Electronically Delivered

September 19, 2025

Licensee
Bimsol Homecare LLC
2551 115th Avenue Nw
Coon Rapids, MN 55433

RE: Project Number(s) SL38266016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 30, 2025, 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.

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 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00
St - 0 - 0780 - 144g.45 Subd. 2 (a) (1) - 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 $1,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders 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

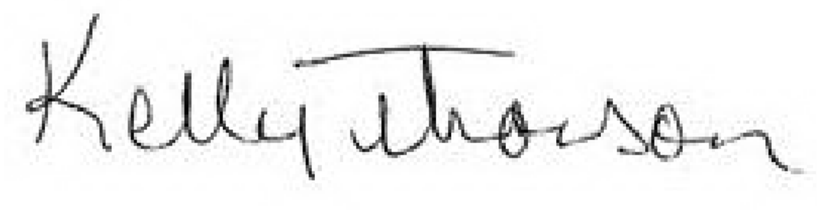
a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

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. 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,



Kelly Thorson, Supervisor
State Evaluation Team
Email: Kelly.Thorson@state.mn.us
Telephone: 320-223-7336 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
	38266	A. BUILDING: _____ B. WING _____	07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIMSOL HOMECARE LLC	2551 115TH AVENUE NW COON RAPIDS, MN 55433

(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: SL38266016-0 On July 28, 2025, through July 30, 2025, 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 four residents; four receiving 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.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470		

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0 470	Continued From page 1 determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the clinical nurse supervisor (CNS) developed and implemented a staffing plan to determine staffing levels to meet the needs of all residents, which included reviewing the staffing plan at least twice per year. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a	0 470		

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0 470	Continued From page 2 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's 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 of the residents). The findings include: The licensee held an assisted living facility license and was licensed for a capacity of five residents, with a census of four residents. During the entrance conference on July 28, 2025, at 10:23 a.m., clinical nurse supervisor/ owner (CNS/O)-A stated the licensee was familiar with current minimum assisted living requirements. On July 28, 2025, at 12:41 p.m., the surveyor reviewed the Facility Staffing Plan dated October 30, 2022, with CNS/O-A. CNS/O-A stated CNS/O-A reviewed the staffing plan but there was no documented evidence of the reviews. CNS/O-A further stated CNS/O-A was aware the staffing plan required review but was not aware the staffing plan needed to be reviewed at minimum twice per year. The surveyor requested to view the staffing plan after October 30, 2022, however, CNS/O-A stated the licensee did not have documentation of a staffing plan after October 30, 2022. The licensee's Staffing Plan policy, undated, indicated critical functions encompassed the essential job duties performed by the agency on a regular basis. The policy did not address an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility.	0 470		

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0 470	Continued From page 3 No further information was provided. TIME PERIOD OF CORRECTION: Seven (7) days	0 470		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage;	0 480		

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0 480	Continued From page 4 (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. 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).	0 480		

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0 480	Continued From page 5 The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated, July 29, 2025, for the specific Minnesota Food Code violations. The FBEIR was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 485 SS=C	144G.41 Subdivision 1.a (a) Minimum requirements; required food services (a) All assisted living facilities must offer to provide or make available at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes. The facility must not require a resident to include and pay for meals in the resident's contract. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not require any resident to include	0 485		

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0 485	Continued From page 6 and pay for meals as a part of their assisted living contract. This had the potential to affect all residents. 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: During the entrance conference on July 28, 2025, at 10:32 a.m., clinical nurse supervisor/owner (CNS/O)-A stated the licensee provided residents three meals per day and the licensee included meal costs in the contracted housing rate. Page two of the licensee's undated Residency Agreement- Assisted Living Contract indicated the cost of a meal plan, if selected, is included in the resident's monthly base fee. Residency Agreement- Assisted Living Contracts lacked an option for residents to opt out of payment for one, two, or three meals a resident would not want. On July 28, 2025, at 2:55 p.m., CNS/O-A stated the licensee stated residents were given the option to decline any or all meals however, the cost of all meals was included in the resident's monthly rent. The Minnesota Department of Health Assisted Living Resources and Frequently Asked Questions (FAQs) website, last updated December 13, 2024, indicated the provider	0 485		

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0 485	Continued From page 7 cannot have a blanket "one size fits all" meal charge. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation interview and record review, the licensee failed to post the required information related to the grievance procedure. This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 550		

