Electronically Delivered

June 18, 2026

Licensee
TC Care LLC
8454 Kell Avenue South
Bloomington, MN 55437

RE: Project Number(s) SL35376016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on May 19, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

MDH 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. MDH documents state licensing 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.

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

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

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with 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

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.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers.

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

If you have any questions, please contact me.

Sincerely,

Jess Schoenecker, Supervisor
State Rapid Response Team / State Evaluation Team
Email: Jess.Schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-800-337-9238 / 1-866-890-9290

KKM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35376	A. BUILDING: _____ B. WING _____	05/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TC CARE LLC	8454 KELL AVENUE SOUTH BLOOMINGTON, MN 55437

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL35376016-0 On May 18, 2026, through May 19, 2026, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were three (3) residents; 3 whom received services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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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		

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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: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated May 18, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.	0 480		

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0 480	Continued From page 3 TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 650 SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records included all required content 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	0 650		

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0 650	Continued From page 4 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: During entrance conference on May 18, 2026, at 10:30 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated they were aware of the required contents of the employee records. ULP-B was hired on March 5, 2025, to provide assisted living services to residents. ULP-B's Unplanned Time Away (UTA) Medication Preparation and Handling training form dated March 6, 2025, was signed by ULP-B and house manager/ULP (HM/ULP)-C. ULP-B's training record lacked documentation of completed training and competency evaluation by a registered nurse. R3's Med Admin Summary-Month dated May 2026, indicated ULP-B documented that R3's bedtime, next morning, and afternoon medications were sent with resident and R3's medical record was put on hold starting May 18, 2026, at 7:00 p.m. During interview on May 19, 2026, at 11:57 a.m., LALD/CNS-A stated HM/ULP-C signed at the bottom of the page under trainer's signature. LALD/CNS-A stated they provided training on UTA medication preparation but when surveyor	0 650		

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0 650	Continued From page 5 asked why HM/ULP-C's signed the training form, LALD/CNS-A stated ULP-B received training from both LALD/CNS-A and HM/ULP-C but did not have documentation they provided the training and evaluated for competency. LALD/CNS-A then explained under the medication administration competency, UTA medication preparation competency was part of it even though it did not list it. LALD/CNS-A stated all ULPs' training records lacked documentation, and they would update the training and competency form to include UTA medication preparation. The licensee's 5.10 Training Records policy dated August 1, 2021, indicated the licensee would document for each competency evaluation, training, retraining, and orientation topic the name and title of the instructor and the instructor's signature, and the name and title of the competency evaluator and the evaluator's signature with a statement attesting that the employee successfully completed the training and competency evaluation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 790 SS=F	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	0 790		

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0 790	Continued From page 6 maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated May 19, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 790		
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		

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0 810	Continued From page 7 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: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G.	0 810		

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0 810	Continued From page 8 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated May 19, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	0 810		
0 940 SS=C	144G.50 Subd. 2 (e; 5-7) Contract information (5) a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: (i) whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; (ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); (iii) whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If	0 940		

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0 940	Continued From page 9 so, the limit must be provided; (iv) whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; (v) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; (vi) a statement that residents may be eligible for assistance with rent through the housing support program; and (vii) a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; (6) the contact information to obtain long-term care consulting services under section 256B.0911; and (7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written assisted living contract with the required content for one of one resident (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 potential to affect a large portion or all of the residents). The findings include: R3 was admitted to the licensee on August 16,	0 940		

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0 940	Continued From page 10 2022, and began receiving assisted living services. R3's Assisted Living Contract signed on August 6, 2025, lacked the following required content: -whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; -whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; and - a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program. During interview on May 19, 2026, at 12:41 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated during the previous survey, they were told by the previous surveyor that the missing content was unethical, and it needed to be removed. After reviewing statute 144G.50 Subdivision 2 (e; 5-7) together, LALD/CNS-A stated they would add the required content back into the contract. The licensee's 1.05 Signing an Assisted Living Contract policy dated August 1, 2021, indicated to emphasize to the prospective resident and/or responsible person that the assisted living contract is a legal, binding contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 940		

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0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the Resident Information Handbook did not include language waiving the licensee's liability for health, safety, or personal property of a resident for one of one resident (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 potential to affect a large portion or all of the residents). The findings include: R3 was admitted to the licensee on August 16, 2022, and began receiving assisted living services. R3's Assisted Living Contract signed on August 6, 2025, did not include a waiver of liability but on page 11, under Resident Policies, Rules and Regulations, indicated the following statement, "By signing this Agreement, you agree to abide by	0 970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35376	A. BUILDING: _____ B. WING _____	05/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TC CARE LLC	8454 KELL AVENUE SOUTH BLOOMINGTON, MN 55437

