content would be provided to new employees. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470			
01530 SS=D	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness	01530			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/30/2025
NAME OF PROVIDER OR SUPPLIER RICHANGEL CARE INC		STREET ADDRESS, CITY, STATE, ZIP CODE 66 KIPLING STREET SAINT PAUL, MN 55119			
(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
01530	Continued From page 29 and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure all employees received eight hours of initial dementia care training within the first 160 working hours of employment for direct care employees as required for one of one unlicensed personnel ((ULP)-C). This practice resulted in a level two violation (a	01530			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/30/2025
NAME OF PROVIDER OR SUPPLIER RICHANGEL CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 66 KIPLING STREET SAINT PAUL, MN 55119		
(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
01530	Continued From page 30 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: ULP-C was hired on September 15, 2022, working full time (40 hours a week) to provide direct care to the residents. ULP-C's employee record included the following initial dementia training: -Dementia Communication Overview (1 hour) completed on October 4, 2022; and -Dementia - Overview - Alzheimer's Disease (0.75 hour) completed on October 17, 2022. ULP-C had a total of 1.75 hours completed within 160 hours of working for the licensee. ULP-C's personnel record lacked the required eight hours of dementia care training within 160 hours of working for the licensee. On October 27, 2025, at 1:00 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she was unsure if ULP-C completed the initial 8 hours of dementia care training and was an oversight. LALD/CNS-A also stated the licensee has changed the dementia training platform and would ensure any new employee would be provided 8 hours of the initial dementia training. The licensee's Dementia Education policy, dated	01530			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/30/2025
NAME OF PROVIDER OR SUPPLIER RICHANGEL CARE INC		STREET ADDRESS, CITY, STATE, ZIP CODE 66 KIPLING STREET SAINT PAUL, MN 55119			
(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
01530	Continued From page 31 August 5, 2024, indicated direct care employees would complete at least eight hours of initial dementia training within 160 working hours of employment start date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530			
01620 SS=F	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. (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	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/30/2025
NAME OF PROVIDER OR SUPPLIER RICHANGEL CARE INC		STREET ADDRESS, CITY, STATE, ZIP CODE 66 KIPLING STREET SAINT PAUL, MN 55119			
(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 32 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 interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident monitoring and reassessment no more than 90 days after the previous assessment for one of one resident (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	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/30/2025
NAME OF PROVIDER OR SUPPLIER RICHANGEL CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 66 KIPLING STREET SAINT PAUL, MN 55119		
(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 33 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: R2 was admitted on February 4, 2025. R2's 90-day Assessment was completed on May 27, 2025, with the next assessment due within 90 days or by August 25, 2025. R2's record included a subsequent 90-day assessment on September 26, 2025, which was 32 days past due. On October 27, 2025, at 3:15 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A acknowledged R2's 90-day assessments were more than 90 days apart. LALD/CNS-A stated the licensee was unaware of the 90-day assessment requirement. The licensee's Assessment and Reassessment policy, dated August 5, 2024, indicated the licensee would complete ongoing resident assessment not to exceed 90 calendar days from the resident's last date of the assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620			
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and	01880			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/30/2025
NAME OF PROVIDER OR SUPPLIER RICHANGEL CARE INC		STREET ADDRESS, CITY, STATE, ZIP CODE 66 KIPLING STREET SAINT PAUL, MN 55119			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01880	Continued From page 34 permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure refrigerated medications were stored securely and maintained at manufacturer recommended temperatures by failing to monitor and document medication refrigerator temperatures 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 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 October 27, 2025, at approximately 10:30 a.m., during a tour of the facility, the surveyor observed an unlocked full-size refrigerator in unoccupied bedroom 5 on the main level that contained a thermometer but lacked a temperature log. One (1) prefilled pen of the medication Lantus Solostar (insulin glargine) 100 unit/milliliter (ml) for R2 and five (5) prefilled pens of the medication Lantus Solostar (insulin glargine) 100 unit/ml for R3 was observed stored in the refrigerator. R2 R2 was admitted on February 4, 2025.	01880			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/30/2025
NAME OF PROVIDER OR SUPPLIER RICHANGEL CARE INC		STREET ADDRESS, CITY, STATE, ZIP CODE 66 KIPLING STREET SAINT PAUL, MN 55119			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01880	Continued From page 35 R2's Service Plan dated February 4, 2025, indicated services R2 was receiving that included medication administration. R2's Assessment dated September 6, 2025, indicated R2 needed medication management that included help with injectable medications and secured storage of medications. R2's medication orders dated September 4, 2025, indicated medication Lantus Solostar (insulin glargine) 100 unit/ml (inject 18 Units subcutaneously every morning for type 2 diabetes mellitus). R3 R3 was admitted on October 8, 2025. R3's Service Plan dated October 8, 2025, indicated services R3 was receiving that included medication administration. R3's Assessment dated October 24, 2025, indicated R3 needed medication management that included help with injectable medications and secured storage of medications. R3's record contained a Medication Review Report dated August 25, 2025, that indicated medication Lantus Solostar (insulin glargine) 100 unit/ml (inject 10 Units subcutaneously at bedtime for type 2 diabetes mellitus). Manufacturer storage directions for Lantus (insulin glargine) U-100 Insulin 100 units/ml dated August 2022, indicated protect from light, store in the refrigerator at 36°F [degrees Fahrenheit] to 46°F, and do not freeze.	01880			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/30/2025