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0 550	Continued From page 8 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 the entrance conference on July 28, 2025, at 10:23 a.m., clinical nurse supervisor/ owner (CNS/O)-A stated the licensee was familiar with current minimum assisted living requirements. On July 28, 2025, at 11:04 a.m., the surveyor toured the licensee's facility with CNS/O-A. Surveyor and CNS/O-A observed the posted complaint reporting policy and form. The posting lacked the name and email address for the individual who was responsible for handling resident grievances. On July 28, 2025, at 2:50 p.m., CNS/O-A stated residents' family members were given CNS/O-A's phone number during the move-in process and agreed CNS/O-A's name and email were not on the posting. The licensee's undated Complaint and Investigation Process policy indicated the policy is to provide a mechanism for handling resident/family complaints and/or grievances in an expedient and efficient manner. No further information was provided. TIME PERIOD OF CORRECTION: Twenty-One (21) days	0 550		

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0 680	Continued From page 9	0 680		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. In addition, the licensee failed to ensure the missing resident plan was reviewed quarterly. This had the potential to affect all residents, staff, and visitors of the facility.	0 680		

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0 680	Continued From page 10 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: During the entrance conference on July 28, 2025, at 10:23 a.m., clinical nurse supervisor/ owner (CNS/O)-A stated the licensee was familiar with current minimum assisted living requirements. The licensee's undated EPP lacked the following content and/or policies and procedures to address: - a completed hazards risk assessment; - annual review of the EPP; - a missing resident plan that was reviewed quarterly; - a list of subsistence needs for staff and residents to include food, water, and pharmaceutical supplies; - shelter in place; - tracking system for residents and staff; - address the role of the facility under a waiver declared by the secretary in accordance with section 1135 of the act; and - must conduct exercises to test the EPP at least twice per year, including unannounced staff drills using the EPP. On July 28, 2025, at 3:40 p.m., CNS/O-A stated the annual review of the EPP was missed in 2024 and the missing resident policy was reviewed	0 680		

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0 680	Continued From page 11 during a meeting however the review was not documented. CNS/O-A further stated a kit with supplies to last one day is available for use during an evacuation however the licensee has not created a plan for subsistence needs in the event of a shelter in place. On July 28, 2025, at 4:02 p.m., CNS/O-A stated the licensee had only conducted fire drills. CNS/O-A further stated CNS/O-A was unaware of the requirement for disaster drills to be conducted twice per year. The licensee's undated Hazard Vulnerability Analysis policy indicated the Emergency Disaster Plan (EDP) will be developed based on the documented, facility-based and community-based risk assessment utilizing a proactive all-hazards approach [sic]. The licensee's undated Missing Resident policy did not address how often the policy would be reviewed. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0110, Subp. 4, effective October 2022, licensed assisted living director (LALD) and CNS must review the missing person plan at least quarterly and document any changes to the plan. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0100, sections A and B, effective October 2022, assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.73, or successor requirements. This part references documents, specifications, methods, and standards in "State Operations Manual Appendix Z - Emergency Preparedness for All	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38266	A. BUILDING: _____ B. WING _____	07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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0 680	Continued From page 12 Providers and Certified Supplier Types: Interpretive Guidance," which is incorporated by reference. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with Minnesota State Fire Code in Minnesota Rules chapter 7511. This deficient condition had the ability to affect all staff 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 July 30, 2025, at approximately 12:30 p.m., the surveyor toured the facility with clinical nurse supervisor/owner (CNS/O)-A. The following was	0 775		

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0 775	Continued From page 13 observed. 1. Carbon monoxide alarms were not provided throughout the facility. When carbon monoxide alarms are not tied into the building fire alarm system, carbon monoxide alarms are required to be installed within ten feet of all sleeping rooms. 2. The designated exit at the kitchen/dining room area was blocked. The exit shall free and unobstructed path to the exterior. 3. The designated exit at the kitchen area was blocked at the exterior. The ramp on the exterior terminated at the base of the stairs, and did not allow for a landing at the bottom of the stairs. There shall be a floor or landing at the top and bottom of each stairway. On July 30, 2025, CNS/O-A acknowledged the above listed deficiencies while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not	0 780		

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0 780	Continued From page 14 including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed provide interconnected smoke alarms in required locations. These deficient conditions had the ability to affect all staff 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 July 30, 2025, at approximately 12:30 p.m., the surveyor toured the facility with clinical nurse supervisor/owner (CNS/O)-A. During the tour, the surveyor observed bedroom 1 is equipped with a	0 780		

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0 780	Continued From page 15 visual strobe smoke alarm for the hearing-impaired resident. The smoke alarms were tested for interconnection by the licensee, upon activation the visual strobe smoke alarm was not interconnected as required by state statute. During the facility tour interview on July 30, 2025, CNS/O-A acknowledged the observation while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a	0 800		

