Electronically Delivered

March 3, 2026

Licensee
MN Best Home Care LLC
8217 Iris Drive North
Brooklyn Center, MN 55428

RE: Project Number(s) SL41118015

Dear Licensee:

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

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

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

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

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
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the

correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

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

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

If you have any questions, please contact me.

Sincerely,

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

CLN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41118	A. BUILDING: _____ B. WING _____	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MN BEST HOME CARE LLC	8217 IRIS DRIVE NORTH BROOKLYN CENTER, MN 55428

(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#41118015 On February 2, 2026, through February 5, 2026, 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 was 1 resident; 1 receiving services under the Provisional Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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.	
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma	0 630		

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0 630	Continued From page 1 (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop an individual abuse prevention plan (IAPP) with the required content for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: R1 was admitted on September 7, 2025. On February 2, 2026, at approximately 12:30 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated R1's IAPP was included in R1's Assessment. R1's Assessment dated September 7, 2025,	0 630		

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0 630	Continued From page 2 indicated R1 was at risk of being abused and did not include: - the resident's susceptibility to abuse by another individual, including other vulnerable adults; - the resident's risk of abusing 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 February 2, 2026, at approximately 1:30 p.m., LALD/CNS-A confirmed R1's IAPP 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 unaware of all the required contents of the IAPP and the IAPPs for all the residents of the licensee would be the same. The licensee's Abuse Prevention Plan policy, undated, indicated the licensee would develop and implement IAPPs that included 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) 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	0 640		

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0 640	Continued From page 3 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, 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: On February 2, 2026, at approximately 11:00 a.m., during the facility tour, the surveyor observed the main areas of the facility with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A. The surveyor did not observe the 911 emergency number posted near one cordless telephone located on a cabinet counter next to the fireplace in the living room on the main level.	0 640		

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0 640	Continued From page 4 On February 2, 2026, at approximately 11:05 a.m., LALD/CNS-A stated the cordless telephones could be used by staff, residents, or visitors. On February 2, 2026, at approximately 11:10 p.m., LALD/CNS-A stated the licensee was unaware of the requirement for the 911 emergency number to be posted near the cordless telephone in the common areas. The licensee's Reporting Maltreatment of Vulnerable Adult policy, undated, indicated the licensee would post the 911 emergency number in common areas and near telephones provided by the facility. 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; (4) post emergency exit diagrams on each floor; and	0 680		

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0 680	Continued From page 5 (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 February 2, 2026, at approximately 12:00 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A provided a binder and stated the contents were the licensee's EPP. The licensee's EPP, undated, lacked an	0 680		

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0 680	Continued From page 6 individualized plan to include all the required content below: -missing resident quarterly review; -missing hazard and vulnerability assessment (HVA); -emergency preparedness (EP) program resident population; -process for EP collaboration; -development of all policies/procedures (P/P) based on HVA; -roles under a waiver declared by secretary; -development of communication plan; and -EP training and testing program. On February 2, 2025, at approximately 2:30 p.m., LALD/CNS-A acknowledged the licensee's EPP lacked the above listed required content. LALD/CNS-A stated the licensee was not aware of the HVA and all the requirements of Appendix Z. The licensee's Emergency Management policy, undated, 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:	0 775		

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0 775	Continued From page 7 This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a 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: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated February 2, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire	0 810		

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0 810	Continued From page 8 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, record review, and interview, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	0 810		

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0 810	Continued From page 9 cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated February 2, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 900 SS=F	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (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.	0 900		

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0 900	Continued From page 10 (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 authenticate the licensee's current assisted living contract for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: R1 was admitted on September 7, 2025. On February 2, 2026, at 12:35 p.m., R1's [licensee] Resident Contract for Assisted Living dated September 7, 2025, was provided by licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A and indicated as R1's current contract. R1's contract was signed or authenticated by R1's designated representative	0 900		

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0 900	Continued From page 11 but was not signed or authenticated by the licensee's representative. On February 2, 2026, at approximately 1:45 p.m., LALD/CNS-A confirmed R1's contract was not signed or authenticated by the licensee. LALD/CNS-A stated the licensee was aware that the resident's contract needed to be signed by the resident or resident's representative and the licensee. LALD/CNS-A also stated the licensee thought R1's contract was signed and was unsure why R1's contract was not signed by the licensee. The licensee's Assisted Living Contracts policy, undated, indicated the contract would contain the required elements for compliance. 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. (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	0 910		