NAME OF PROVIDER OR SUPPLIER RICHANGEL CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 66 KIPLING STREET SAINT PAUL, MN 55119		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01880	Continued From page 36 On October 27, 2025, at 12:00 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A and program director (PD)-B acknowledged R2 and R3's insulin medications were not stored in a secured refrigerator and lacked temperature tracking. LALD/CNS-A stated it was an oversight by the licensee for R2 and R3's insulin medications that were stored unsecured. LALD/CNS-A also stated the licensee had a temperature gauge in the medication refrigerator but no record of daily temperature tracking was documented and was unaware of this requirement. The licensee's Storage/Control of Medications policy, dated August 5, 2024, indicated medication stored would be secured and consistent with manufacturer's recommendations. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880			
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care,	02310	During the course of the survey, the licensee took action to mitigate the imminent risk. Noncompliance remained		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/30/2025
NAME OF PROVIDER OR SUPPLIER RICHANGEL CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 66 KIPLING STREET SAINT PAUL, MN 55119		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
02310	Continued From page 37 medical or nursing standards for one of one resident (R2) who utilized a hospital bed rail. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On October 27, 2025, at approximately 10:15 a.m., during facility tour, the surveyor observed a hospital style bed in the corner of R2's room with one upper ½ bed rail attached. The bed rail was located on the side of the bed that was next to the wall. The bed's wheels were in a locked position and the bed did not move away from the wall when the surveyor attempted to move the bed. The surveyor also observed no means to request assistance were available in R2's room. On October 27, 2025, at approximately 11:05 a.m., during the entrance conference, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee did not have a means for residents to summon staff for assistance. LALD/CNS-A also stated residents would verbally call out to the licensee's staff if needing assistance. R2 was admitted to the licensee on February 4, 2025. R2's registered nurse (RN) bed safety assessment dated September 26, 2025,	02310	and the scope and level remain unchanged.		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/30/2025
NAME OF PROVIDER OR SUPPLIER RICHANGEL CARE INC		STREET ADDRESS, CITY, STATE, ZIP CODE 66 KIPLING STREET SAINT PAUL, MN 55119			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
02310	Continued From page 38 indicated there was a hospital bed in use for R2 and the hospital bed safety zone assessment was not applicable as R2 did not use a bed rail. R2's RN vulnerability assessment dated September 26, 2025, indicated R2 was confused and forgetful. R2's RN mental status questionnaire assessment dated September 26, 2025, indicated R2 had severe intellectual impairment. R2's medical record lacked and individualized bed rail assessment, documentation the risks and benefits were discussed with the resident/responsible party, zone measurements per the Food and Drug Administration (FDA) guidelines for zones of entrapment, and the bed rail was FDA compliant. On October 27, 2025, at 2:30 p.m., LALD/CNS-A acknowledged the bed safety assessment lacked an assessment and documentation on R2's bed rail. LALD/CNS-A stated the licensee thought R2's bed safety assessment was not required because there was only one bed rail on R2's bed and LALD/CNS-A wasn't sure if the bed rail was used by R2. On October 27, 2025, at 3:30 p.m., R2 stated she had not used the bed rail for repositioning or for any other purpose. On October 28, 2025, at 12:05 p.m., per phone conversation, LALD/CNS-A stated R2 would not verbally communicate to the licensee's staff of R2's needs unless staff initiated the conversation with R2.	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/30/2025
NAME OF PROVIDER OR SUPPLIER RICHANGEL CARE INC		STREET ADDRESS, CITY, STATE, ZIP CODE 66 KIPLING STREET SAINT PAUL, MN 55119			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
02310	Continued From page 39 The licensee's Side Rail Use policy dated August 5, 2024, indicated the licensee would assess if bed rails used by residents meet FDA safety guidelines. The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Additionally, the FAQ indicated the nurse must abide by accepted health care standards, and the use of portable bed rails according to manufacturer's guidelines is one of those accepted standards. Documentation about a resident's bed rails includes, but is not limited to: - purpose and intention of the bed rail; - measurements; - condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - the resident's bed rail use/need assessment; - risk vs. benefits discussion (individualized to each resident's risks); - the resident's preferences; - installation and use according to manufacturer's guidelines; - physical inspection of bed rail and mattress for areas of entrapment, stability, and correct	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/30/2025
NAME OF PROVIDER OR SUPPLIER RICHANGEL CARE INC		STREET ADDRESS, CITY, STATE, ZIP CODE 66 KIPLING STREET SAINT PAUL, MN 55119			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
02310	Continued From page 40 installation and; - any necessary information related to interventions to mitigate safety risk or negotiated risk agreements. The FDA's, A Guide to Bed Safety, revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients". The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." On page 21, Table 3 Summary of FDA Hospital Bed Dimensional Limit Recommendations indicated specific measurement limits for each entrapment zone. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	02310			
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	03090			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/30/2025
NAME OF PROVIDER OR SUPPLIER RICHANGEL CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 66 KIPLING STREET SAINT PAUL, MN 55119		
(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 41 by: Based on observation, interview, and record review, the licensee failed to ensure the required notice was posted at the main entry way of the establishment to display statutory language to disclose electronic monitoring activity, potentially affecting all current residents in the assisted living facility, staff, and any visitors to the facility. This practice resulted in a level one violation (a violation that has not 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 the residents). The findings include: On October 27, 2025, at 10:00 a.m., the surveyor observed a doorbell with a camera system installed at the main entrance accessible by visitors to the facility that lacked the required notice for electronic monitoring. On October 27, 2025, at 10:10 a.m., program director (PD)-B stated the licensee was not aware of the required verbatim notice to be posted at the entrance accessible by visitors. PD-B also stated the required electronic monitoring posting would need to be placed at the entrance. The licensee's Electronic Monitoring policy, dated August 5, 2024, indicated the licensee would post a sign at each facility entrance accessible by visitors that stated: Electronic monitoring devices, including security cameras and audio devices,	03090			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 41005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/30/2025
NAME OF PROVIDER OR SUPPLIER RICHANGEL CARE INC		STREET ADDRESS, CITY, STATE, ZIP CODE 66 KIPLING STREET SAINT PAUL, MN 55119			
(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 42 may be present to record persons and activities. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090			