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0 800	Continued From page 16 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 July 30, 2025, at approximately 12:30 p.m., the surveyor toured the facility with clinical nurse supervisor/owner (CNS/O)-A. The following was observed. EGRESS WINDOWS: The egress window in bedroom 5 had a broken handle. CNS/O-A could not open the window or close the window with the handle. The window opened and closed freely without the use of the handle. On July 30, 2025, CNS/O-A acknowledged the deficiency while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire	0 810		

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0 810	Continued From page 17 or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training. This had the potential to directly 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	0 810		

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0 810	Continued From page 18 resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On July 30, 2025, clinical nurse supervisor/owner (CNS/O)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP failed to include the following: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The provided FSEP was from a third-party provider and had not been updated to the specific facility. The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include any procedures for assisting residents during	0 810		

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0 810	Continued From page 19 evacuation nor did it include instructions for staff to follow in case of relocation. On July 30, 2025, CNS/O-A stated they understood the areas of their policy that were incomplete and would work on bringing them into compliance. TRAINING: The licensee failed to provide evacuation training to residents at least once per year. CNS/O-A stated the facility provided verbal training to residents, but lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan. The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. CNS/O-A stated that staff training was done in Educare and not on the facilities written FSEP. No other training documentation was provided. On July 30, 2025, CNS/O-A stated they understood the requirements for training residents and staff and would implement a training program that was compliant with statute requirements. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
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,	0 910		

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0 910	Continued From page 20 telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for two of two residents (R3 and R6). This had the potential to affect all four residents who received assisted living services. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on July 28, 2025, at 10:23 a.m., clinical nurse supervisor/ owner (CNS/O)-A stated the licensee was familiar with current minimum assisted living requirements. R3 R3 admitted to the licensee and began receiving assisted living services on May 1, 2022. R3's Resident Contract, version undated, was signed on May 1, 2022.	0 910		

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0 910	Continued From page 21 R3's signed contract lacked the licensee's healthcare facility identification number (HFID). R6 R6 admitted to the licensee and began receiving assisted living services on February 15, 2025. R6's Residency Agreement- Assisted Living Contract, version undated, was signed on June 1, 2025. R6's signed contract lacked the licensee's legal name and HFID. On July 29, 2025, at 9:30 a.m., CNS/O-A stated a new contract was executed since 2023, and one resident signed the new contract. All other residents signed the same former contract version. CNS/O-A further stated both contracts used were obtained from a third-party and CNS/O-A was unaware they were missing required content. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 910		
0 920 SS=C	144G.50 Subd. 2 (c) Contract information (c) The contract must include: (1) a disclosure of the category of assisted living facility license held by the facility and, if the facility is not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license; (2) a description of all the terms and conditions of the contract, including a description of and any	0 920		

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0 920	Continued From page 22 limitations to the housing or assisted living services to be provided for the contracted amount; (3) a delineation of the cost and nature of any other services to be provided for an additional fee; (4) a delineation and description of any additional fees the resident may be required to pay if the resident's condition changes during the term of the contract; (5) a delineation of the grounds under which the resident may be transferred or have housing or services terminated or be subject to an emergency relocation; (6) billing and payment procedures and requirements; and (7) disclosure of the facility's ability to provide specialized diets. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for one of one resident (R6). This had the potential to affect all four residents who received assisted living services. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on July 28, 2025, at 10:23 a.m., clinical nurse supervisor/ owner	0 920		

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0 920	Continued From page 23 (CNS/O)-A stated the licensee was familiar with current minimum assisted living requirements. R6 admitted to the licensee and began receiving assisted living services on February 15, 2025. R6's Residency Agreement- Assisted Living Contract, version undated, was signed on June 1, 2025. R6's signed contract lacked the licensee's disclosure of the category of assisted living facility license held by the facility and disclosure the licensee does not hold an assisted living with dementia care license. On July 29, 2025, at 9:30 a.m., CNS/O-A stated a new contract was executed since 2023, and one resident signed the new contract. All other residents signed the same former contract version. CNS/O-A further stated both contracts used were obtained from a third-party and CNS/O-A was unaware they were missing required content. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 920		
0 930 SS=C	144G.50 Subd. 2 (d-e; 1-4) Contract information (d) The contract must include a description of the facility's complaint resolution process available to residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints. (e) The contract must include a clear and	0 930		

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0 930	Continued From page 24 conspicuous notice of: (1) the right under section 144G.54 to appeal the termination of an assisted living contract; (2) the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer; (3) contact information for the Office of Ombudsman for Long-Term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints; (4) the resident's right to obtain services from an unaffiliated service provider; 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 two of two residents (R3, R6). 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: During the entrance conference on July 28, 2025, at 10:23 a.m., clinical nurse supervisor/ owner (CNS/O)-A stated the licensee was familiar with current minimum assisted living requirements. R3	0 930		

