STATE LICENSING COMPLIANCE REPORT

Report #: HL313368821C

Date Concluded: May 11, 2026

Name, Address, and County of Facility Investigated:
Caring Nurses LLC
7700 Shingle Creek Drive
Brooklyn Park, MN 55443
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Michele Larson, RN

The Minnesota Department of Health conducted a complaint investigation to determine compliance with state laws and rules governing the provision of care under Minnesota Statutes, Chapter 144G. The purpose of this complaint investigation was to review if facility policies and practices comply with applicable laws and rules. No maltreatment under Minnesota Statutes, Chapter 626 was alleged.

To view a copy of the correction orders, if any, please visit: https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html, or call 651-201-4201 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached state form.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31336	A. BUILDING: _____ B. WING _____	C 03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING NURSES LLC	7700 SHINGLE CREEK DRIVE BROOKLYN CENTER, MN 55443

(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 CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, this correction order is issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL313368821C On March 19, 2026, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 4 residents receiving services under the provider's Assisted Living license. The following correction orders is issued for #HL313368821C, tag identification 0330, 495.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31336	A. BUILDING: _____ B. WING _____	C 03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING NURSES LLC	7700 SHINGLE CREEK DRIVE BROOKLYN CENTER, MN 55443

(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	Continued From page 1	0 000	ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 330 SS=F	144G.30 Subd. 4 Information provided by facility (a) The assisted living facility shall provide accurate and truthful information to the department during a survey, investigation, or other licensing activities. (b) Upon request of a surveyor, assisted living facilities shall within a reasonable period of time provide a list of current and past residents and their legal representatives and designated representatives that includes addresses and telephone numbers and any other information requested about the services to residents. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide accurate and truthful information to the Minnesota Department of Health (MDH) regarding the availability of an on-call nurse. This had the potential to affect all residents in the licensee's facilities. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	0 330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31336	A. BUILDING: _____ B. WING _____	C 03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING NURSES LLC	7700 SHINGLE CREEK DRIVE BROOKLYN CENTER, MN 55443

(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
0 330	Continued From page 2 Minnesota (MN) Statute 144G.30, Subd. 4, indicated the assisted living facility shall provide accurate and truthful information to the department during a survey, investigation, or other licensing activities. On March 19, 2026, a complaint investigation was initiated at the licensee's facility. During the entrance conference phone call on March 19, 2026, at 10:40 a.m., the owner/registered nurse (OW)-B stated she was unable to meet the investigator at the facility, stating she was visiting family on the East coast. OW-B stated she was the owner and full-time registered nurse for the facility and worked Monday through Friday and was on-call during the weekends. OW-B stated the licensee also had an on-call registered nurse (RN)-E. OW-B stated RN-E picked up shifts whenever the facility needed RN-E. OW-B provided the investigator RN-E's first name but was unable to provide RN-E's last name or phone number stating she would have to obtain RN-E's phone number from the office. OW-B stated RN-E's phone number was not posted on facility walls only OW-B's phone number. On March 19, 2026, at 11:57 a.m., unlicensed personnel/housing manager (HM)-A stated OW-B was the only on-call nurse. When interviewed, multiple staff stated they did not know who RN-E was. On March 19, 2026, at 12:15 p.m., licensed assisted living director (LALD)-C confirmed OW-B was the facility RN and told the investigator OW-B was in Maryland visiting family and was unsure when OW-B's return date was.	0 330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31336	A. BUILDING: _____ B. WING _____	C 03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING NURSES LLC	7700 SHINGLE CREEK DRIVE BROOKLYN CENTER, MN 55443

(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
0 330	Continued From page 3 On March 19, 2026 at 4:52 p.m., LALD-C stated RN-E worked full time at another assisted living facility and that RN-E did not have regular on-call hours with the licensee. LALD-C stated staff called OW-B for any nursing related issues and if they were unable to reach OW-B then staff calls were transferred to RN-E. LALD-C provided the investigator with RN-E's phone number. On March 19, 2026, at 5:30 p.m., RN-E stated she was not the licensee's on-call nurse stating she used to work for the licensee a "very" long time ago, around nine months ago. A background search of RN-E on the Minnesota Department of Human Services (DHS) website (htpps://netstudy2.dhs.mn.us), indicated RN-D was not affiliated with the licensee's facility. On March 20, 2026, at 7:56 a.m., the investigator called OW-B. The investigator left a voice message on OW-B's phone to call the investigator. On March 23, 2026, at 8:14 a.m., the investigator called OW-B and left a second voice message to call the investigator by 12:00 p.m. On March 23, 2026, at 11:55 a.m., OW-B returned the investigator's phone calls stating she did not get the investigator's previous voice messages until prior to calling the investigator, stating her phone was either not working or the battery was dead at the time the investigator left the voice messages. During the phone call, OW-B stated she was the only on-call nurse for the licensee's facility and stated she never said RN-E was the licensee's on-call nurse, contradicting what she initially stated during the	0 330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31336	A. BUILDING: _____ B. WING _____	C 03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING NURSES LLC	7700 SHINGLE CREEK DRIVE BROOKLYN CENTER, MN 55443