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

Page: 1

Establishment Info

RICHANGEL CARE INC
425 LAURIE ROAD EAST
Maplewood, MN 55117
Ramsey County
Parcel:

Phone:

License Info

License: HFID 41005

Risk:
License:
Expires on:
CFPM: ANGELA IKERI
CFPM #: 120901; Exp: 1/11/2027

Inspection Info

Report Number: F1023251200
Inspection Type: Full - Single
Date: 10/28/2025 Time: 10:17:42 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 1
Total Priority 2 Orders: 0
Total Priority 3 Orders: 1
Delivery:

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

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

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

COMMENT: RAW SHELL EGGS STORED OVER READY TO EAT FOODS. EGGS MOVED TO SAFE LOCATION DURING INSPECTION.

Comply By: 10/28/2025 Originally Issued On: 10/28/2025

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: OPERATOR STATED LEFTOVERS ARE SOMETIMES SAVED. DISCONTINUE SAVING LEFTOVERS.

Comply By: 10/28/2025 Originally Issued On: 10/28/2025

Food & Beverage General Comment

THIS INSPECTION WAS CONDUCTED IN CONJUNCTION WITH MDH HEALTH REGULATORY DIVISION (HRD) SURVEY. INSPECTION CONDUCTED IN PRESENCE OF THE PERSON IN CHARGE.

THIS FACILITY DOES NOT HAVE ALL COMMERCIAL GRADE ANSI EQUIPMENT. ALL FOOD MUST BE SERVED THE SAME DAY IT IS PREPARED, AND LEFTOVERS CAN NEVER BE SAVED. FOOD SERVICE IS PROVIDED BY FACILITY STAFF.

FOOD SERVICE AREA FLOORS, WALLS, CEILINGS, COUNTERTOPS, AND FINISH MATERIALS MUST BE NON-ABSORBANT, SMOOTH, DURABLE, AND EASILY CLEANABLE. WOOD IS NOT AN APPROVED FOOD CONTACT SURFACE.

THESE TOPICS WERE DISCUSSED WITH THE PERSON IN CHARGE:

- EMPLOYEE ILLNESS EXCLUSION
- HAND WASHING PROCEDURE
- NO BARE HAND CONTACT WITH RTE FOOD

-
- VOMIT CLEAN UP PROCEDURE
 - FULLY COOKING FOOD FOR HIGH RISK POPULATIONS
 - ANSI 184 DISH WASHER
-

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 F1023251200 from 10/28/2025

Gregory T Nelson

ANGELA IKERI
PERSON IN CHARGE

Greg Nelson,
Public Health Sanitarian 3
651-201-4259
greg.nelson@state.mn.us



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

Temperature Observations/Recordings

Page: 1

Establishment Info	Inspection Info
RICHANGEL CARE INC	Report Number: F1023251200
Maplewood	Inspection Type: Full
County/Group: Ramsey County	Date: 10/28/2025
	Time: 10:17:42 AM

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

Location: Refrigerator at 39 Degrees F.

Comment:

Violation Issued?: No



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

Sanitizer Observations/Recordings

Page: 1

Establishment Info	Inspection Info
RICHANGEL CARE INC	Report Number: F1023251200
Maplewood	Inspection Type: Full
County/Group: Ramsey County	Date: 10/28/2025
	Time: 10:17:42 AM

Sanitizing Equipment: Product: Hot Water; **Sanitizing Process:** Dish Machine

Location: Kitchen **Greater Than** 150 Degrees F.

Comment:

Violation Issued?: No

Sanitizing Chemical: Product: Chlorine; **Sanitizing Process:** Pre-Soaked Towelettes

Location: Kitchen **Equal To** 50 PPM

Comment:

Violation Issued?: No