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0 930	Continued From page 25 R3 admitted to the licensee and began receiving assisted living services on May 1, 2022. R3's Resident Contract, version undated, was signed on May 1, 2022. R6 R6 admitted to the licensee and began receiving assisted living services on February 15, 2025. R6's Residency Agreement- Assisted Living Contract, version undated, was signed on June 1, 2025. R3's Resident Contract and R6's Resident Agreement lacked the name and contact information of the person who represented the facility and is designated to handle and resolve complaints. On July 29, 2025, at 9:30 a.m., CNS/O-A stated a new contract was executed since 2023, and one resident signed the new contract. All other residents signed the same former contract version. CNS/O-A further stated both contracts used were obtained from a third-party and CNS/O-A was unaware they were missing required content. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 930		
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	0 940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38266	A. BUILDING: _____ B. WING _____	07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIMSOL HOMECARE LLC	2551 115TH AVENUE NW COON RAPIDS, MN 55433

(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
0 940	Continued From page 26 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 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 contract with the required content for two of two residents (R3 and R6).	0 940		

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0 940	Continued From page 27 This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on July 28, 2025, at 10:23 a.m., clinical nurse supervisor/ owner (CNS/O)-A stated the licensee was familiar with current minimum assisted living requirements. R3 R3 admitted to the licensee and began receiving assisted living services on May 1, 2022. R3's Resident Contract, version undated, was signed on May 1, 2022. R3's Resident Contract lacked the following required content: - whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); - 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; - a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; - a statement that residents may be eligible for assistance with rent through the housing support program;	0 940		

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0 940	Continued From page 28 - 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; and - the contact information to obtain long-term care consulting services under section 256B.0911. R6 R6 admitted to the licensee and began receiving assisted living services on February 15, 2025. R6's Residency Agreement- Assisted Living Contract, version undated, was signed on June 1, 2025. R6's Residency Agreement- Assisted Living Contract lacked the following required content: - whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); - 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; - a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; 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; and - the contact information to obtain long-term care consulting services under section 256B.0911 . On July 29, 2025, at 9:30 a.m., CNS/O-A stated a new contract was executed since 2023, and one resident signed the new contract. All other residents signed the same former contract version. CNS/O-A further stated both contracts	0 940		

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0 940	Continued From page 29 used were obtained from a third-party and CNS/O-A was unaware they were missing required content. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 940		
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 assisted living contract did not include language waiving the facility's liability for health, safety, or personal property of a resident. This had the potential to affect all residents. 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).	0 970		

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0 970	Continued From page 30 The findings include: The licensee's undated Resident Responsibilities-House Rules included the following clauses that a resident would waive the facility's liability for health, safety, or personal property of the resident: -page 1, 9. Report all suspected theft or damage claims to the agency for a thorough investigation. The agency will not be held liable if the resident or their family voluntarily grants employee access or fails to make reasonable efforts to secure items; and -page 1, 10. Understand that the agency will not be held liable for accidental damage to the resident or their family's personal property. On July 29, 2025, at 9:30 a.m., clinical nurse supervisor/owner (CNS/O)-A stated a new contract was executed since 2023, and one resident signed the new contract. All other residents signed the same former contract version. CNS/O-A further stated both contracts used were obtained from a third-party and CNS/O-A was unaware they were missing required content. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member.	01060		

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01060	Continued From page 31 An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by:	01060		

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01060	Continued From page 32 Based on interview and record review, the licensee failed to provide written notice with required content to the resident, legal representative, and designated representative, and failed to provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC) when the resident did not return from the emergency relocation within four days 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), 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: During the entrance conference on July 28, 2025, at 10:23 a.m., clinical nurse supervisor/ owner (CNS/O)-A stated the licensee was familiar with current minimum assisted living requirements. R1's Discharge/Transfer Summary dated June 11, 2025, indicated R1 was admitted to [name of hospital] on May 23, 2025, through his demise on May 29, 2025. R1's record lacked a written notice that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the OOLTC; - if known and applicable, the approximate date or range of dates within which the resident is	01060		

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01060	Continued From page 33 expected to return to the facility, or a statement that a return date is not currently known; and - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. In addition, R1's record lacked notification to the OOLTC that the resident had been relocated and had not returned to the facility within four days. On June 28, 2025, CNS/O-A stated R1 was hospitalized following a medical emergency that occurred outside of the licensee's facility. CNS/O-A further stated the licensee was not aware of the emergency relocation including notification to the OOLTC if the resident had not returned to the facility within four days. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01290 SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12.	01290		