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0 970	Continued From page 12 and comply with all of the Community's policies, rules and regulations, which have been provided to you in the Resident Handbook. The Resident Handbook is incorporated in and considered part of this Agreement. The licensee's undated Resident Information Handbook included the following waiver of liability: -page nine (9), "Liability: [Licensee] and management are not responsible for any injury or damages suffered as a result of the acts of any other resident of [Licensee];" and -page 10, "Personal Insurance: The resident acknowledges that [Licensee] will not be liable for the loss of damage of an individual's personal property." During interview on May 19, 2026, at 12:41 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated during the previous survey, they were informed there was a waiver of liability within the contract, so they removed it and had all residents sign a new contract. All residents were provided the resident handbook as well. At 2:00 p.m., LALD/CNS-A stated they were not sure if there was a waiver of liability within the resident handbook. After reviewing the resident handbook, LALD/CNS-A stated the above content was a waiver of liability and the reason the content was in there was due to behavior of a previous resident that resided there. The licensee's 1.05 Signing an Assisted Living Contract policy dated August 1, 2021, indicated to emphasize to the prospective resident and/or responsible person that the assisted living contract is a legal, binding contract.	0 970		

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TC CARE LLC	8454 KELL AVENUE SOUTH BLOOMINGTON, MN 55437

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0 970	Continued From page 13 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01530 SS=F	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 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	01530		

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01530	Continued From page 14 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 observation, interview, and record review, the licensee failed to ensure direct care staff received the required 2 hours of initial training on mental illness and de-escalation topics within 160 hours of start date for three of three employees (unlicensed personnel (ULP)-B, ULP-D, ULP-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During entrance conference on May 18, 2026, at 10:30 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated they were aware of the required contents of the employee records. LALD/CNS-A stated upon hire, their process included assigning all Educare courses (online training program) and having them completed before "they set foot on	01530		

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01530	Continued From page 15 the floor." On May 18, 2026, throughout the day, the surveyor was set up in the lower level of a rambler style facility where R2 and R3's bedrooms were. The surveyor observed R2 and R3 leave their rooms frequently to smoke a cigarette, eat meals, and receive medications. At 2:27 p.m., house manager/ULP (HM/ULP)-C administered one oral medication to R3 and completed a mouth check to ensure R3 swallowed the medication. R3 had diagnoses of bipolar disorder, anxiety, depression, disorders of impulse control, and obsessive-compulsive disorder. R3's signed Service Plan (Waiver)-Addendum to Contract dated February 2, 2026, indicated R3 required assistance with behavior management, medication administration, and mouth checks after medication administration. ULP-B, ULP-D, and ULP-E were hired on March 5, 2025, December 2, 2025, and March 9, 2026, respectively, to provide assisted living services to residents. On May 19, 2026, at 9:30 a.m., during ULP-B's record review, the surveyor inquired why the Educare courses including orientation, were all completed before ULP-B's hire date, LALD/CNS-A stated ULP-B's hire date was listed as March 5, 2025, because that was when ULP-B had completed the Educare courses. ULP-D's training transcript indicated ULP-D completed orientation and other various courses between November 20-25, 2025.	01530		

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01530	Continued From page 16 ULP-E's training transcript indicated ULP-E completed orientiation and other courses between February 16, 2026 through March 1, 2026. ULP-B, ULP-D, and ULP-E's employee training transcripts indicated they lacked the required two hours of initial mental illness and de-escalation training within 160 hours of work, to include the following training topics: - recognizing symptoms of common mental illness diagnoses, including but not limited to mood disorders, anxiety disorders, trauma- and stressor related disorders, personality and psychotic disorders, substance use disorder, and substance misuse - de-escalation techniques and communication; and - crisis resolution and suicide prevention, including procedures for contacting county crisis response teams and 988 suicide and crisis lifelines. The licensee's Weekly Staffing Plan dated May 17-23, 2026, indicated the following schedule: -ULP-B was scheduled to work 12-hour shifts Monday through Thursday and eight (8) hour shift on Friday; and -ULP-D and ULP-E were scheduled to work eight (8) hour shifts on Saturday and Sunday. During interview on May 19, 2026, at 11:57 a.m., LALD/CNS-A stated they provided two (2) hours of mental illness training and thought the annual requirement was also 2 hours. The mental illness training was incorporated in resident rights and vulnerable adult training courses. LALD/CNS-A stated all staff did not receive training on all required topics and would assign the mental illness courses right away.	01530		

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01530	Continued From page 17 The licensee's undated Mental Illness, and De-escalation Policy indicated all direct care staff and supervisors providing direct services must complete required training related to mental illness and de-escalation, as required: -common signs and symptoms of mental illness; -trauma-informed care; -de-escalation techniques; -suicide/self-harm warning signs and response; -respectful communication; -resident rights and privacy; -when to notify the a nurse, supervisor, provider, emergency contact, 988 (suicide and crisis lifeline), or 911; -documentation and indecent reporting; and -maltreatment prevention and reporting. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
02310 SS=F	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, medical, or nursing standards for storage of oxygen for one of one resident (R1) with oxygen	02310		