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0 910	Continued From page 12 by: Based on interview and record review, the licensee failed to execute a written contract with the required content for one of one resident (R1). 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: R1 was admitted on September 7, 2025. On February 2, 2026, at 12:35 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A provided R1's [licensee] Resident Contract for Assisted Living and stated the contract was used by the licensee for all residents who would live in the facility. R1's Assisted Living Contract dated September 7, 2025, lacked inclusion with the licensee's health facility identification (HFID) number. On February 2, 2026, at approximately 2:30 p.m., LALD/CNS-A stated the licensee was not aware of the requirement to have the HFID number on the contract. The licensee's Assisted Living Contracts policy, undated, indicated the contract would contain the required elements for compliance. No further information was provided.	0 910		

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	41118	A. BUILDING: _____ B. WING _____	02/05/2026

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0 910	Continued From page 13 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 910		
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or 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),	01470		

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01470	Continued From page 14 orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure orientation with all the required content was completed for one of one employee (unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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).	01470		

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01470	Continued From page 15 The findings include: ULP-C was hired on September 7, 2025. On February 2, 2026, at approximately 10:40 a.m., during the entrance conference, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated he was responsible for all orientation requirements for the licensee. On February 2, 2026, at approximately 12:40 p.m., LALD/CNS-A provided ULP-B's orientation checklist dated September 24, 2024, and stated this was the orientation checklist provided to all employees upon hire. ULP-B's orientation checklist indicated orientation to a comprehensive home care license versus an assisted living license. ULP-B's employee record lacked documentation of a completed orientation to assisted living regulations with the required content related to: -overview of assisted living (AL) statues; -review of provider's policies and procedures related to AL provisions; -AL Bill of Rights; and -review of types of AL services the employee will provide and provider's scope of license. On February 2, 2026, at approximately 2:10 p.m., LALD/CNS-A verified ULP-B's orientation lacked the listed above content. LALD/CNS-A stated it was an oversight by the licensee to provide home care versus assisted living orientation for employees upon hire. LALD/CNS-A also stated the licensee would ensure all the assisted living required training would be assigned to all employees during orientation. The licensee's Facility Employee Orientation	01470		

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01470	Continued From page 16 policy, undated, 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		
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 in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse	01620		

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01620	Continued From page 17 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 a registered nurse (RN) completed comprehensive assessments to include all required content identified by Minnesota Administrative Rule 4659.0150 Uniform Assessment Tool for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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).	01620		

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01620	Continued From page 18 The findings include: R1 was admitted on September 7, 2025. R1's 14-Day [licensee] Nursing Assessment, dated September 21, 2025, and 90-day [licensee] Nursing Assessment, dated December 5, 2025, were two-page documents identified by licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A as R1's last two (2) consecutive RN assessments completed by the licensee. The assessments lacked a full physical and cognitive assessment as required on the uniform assessment tool per Minnesota Administrative Rule 4659.0140 Subp. 2. B. (3). On February 2, 2026, at approximately 1:40 p.m., LALD/CNS-A stated the licensee performed a comprehensive assessment on residents upon admission that included all the elements of the uniform assessment tool, then used the two-page RN assessment for all other assessments and was not aware of the Uniform Assessment Tool requirement for reassessments. The licensee's Comprehensive Resident Assessment policy, undated, indicated the licensee would complete a RN comprehensive assessment for the initial assessment and all reassessments for the residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to	01640		

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01640	Continued From page 19 (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 (R1). This practice resulted in a level two violation (a violation that did not harm resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when	01640		

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01640	Continued From page 20 problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 was admitted on September 7, 2025. On February 2, 2026, at 12:35 p.m., R1's Service Plan dated September 7, 2025, was provided by licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A and indicated as R1's current service plan with services R1 was receiving. R1's Service Plan was signed or authenticated by R1's designated representative but was not signed or authenticated by the licensee's representative. On February 2, 2026, at approximately 1:45 p.m., LALD/CNS-A confirmed R1's Service Plan was not signed by the licensee. LALD/CNS-A stated the licensee was aware that residents' service plans needed to be signed by the resident or resident's representative and the licensee. LALD/CNS-A also stated the licensee thought R1's service plan was signed and was unsure why R1's service plan was not signed. The licensee's Service Plan policy, undated, indicated the initial service plan, and any revisions to the resident's service plan would be signed by the resident or the resident's representative and the licensee's representative. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		

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01690	Continued From page 21	01690		
01690 SS=F	144G.71 Subdivision 1 Medication management services (a) This section applies only to assisted living facilities that provide medication management services. (b) An assisted living facility that provides medication management services must develop, implement, and maintain current written medication management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse, licensed health professional, or pharmacist consistent with current practice standards and guidelines. (c) The written policies and procedures must address requesting and receiving prescriptions for medications; preparing and giving medications; verifying that prescription drugs are administered as prescribed; documenting medication management activities; controlling and storing medications; monitoring and evaluating medication use; resolving medication errors; communicating with the prescriber, pharmacist, and resident and legal and designated representatives; disposing of unused medications; and educating residents and legal and designated representatives about medications. When controlled substances are being managed, the policies and procedures must also identify how the provider will ensure security and accountability for the overall management, control, and disposition of those substances in compliance with state and federal regulations and with subdivision 23. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and maintain current	01690		