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01290	Continued From page 34 (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure background studies were affiliated with the correct health facility identification (HFID) 38266 for four of 13 employees (unlicensed personnel (ULP)-D, ULP-E, ULP-F, and ULP-G). 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: During the entrance conference on July 28, 2025, at 10:47 a.m., clinical nurse supervisor/ owner (CNS/O)-A stated the licensee aware of the required contents of the employee record. ULP- D was hired on April 2, 2025, to provide direct care services to residents at the assisted living facility. ULP- E was hired on August 1, 2024, to provide direct care services to residents at the assisted living facility.	01290		

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01290	Continued From page 35 ULP- F was hired on May 10, 2025, to provide direct care services to residents at the assisted living facility. ULP- G was hired on February 1, 2024, to provide direct care services to residents at the assisted living facility. On July 28, 2025, at 12:48 p.m., CNS/O-A provided the surveyor NETStudy 2.0 (background study website) rosters for the licensee HFID 38266 and for the licensee's sister-site, HFID 39959. Surveyor reviewed both rosters and determined ULP-D, ULP-E, ULP-F, and ULP-G each had a cleared background study however, they were not affiliated to the HFID for this licensee. On July 28, 2025, at 2:45 p.m., CNS/O-A stated CNS/O-A wasn't aware an employee's background study needed to be affiliated to both locations and believed employees were able to work at either location. The licensee's undated Employee Records policy indicated employee records must include documentation of the background study as required under section 144.057. The licensee's Personnel Records policy dated February 19, 2024, indicated all personnel records would contain documentation of a completed background study. The licensee's undated Background Studies policy indicated all employees of the facility are required to have a background study completed. The policy did not address background study affiliation.	01290		

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01290	Continued From page 36 No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure direct supervision of staff performing delegated tasks was provided within 30 calendar days after the	01440		

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01440	Continued From page 37 date on which the individual had begun working for the licensee for two of two employees (unlicensed personnel (ULP)-B, ULP-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: ULP-B ULP-B was hired April 3, 2023, to provide assisted living services. On July 29, 2025, at 8:05 a.m., the surveyor observed ULP-B provide scheduled morning medication administration to R5. ULP-C ULP-C was hired June 10, 2023, to provide assisted living services. On July 29, 2025, at 8:20 a.m., the surveyor observed ULP-C assist R3 with scheduled repositioning and catheter care services. ULP-B and ULP-C's employee record lacked documentation of an appropriate licensed health professional or registered nurse (RN) supervising ULP-E performing a delegated task within 30 days of providing a delegated task. On July 29, 2025, at 12:23 p.m., clinical nurse supervisor/owner (CNS/O)-A stated no ULP	01440		

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01440	Continued From page 38 employee records would contain a 30-day supervision of a delegated task or treatment. CNS/O-A further stated the licensee was not aware a 30-day supervision of a delegated task was required. The licensee's undated Supervision of Unlicensed Personnel policy indicated the direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs delegated tasks for residents, and thereafter as needed based on performance. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		
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	01530		

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01530	Continued From page 39 eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure direct care staff received the required two hours of initial training on mental illness and de-escalation topics for two of two employees (unlicensed personnel (ULP)-B and ULP-C). This had the potential to affect all residents and staff. 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	01530		

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	38266	A. BUILDING: _____ B. WING _____	07/30/2025

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BIMSOL HOMECARE LLC	2551 115TH AVENUE NW COON RAPIDS, MN 55433

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01530	Continued From page 40 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: ULP-B ULP-B was hired April 3, 2023, to provide assisted living services. On July 29, 2025, at 8:05 a.m., the surveyor observed ULP-B provide scheduled morning medication administration to R5. ULP-C ULP-C was hired June 10, 2023, to provide assisted living services. On July 29, 2025, at 8:20 a.m., the surveyor observed ULP-C assist R3 with scheduled repositioning and catheter care services. ULP-B and ULP-C's records lacked documentation the required two hours of initial training on mental illness and de-escalation topics were completed which became effective July 1, 2025. On July 29, 2025, at 12:20 p.m., clinical nurse supervisor/owner (CNS/O)-A stated CNS/O depended on Educare (web-based training program) to assign required trainings as required by the Minnesota Department of Health (MDH) and none of the staff currently employed at [licensee] had been issued the required courses. The licensee's undated Qualifications, Training and Competency policy indicated the licensee shall provide training to staff providing and	01530		