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02310	Continued From page 18 tanks. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On May 18, 2026, at 11:07 a.m., the Minnesota Department of Health (MDH) environmental engineer (EE) stated they had something to show the surveyor on the first level. Once in R1's room, EE showed the surveyor two oxygen tanks standing upright within the closet unsecured. The other oxygen tanks were either in a transport cart or placed inside a secure rack. The surveyor observed six (6) small oxygen cylinders and two (2) large cylinders within the closet. There was a long article of clothing draped over the cylinders. During interview on May 19, 2026, at 2:00 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated they were informed by EE that oxygen cylinders needed to be secured properly even if they were empty. LALD/CNS-A stated someone from the respiratory company stated it was okay to store the oxygen cylinders in R1's closest when they were delivered. The licensee's 7.40 Oxygen policy dated August 1, 2021, indicated to keep oxygen cylinders and vessels in a well-ventilated area (not in closets, behind curtains, or other confined space).	02310		

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02310	Continued From page 19 Oxygen cylinders and vessels must always remain upright. The policy did not specify if oxygen cylinders needed to be secured in racks or by chains. The Minnesota Department of Health (MDH) Oxygen Cylinder Storage Requirements dated April 16, 2020, based on the National Fire Protection Association, Standard 99 (NFPA 99), indicated a common hazard in a health care facility is storing and handling compressed oxygen in cylinders. When storing oxygen cylinders, they must be secured in racks or by chains to prevent them from falling over. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		

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

TC CARE LLC
8454 KELL AVENUE SOUTH
Bloomington, MN 55437
Hennepin County
Parcel:

Phone:

License Info

License: HFID 35376

Risk:
License:
Expires on:
CFPM: BALQISA HASSAN
CFPM #: 107755; Exp: 9-14-2027

Inspection Info

Report Number: F1062261113
Inspection Type: Full - Single
Date: 5/18/2026 Time: 11:00 am
Duration: minutes
Announced Inspection: Yes
Total Priority 1 Orders: 0
Total Priority 2 Orders: 1
Total Priority 3 Orders: 0
Delivery: Emailed

New Order: 4-300 Equipment Numbers and Capacities
4-302.13B *Priority Level: Priority 2 CFP#: 48*
MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.
COMMENT: NO IRREVERSIBLE REGISTERING TEMPERATURE INDICATOR AVAILABLE AT FACILITY AT TIME OF INSPECTION. GUIDANCE ON APPROPRIATE TOOLS FOR MEASURING HOT WATER WAREWASHING TEMPS WILL BE PROVIDED. COMPLY WITH RULE ABOVE.
Comply By: 5/18/2026 Originally Issued On: 5/18/2026

Food & Beverage General Comment

INSPECTION COMPLETED ON BEHALF OF ANNA BOHNEN (HRD)

FACILITY USES A RESIDENTIAL KITCHEN. 2 BASIN SINK WITH LEFT BASIN DEDICATED TO HANDWASHING.

SEALED WOOD FLOORS, LAMINATE COUNTERS, TILED BACKSPLASH

DISCUSSED LEFTOVER PROHIBITIONS, HOT WATER SANITIZING AND TESTING, ILLNESS RECORDING FOR EMPLOYEES, AND PROHIBITIONS AGAINST UNDERCOOKED 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 F1062261113 from 5/18/2026

BALQISA HASSAN
CFPM

Nicholas Streeter, RS
Public Health Sanitarian 2
nicholas.streeter@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

TC CARE LLC
Bloomington
County/Group: Hennepin County

Inspection Info

Report Number: F1062261113
Inspection Type: Full
Date: 5/18/2026
Time: 11:00 am

Food Temperature: Product/Item/Unit: PRECOOKED SHREDDED CHICKEN**; Temperature Process:** Cold-Holding
Location: Refrigerator at 41 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

Establishment Info

TC CARE LLC
Bloomington
County/Group: Hennepin County

Inspection Info

Report Number: F1062261113
Inspection Type: Full
Date: 5/18/2026
Time: 11:00 am

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Kitchen **Equal To** 170 Degrees F.
Comment:
Violation Issued?: No

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL35376016-0	**Date:** May 19, 2026
Facility Name: TC CARE LLC	
Facility Address: 8454 KELL AVE S, BLOOMINGTON, MN 55437	

☒ **TAG IDENTIFICATION: 0790**

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

1. Portable fire extinguishers installed and maintained to MN State Fire Code. [Minn. Stat. 144G.45 subd.2]

   Comments: Facility fire extinguishers had monthly sign-off tags but no evidence of being annually serviced by licensed technician.

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Twenty One (21) days

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

   Comments: The FSEP failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate).

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 FSEP did not identify specific fire protection actions for residents. There was no section in the plan that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency.

3. Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. [Minn. Stat. 144G.45 subd.2]

   Comments: The licensed assisted living director/clinical nurse supervisor (LALD/CNS-A) failed to provide documentation verifying that employees received training on the Fire Safety and Evacuation Plan (FSEP) upon hire and biannually. While LALD/CNS-A completed a third-party basic fire safety module online, it did not cover the required facility-specific FSEP. Although general orientation and annual meeting training records were provided, they lacked any evidence of FSEP-specific instruction.