(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
0 330	Continued From page 4 entrance conference phone call with the investigator on March 19, 2026. On March 23, 2026, at 1:40 p.m., LALD-C reiterated that RN-E was the licensee's on-call nurse, stating she called RN-E when she needed a nurse to come to the facility when OW-B was unavailable. A request was made for RN-E's employee file. RN-E's employee file was not provided by the licensee. No further information was provided. TIME PERIOD TO CORRECT: Two-days.	0 330		
0 495 SS=F	144G.41 Subdivision. 1 (13) Minimum Requirements (13) provide staff access to an on-call registered nurse 24 hours per day, seven days per week. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure access to an on-call registered nurse 24 hours per day, seven days per week. This had the potential to impact all residents who resided at the assisted living facility. 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	0 495		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31336	A. BUILDING: _____ B. WING _____	C 03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING NURSES LLC	7700 SHINGLE CREEK DRIVE BROOKLYN CENTER, MN 55443

(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
0 495	Continued From page 5 failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On March 19, 2026, at 9:50 a.m., the Minnesota Department of Health (MDH) investigator arrived at the facility to initiate a complaint investigation. Unlicensed Personnel/Housing manager (HM)-A stated there were four female residents who resided at the facility (R1, R2, R3, R4). HM-A stated the owner/registered nurse (OW)-B was not currently at the facility and was unavailable but stated she would call OW-B to let her know the investigator was at the facility. On the wall behind the dining room table the investigator observed a bulletin board hanging on the wall. The investigator observed only OW-B's name and phone number were listed as the licensee's registered nurse. On March 19, 2026, at 10:40 a.m., during the entrance conference phone call, OW-B stated she was unable to meet in person due to being out of state visiting family on the East coast. During the call, OW-B stated she was unsure when she would return back to Minnesota. OW-B stated she was the owner and main nurse and worked Monday through Friday from 8:00 a.m. until 4:30 p.m. and was on-call during the weekends. OW-B stated the only nurse number available to staff was OW-B's. OW-B stated the licensee also had an on-call registered nurse (RN)-E, stating RN-E picked up shifts whenever they needed her. When asked for RN-E's phone number, OW-B stated she would call the office to obtain RN-E's number. On March 19, 2026, at 11:57 a.m., HM-A stated as far as she was aware, OW-B was the only	0 495		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31336	A. BUILDING: _____ B. WING _____	C 03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING NURSES LLC	7700 SHINGLE CREEK DRIVE BROOKLYN CENTER, MN 55443

(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
0 495	Continued From page 6 on-call nurse. On March 19, 2026, The investigator observed the bulletin board and noticed only OW-B's name and phone number on the bulletin board. No other nurse name, phone number, or contact information was posted for staff to call in case they were unable to reach OW-B. An unlicensed personnel, ULP-D stated he never heard of RN-E, stating he only recalled a different nurse who quit working for the licensee over a year ago. When interviewed, multiple staff stated they did not know who RN-E was. On March 19, 2026 at 4:52 p.m., licensed assisted living director (LALD)-C stated RN-E worked full time at another assisted living facility and RN-E did not have regular on-call hours with the licensee. LALD-C stated staff called OW-B for any nursing related issues and if they were unable to reach OW-B then staff calls were transferred to RN-E. LALD-C provided the investigator with RN-E's phone number. On March 19, 2026, at 5:30 p.m., RN-E stated she was not the licensee's on-call nurse stating she used to work for the licensee a "very" long time ago. A background search of RN-E on the Minnesota Department of Human Services (DHS) website (htpps://netstudy2.dhs.mn.us), indicated RN-E was never linked or affiliated with the licensee's facilities. On March 20, 2026, at 7:56 a.m., the investigator called OW-B. The investigator left a voice message on OW-B's phone to call the investigator. The call was not returned.	0 495		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31336	A. BUILDING: _____ B. WING _____	C 03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING NURSES LLC	7700 SHINGLE CREEK DRIVE BROOKLYN CENTER, MN 55443

(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
0 495	Continued From page 7 On March 23, 2026, at 8:14 a.m., the investigator called OW-B and left a second voice message to give the investigator a call by 12:00 p.m. On March 23, 2026, at 11:55 a.m., OW-B returned the investigator's phone calls stating she did not get the investigator's voice message from a few days ago because her phone was either not working or the battery was dead at the time the investigator left the voice messages. During the phone call, OW-B stated she was the only on-call nurse for the licensee's facilities and stated she never said RN-E was the licensee's on-call nurse, contradicting what she initially told the investigator during the entrance conference phone call on March 19, 2026. On March 23, 2026, at 1:40 p.m., LALD-C reiterated that RN-E was the licensee's on-call nurse, stating she called RN-E when she needed a nurse to come into the facilities. RN-E's personel file was requested but not provided by the facility. No further information was provided. TIME PERIOD TO CORRECT: Two (2) days.	0 495		