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01530	Continued From page 41 supervising assisted living services at the time of hire, and as needed to meet state guideline and quality standards. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed	01620		

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01620	Continued From page 42 practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the RN conducted assessments with the uniform assessment tool that included all required content for one of one resident (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	01620		

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01620	Continued From page 43 The findings include: During the entrance conference on July 28, 2025, at 10:33 a.m., clinical nurse supervisor/owner (CNS/O)-A stated upon admission of a resident, the licensee completed a comprehensive assessment on admission, 14 days after admission, and then at least every 90 days unless the resident had a change of condition. R3's diagnoses included spinal cord injury, neurogenic bladder (bladder muscles and nerves don't function properly), and chronic pain. R3's service plan dated May 10, 2025, indicated R3 received assistance with bathing, grooming, dressing, incontinence care, housekeeping and behavior management. On July 29, 2025, at 8:20 a.m., the surveyor observed unlicensed personnel (ULP)-C assist R3 with scheduled repositioning and catheter care services. R3's record contained comprehensive assessments completed on December 4, 2024, February 6, 2025, and May 3, 2025. R3's comprehensive assessments lacked assessment of the resident's sleep and spiritual preferences. On July 29, 2025, at 1:14 p.m., CNS/O-A stated the facility used an assessment template created by RTasks (electronic charting software) for all resident assessment. CNS/O-A further stated CNS/O-A was unaware of the uniform assessment tool (UAT) and believed the assessment used contained all required information. The licensee's undated Nursing Assessment and	01620		

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01620	Continued From page 44 Reassessment of Residents policy indicated comprehensive assessments included requirements outlined in Minnesota rules including resident preference of sleep schedule and spiritual preferences. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0140, Subp. 2, effective October 2022, a nursing assessment or reassessment under Minnesota Statutes, section 144G.70, subdivision 2, paragraphs (b) and (c), must be conducted on a prospective resident or resident receiving any of the assisted living services identified in Minnesota Statutes, section 144G.08, subdivision 9, clauses (6) to (12). B. The nursing assessment or reassessment under item A must: (1) address part 4659.0150, subpart 2, items A to N; (2) be conducted in person unless an exception under Minnesota Statues, section 144G.70, subdivision 2, paragraph (b), applies; (3) be conducted using a uniform assessment tool that complies with part 4659.0150; and (4) be in writing, dated, and signed by the registered nurse who conducted the assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access.	01880		

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01880	Continued From page 45 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of one refrigerator storing medications maintained an acceptable temperature. 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: During the entrance conference on July 28, 2025, at 10:31 a.m., clinical nurse supervisor/owner (CNS/O)-A stated the licensee provided medication management services to residents at the facility. On July 28, 2025, at 10:33 a.m., the surveyor observed licensee's medication refrigerator in the secure nursing office. On July 28, 2025, at 2:53 p.m., CNS/O-A stated the medication refrigerator's current temperature was 44 degrees Fahrenheit (F). CNS/O-A further stated the medication refrigerator temperature was checked every morning by CNS/O-A however, if CNS/O-A was not there it was unknown if the temperature of the medication refrigerator stays within range because the refrigerator temperature was not checked, and a temperature log had not been created to record	01880		

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01880	Continued From page 46 daily temperatures. The medication refrigerator contained one unopened Ozempic 2 milligram (mg)/ milliliter (mL). The manufacturer's instructions for Ozempic dated October 2022, indicated to store unopened Ozempic pens in the refrigerator at 36 to 46 degrees F. Do not allow Ozempic to freeze. The licensee's undated Individualized Medication Management Plan and Record policy indicated a resident's medication would be stored consistent with the manufacturer's directions. 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 medication carts. 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	01890		

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01890	Continued From page 47 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 the entrance conference on July 28, 2025, at 10:31 a.m., clinical nurse supervisor/owner (CNS/O)-A stated the licensee provided medication management services to residents at the facility. On July 29, 2025, at 9:12 a.m., the surveyor reviewed the locked medication cart with CNS/O-A and observed the following expired medications: -R4's open box with unknown quantity of chloraseptic lozenges, expired August 2023; -R4's open bottle of milk of magnesia, partial bottle, expired September 2023; -R4's Guaifenesin 200 mg, partial bottle, expired October 2023; -R4's methocarbamol 500 mg, quantity 13 tablets, expired January 8, 2025; -R5's albuterol 90 micrograms (mcg)/actuation (act), quantity one inhaler, expired October 2021; -R5's nystatin cream 100,000, quantity one open tube, expired October 2023; and -R5's albuterol 90 mcg/act, quantity one inhaler, expired September 2024. On July 29, 2025, at 9:29 a.m., CNS/O-A stated facility nurses audited resident medications in the medication cart for expiration dates "when they have time." CNS/O-A further stated only active medications were reviewed for expiration dates. The licensee's undated Medication Disposition or	01890		