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01690	Continued From page 22 written medication management policies and procedures under the supervision and direction of a registered nurse (RN). 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 February 2, 2026, at 10:35 a.m., during entrance conference, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee provided medication management to the licensee's residents. On February 2, 2026, at approximately 12:05 p.m., LALD/CNS-A provided a binder and stated the contents were the licensee's policies. The licensee's provided policies lacked a policy on storing medications. On February 2, 2026, at approximately 2:00 p.m., LALD/CNS-A verified the licensee lacked a policy on storing medications and was unsure why. The licensee's Medication Management Services policy, undated, indicated the licensee would develop and update as needed a policy on storing medications. No further information was provided.	01690		

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01690	Continued From page 23 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01690		
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 stored securely for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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 February 2, 2026, at 10:35 a.m., during entrance conference, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee provided medication management for R1. On February 2, 2026, at 11:20 a.m., during the facility tour, the surveyor observed in the kitchen area on the main level, an unlocked full-size	01880		

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01880	Continued From page 24 refrigerator that contained 15 prefilled pens of the medication Humalog Kwikpen (insulin lispro) 100 unit/milliliter (ml) for R1's Type 2 diabetes. R1 was admitted on September 7, 2025. R1's Service Plan dated September 7, 2025, indicated services R1 was receiving included medication administration. R1's Assessment dated September 7, 2025, indicated R1 needed full medication management that included help with injectable medications and secured storage of medications. R1's medication prescription dated November 6, 2025, indicated medication Humalog Kwikpen (insulin lispro) 100 unit/ml was injected subcutaneously based on R1's blood glucose (BG) check results: -do not give if BG less than 200 milligrams/deciliter (mg/dl); -if BG was between 200 mg/dl - 250 mg/dl, give four (4) units; -if BG was between 251 mg/dl - 300 mg/dl, give six (6) units; -if BG was between 301 mg/dl - 350 mg/dl, give eight (8) units; -if BG was between 351 mg/dl - 400 mg/dl, give 10 units; and -if BG was more than 400 mg/dl, notify medical doctor. On February 2, 2026, at 11:25 a.m., LALD/CNS-A acknowledged R1's insulin medications were not stored in a secure refrigerator. LALD/CNS-A stated it was an oversight by the licensee for R1's insulin medications that were stored unsecured. The licensee lacked a policy related to medication	01880		

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01880	Continued From page 25 storage. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to monitor for expired medications for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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 February 2, 2026, at 10:35 a.m., during entrance conference, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee provided medication	01890		

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01890	Continued From page 26 management for R1. On February 2, 2026, at 11:20 a.m., during the facility tour, the surveyor observed in the kitchen area on the main level, a full-size refrigerator that contained 15 prefilled pens of the medication Humalog Kwikpen (insulin lispro) 100 unit/milliliter (ml) for R1's Type 2 diabetes. On February 2, 2026, at 11:25 a.m., the surveyor reviewed R1's insulin medications that were stored in the licensee's refrigerator with LALD/CNS-A and noted all the insulin medications for R1 expired on October 23, 2025. R1 was admitted on September 7, 2025. R1's Service Plan dated September 7, 2025, indicated services R1 was receiving included medication administration. R1's Assessment dated September 7, 2025, indicated R1 needed full medication management that included the licensee's nurse would conduct a thorough review of R1's medication prescriptions and ensure medications were ordered promptly. R1's medication prescription dated November 6, 2025, indicated medication Humalog Kwikpen (insulin lispro) 100 unit/ml was injected subcutaneously based on R1's blood glucose (BG) check results: -do not give if BG less than 200 milligrams/deciliter (mg/dl); -if BG was between 200 mg/dl - 250 mg/dl, give four (4) units; -if BG was between 251 mg/dl - 300 mg/dl, give six (6) units; -if BG was between 301 mg/dl - 350 mg/dl, give	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41118	A. BUILDING: _____ B. WING _____	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MN BEST HOME CARE LLC	8217 IRIS DRIVE NORTH BROOKLYN CENTER, MN 55428

(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
01890	Continued From page 27 eight (8) units; -if BG was between 351 mg/dl - 400 mg/dl, give 10 units; and -if BG was more than 400 mg/dl, notify medical doctor. On February 2, 2026, at 11:30 a.m., LALD-A acknowledged R1's insulin medications were expired, and unsure why this was not identified. The licensee's Medication Set Up policy, undated, indicated the licensee would read resident medication labels carefully and check for expiration dates. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

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

Food & Beverage Inspection Report

Establishment Info

MN Best Home Care LLC
8217 Iris Drive North
Brooklyn Park, MN 55428
Hennepin County
Parcel:

Phone:

License Info

License: HFID 41118

Risk:
License:
Expires on:
CFPM: Peter Gachukia
CFPM #: 125188; Exp: 9/15/2027

Inspection Info

Report Number: F1025261024
Inspection Type: Full - Single
Date: 2/4/2026 Time: 12:00 PM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery:

No orders were issued for this inspection report.