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01890	Continued From page 48 Disposal policy did not address expired medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident's record all required content for disposition of the medications for one of one resident (R1) upon discharge.	01910		

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01910	Continued From page 49 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: During the entrance conference on July 28, 2025, at 10:31 a.m., clinical nurse supervisor/owner (CNS/O)-A stated the licensee provided medication management services to residents at the facility. The licensee's Discharged or Deceased Resident Roster: State Evaluations dated July 28, 2025, indicated R1 was admitted to the facility on February 17, 2025, and discharged on June 1, 2025. R1's Medication Disposition- Resident dated June 1, 2025, through June 27, 2025, lacked prescription numbers for all medications listed. On June 28, 2025, at 1:50 p.m., CNS/O-A stated prescription numbers were not included on medication disposition forms for all affected residents because CNS/O-A was unaware of the requirement. The licensee's undated Medication Disposition or Disposal policy indicated medication disposition record will include the date, quantity, name of the drug, prescription number, and signatures of the staff involved.	01910		

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01910	Continued From page 50 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
02290 SS=F	144G.91 Subd. 2 Legislative intent The rights established under this section for the benefit of residents do not limit any other rights available under law. No facility may request or require that any resident waive any of these rights at any time for any reason, including as a condition of admission to the facility. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee limited the rights of residents when the licensee required all residents who resided in the facility to follow certain house rules. 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) 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: R3 R3 admitted to the licensee and began receiving assisted living services on May 1, 2022. R3's Resident Contract, version undated, was signed on May 1, 2022.	02290		

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02290	Continued From page 51 R6 R6 admitted to the licensee and began receiving assisted living services on February 15, 2025. R6's Residency Agreement- Assisted Living Contract, version undated, was signed on June 1, 2025. The house rules document indicated the following: - Smoking and Alcohol: . . . Additionally, alcoholic drinks are not allowed anywhere within the premises of the agency; and - Curfew and Sign-In/Sign-Out: Residents are expected to be at home by 10 pm (sic). It is important to inform the staff/manager of your whereabouts for safety purposes. When leaving the premises, you must sign out with a responsible person and sign back in upon your return. On July 29, 2025, at 9:32 a.m., clinical nurse supervisor/owner (CNS/O)-A stated CNS/O-A issued the house rules document to all residents when the contract was signed. In addition, CNS/O-A was unaware the restrictions were not allowed. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02290		

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

BIMSOL HOMECARE LLC
2551 115th Avenue NW
Coon Rapids, MN 55433
Anoka County
Parcel:

Phone:

License Info

License: HFID 38266

Risk:
License:
Expires on:
CFPM: Olabimpe Aladedunye
CFPM #: FM108341; Exp: 11/7/2027

Inspection Info

Report Number: F1004251089
Inspection Type: Full - Single
Date: 7/29/2025 Time: 11:20:00 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 2
Total Priority 2 Orders: 2
Total Priority 3 Orders: 0
Delivery: Emailed

! **New Order: 2-200 Employee Health**
2-201.11C *Priority Level: Priority 1 CFP#: 3*
MN Rule 4626.0040C The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority at the specific request of the regulatory authority.
COMMENT: **NO EMPLOYEE ILLNESS LOG USED BY ESTABLISHMENT. ENSURE PERSON IN CHARGE IS RECORDING ALL EMPLOYEE REPORTS OF VOMITING, DIARRHEA, OR OTHER SYMPTOMS ASSOCIATED WITH ILLNESSES TRANSMISSIBLE THROUGH FOOD. *ILLNESS LOG PROVIDED WITH REPORT**
Comply By: 7/29/2025 Originally Issued On: 7/29/2025

! **New Order: 3-300B Protection from Contamination: cross-contamination, eggs**
3-302.11A(1) *Priority Level: Priority 1 CFP#: 15*
MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.
COMMENT: **RAW SHELL EGGS FOUND STORED OVER PRODUCE/READY-TO-EAT ITEMS IN THE KITCHEN REFRIGERATOR. ENSURE ALL RAW ANIMAL FOODS ARE STORED BELOW AND SEPARATE FROM READY-TO-EAT ITEMS.**
Comply By: 7/29/2025 Originally Issued On: 7/29/2025

New Order: 4-500 Equipment Maintenance and Operation
4-502.11B *Priority Level: Priority 2 CFP#: 36*
MN Rule 4626.0820B Calibrate food temperature measuring devices in accordance with manufacturer's specifications as often as necessary to ensure accuracy.
COMMENT: **PERSON IN CHARGE STATED FOOD THERMOMETERS ARE NOT CALIBRATED/CHECKED FOR ACCURACY. ENSURE ALL TEMPERATURE MEASURING DEVICES USED FOR FOOD ARE CALIBRATED/VERIFIED TO BE ACCURATE ROUTINELY. *INFORMATION PROVIDED WITH REPORT.**
Comply By: 7/29/2025 Originally Issued On: 7/29/2025

New Order: 5-200C Plumbing: Maintenance, fixture location
5-205.11AB *Priority Level: Priority 2 CFP#: 10*
MN Rule 4626.1110AB The handwashing sink must be accessible at all times for employee use, and must be used only for handwashing.
COMMENT: **DESIGNATED HANDWASHING SIDE OF THE SINK HAD DISHES IN THE BASIN. ENSURE THE HANDWASHING SIDE OF THE SINK IS ONLY USED FOR HANDWASHING PURPOSES AND FULLY ACCESSIBLE AT ALL TIMES. *DISHES REMOVED DURING INSPECTION.**
Comply By: 7/29/2025 Originally Issued On: 7/29/2025

Food & Beverage General Comment

INSPECTION WAS CONDUCTED BY MOLLY DOUGHERTY (FPLS) IN CONJUNCTION WITH A HEALTH REGULATIONS DIVISION (HRD) SURVEY CONDUCTED BY ALLISON SKILLINGSTAD.

DISCUSSED:
-EMPLOYEE ILLNESS POLICY AND LOG
-HANDWASHING
-SANITIZER USE
-CLEANING/SANITIZING FOOD CONTACT SURFACES AND UTENSILS
-HIGH TEMPERATURE SANITIZING DISH MACHINE TEMPERATURE VERIFICATION
-DATE MARKING PROCEDURES
-THERMOMETER USE AND CALIBRATION
-SERVING A HIGHLY SUSCEPTIBLE POPULATION (NO RAW/UNDERCOOKED ANIMAL FOODS, NO UNPASTEURIZED JUICE, MILK, ETC)
-VOMIT/FECAL INCIDENT CLEAN UP PROCEDURES
-FOOD SOURCE
-FOOD SERVICE PROCEDURES (SAME DAY SERVICE)
-PEST CONTROL
-PHYSICAL FACILITIES AND MAINTENANCE

*REPORT WAS DISCUSSED WITH THE OPERATOR ON SITE, OLABIMPE, AND THE NURSE EVALUATOR, ALLISON

*FLOORS ARE LINOLEUM, WALLS AND CEILING ARE SMOOTH PAINTED DRYWALL. COUNTERTOPS ARE LAMINATE AND CABINETS ARE VARNISHED WOOD WITH HALLOW BASE. ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT SUCH A TIME THEY ARE FOUND TO BE A CONCERN OR RISK OF CONTAMINATION, THEY WILL BE ORDERED TO BE REPLACED AND BROUGHT UP TO CODE.

*KITCHEN HAS A 2-BASIN SINK. ONE BASIN IS DESIGNATED AS THE HANDWASHING SINK. THIS BASIN MAY ONLY BE USED FOR HANDWASHING PURPOSES.

*IF ANY RESIDENT COMPLAINS OF ILLNESS, CONTACT THE MINNESOTA DEPARTMENT OF HEALTH AND PROVIDE THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER TO THE RESIDENT. THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER IS 1-877-366-3455.

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 F1004251089 from 7/29/2025

Molly Dougherty

Olabimpe Aladedunye
Operator

Molly Dougherty,
Public Health Sanitarian 3
651-201-3978

molly.dougherty@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

BIMSOL HOMECARE LLC
Coon Rapids
County/Group: Anoka County

Inspection Info

Report Number: F1004251089
Inspection Type: Full
Date: 7/29/2025
Time: 11:20:00 AM

Equipment Temperature: Product/Item/Unit: ambient temperature**; Temperature Process:** Cold-Holding
Location: Refrigerator at <40 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: milk**; Temperature Process:** Cold-Holding
Location: Refrigerator at 40 Degrees F.
Comment:
Violation Issued?: No

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
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Sanitizer Observations/Recordings

Establishment Info

BIMSOL HOMECARE LLC
Coon Rapids
County/Group: Anoka County

Inspection Info

Report Number: F1004251089
Inspection Type: Full
Date: 7/29/2025
Time: 11:20:00 AM

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Kitchen **Greater Than** 160 Degrees F.
Comment:
Violation Issued?: No