Food & Beverage General Comment

Dishwasher model WDF750SAY owner's manual lists NSF Residential 184 rinse option. Use this setting when sanitizing utensils.

Between three homes in the business, two CFPM would be required as all are within ~50 miles.

The available food/dish machine min max thermometer was reading but the buttons weren't working. Reset the thermometer and if the min/max setting still doesn't work, replace the thermometer (as this is the setting needed to test the dishwasher to 154 deg F water).

Facility has a wooden built in cutting board that is not used. Suggest a plastic board kept in good condition which can be sanitized in the dishwasher.

Discussed employee health and hygiene, date marking (TCS and discard date), cold holding temperatures, food cooking temperatures, use of the min/max TMD for food and dish machine temperatures, sanitizing in the event of a power outage, food delivery and source, recalls, staff item and utensil use and storage, cook/serve of TCS foods.

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 F1025261024 from 2/4/2026

Establishment Representative

Casey Kipping, MA RS
Public Health Sanitarian 3
651-201-4513
casey.kipping@state.mn.us

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

Temperature Observations/Recordings

Establishment Info

MN Best Home Care LLC
Brooklyn Park
County/Group: Hennepin County

Inspection Info

Report Number: F1025261024
Inspection Type: Full
Date: 2/4/2026
Time: 12:00 PM

Food Temperature: Product/Item/Unit: Milk**; Temperature Process:** Cold holding
Location: Refrigerator at 36 Degrees F.
Comment: Note that the top drawer is a refrigerated, the bottom drawer is a freezer
Violation Issued?: No

Equipment Temperature: Product/Item/Unit: Freezer**; Temperature Process:**
Location: Kitchen at Degrees F.
Comment: Frozen
Violation Issued?: No

Equipment Temperature: Product/Item/Unit: Chest freezer**; Temperature Process:**
Location: at Degrees F.
Comment: Frozen
Violation Issued?: No

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL41118015-0	**Date:** February 2, 2026
Facility Name: MN BEST HOME CARE LLC	
Facility Address: 8217 IRIS DRIVE N, BROOKLYN PARK, MN 55428	

☒ **TAG IDENTIFICATION: 0775**

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

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

2. The means of egress shall be maintained free of obstructions or impediments to full instant use in case of fire or other emergency. [Minn. Stat. 144G.45 subd. 2; MSFC 1031.2]

   Comments: The dining room patio door was labeled as an emergency exit door. A clear continuous egress path from this door to the public right of way was not maintained free of snow.

3. Extension cords and flexible cords shall not be a substitute for permanent wiring. [Minn. Stat. 144G.45 subd. 2; MSFC 604.5]

   Comments: An orange extension cord was used to supply power to a freezer in the attached garage. Improper use of extension cords creates a fire hazard

4. Approved covers shall be provided for all switch and electrical outlet boxes. [Minn. Stat. 144G.45 subd. 2; MSFC 604.6]

   Comments:
   - In the attached garage, covers were not installed on two electrical wall outlets.
   - In the basement, there was a gap above one circuit breaker in the electrical panel.
   Electrical components shall be covered to protect the building occupants from accidental exposure to live electrical parts.

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Twenty One (21) days

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

   Comments:
   - The posted evacuation floor plans labeled the attached garage as an emergency exit and an exit sign was posted at the door leading into the attached garage. Emergency exits are required to lead directly to the exterior of the building and not through a higher-hazard space.
   - The fire safety and evacuation plan documents were from a third party.
   - The fire plan inaccurately referenced pull fire alarms.
   - The written instructions in the fire plan did not identify the location of the basement portable fire extinguisher.
   The licensee failed to develop and maintain the fire safety and evacuation plan with site specific employee actions relative to the facility's building layout and environmental risks.

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

   Comments: The fire safety and evacuation plan (FSEP) resident procedures were limited to stoop or crawl to avoid smoke. The licensee failed to develop the FSEP with site specific fire safety and evacuation instructions for residents.

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

   Comments: The surveyor requested records for employee evacuation drills conducted between August 2025 and February 2026. Two fire drill reports dated September 15, 2025, and December 12, 2025, were provided. The September drill had been completed by combining all shifts. The December drill was completed by combining morning and night shifts. No fire drill reports were provided for October or November 2025. Employee evacuation drills had not been completed at the frequency required by statute and the licensee had inappropriately combined shifts when conducting fire drills.

DEPARTMENT OF HEALTH